



Best practice in comprehensive postabortion care

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Introduction to the RCOG Leading Safe Choices Best Practice Papers

Healthcare professionals providing reproductive health care have an obligation to ensure that the women and men they treat benefit from the latest technology and evidence-based clinical practices. In support of these, and in line with the Royal College of Obstetricians and Gynaecologists' mandate to improve health care for women everywhere, by setting standards for clinical practice, this Best Practice Paper sets out the essential elements of a high-quality comprehensive postabortion care service, including induced abortion when medically indicated, and postabortion contraception.

The best practices described are drawn from current evidence-based guidance produced by organisations such as the World Health Organization (WHO), the Royal College of Obstetricians and Gynaecologists and Ipas.

So as to be readable and useful to staff providing health care on a daily basis, the paper has been deliberately kept short and succinct. To this end, the primary evidence for the recommendations and the strength of that evidence have been omitted but can be found in the original source documents. Recently published evidence has been assessed to determine whether any of the recommendations from existing guidelines should be amended.

Recognising that different health providers may be involved at different stages of the management of women undergoing care, this paper has been divided into sections appropriate for these stages.

The use of the clinical recommendations should be individualised to each woman, with emphasis on her clinical needs.

While the paper may be used for reference in any country, varying legal, regulatory, policy and service-delivery contexts may require some recommendations to be adapted to the local context. Whatever adaptations are made, best practice should always be maintained and in this respect the RCOG is aware that some of the recommendations made are aspirational; these are included in order to assist policy makers in moving their services forward. This paper has been written for use in Tanzania, where abortion is only legal in order to save the life of the mother.

For support on adapting the document while still maintaining best practice, please write to leadingsafechoices@rcog.org.uk.

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The Leading Safe Choices initiative

Globally, 222 million women would like to prevent or delay pregnancy but have no access to contraception. Meeting this need would allow women to control their own fertility and reduce maternal deaths by one-third, with lasting benefits for their families and communities.

Thanks to a three year grant, an important new initiative called Leading Safe Choices offers the RCOG a unique opportunity to address this unmet need. Leading Safe Choices will initially pilot in Tanzania and South Africa and focus on postpartum family planning (PPFP) in both countries, and on comprehensive abortion care in South Africa and comprehensive postabortion care in Tanzania.

The initiative will take an integrated systems approach, working within existing health structures and with professionals currently working in women's health in these two countries. The pilot phase will focus on selected high-volume maternity hospitals and midwifery units, increasing skills and improving quality in PPFP and comprehensive abortion and postabortion care.

The programme has three broad objectives:

- 1 developing RCOG *Best Practice Papers* on PPFP and comprehensive abortion care in South Africa and on comprehensive postabortion care in Tanzania
- 2 training healthcare providers and supporting the delivery of high-quality PPFP and comprehensive abortion care in South Africa and comprehensive postabortion care in Tanzania
- 3 establishing a formal accreditation and certification process to:
 - recognise competence
 - raise standing within professions
 - increase the uptake and quality of service provision.

The long-term vision is to expand the Initiative across South Africa and Tanzania and to other countries, following on from this pilot phase.

Introduction

Each year, 22 million unsafe abortions are estimated to take place, resulting in approximately 47 000 deaths. Around 5 million women suffer injury as a result of complications due to unsafe abortion, often leading to chronic disability. Safe postabortion care should be available and accessible for all women. Comprehensive postabortion care aims to reduce deaths and injury from either incomplete or unsafe abortion by: evacuating the uterus; treating infection; addressing physical, psychological and family planning needs; and referring to other sexual health services as appropriate.

As with many other medical procedures, adherence to best practice standards should help to ensure that the most effective and the safest services are delivered. This paper is therefore designed to be used on a daily basis by healthcare workers responsible for delivering postabortion care services including postabortion contraception.

All aspects of postabortion care should be delivered in a manner that respects women as decision makers. Women should be provided with information and support in a sensitive manner.

Management of incomplete abortion

For women with spontaneous abortion or those whose abortion was performed unsafely, post-abortion care can reduce the morbidity and mortality associated with complications. Management of incomplete abortion entails evacuation of the uterus either by surgery or by medical means. The characteristics of medical and surgical management of incomplete abortion and of abortion where medically indicated are shown in Table 1.

For women who wish to avoid another pregnancy, contraception should be discussed and a method provided. Women experiencing spontaneous abortion and wishing to get pregnant again are usually advised to wait until after at least one normal menstrual period.

Assessment

Incomplete abortion should be suspected when any woman of reproductive age presents with vaginal bleeding and/or abdominal pain after one or more missed menstrual period.

Unsafe abortion

Indications that an abortion has been attempted by unsafe methods include the presence of:

- vaginal laceration
- cervical injury
- uterine enlargement equivalent to a pregnancy of more than 12 weeks of gestation
- products of conception visible at the cervix.

Infection

It is vital to identify women who may have ongoing infection and to manage this urgently. Infection is much more likely, and much more likely to be severe, if the abortion has been unsafe. Clinical features suggestive of infection include:

- temperature above 37.5 °C
- localised or general abdominal tenderness, guarding and rebound
- foul odour or pus visible in the cervical os
- uterine tenderness.

Features suggestive of sepsis and indicating the need for emergency action include:

- hypotension
- tachycardia
- increased respiratory rate.

Management

The management of an incomplete abortion will depend on the woman's condition, whether infection is present, the gestation of the pregnancy *and* on the skills of available personnel and the facilities and equipment available. When uterine evacuation is an emergency (the woman is shocked, bleeding heavily or has severe infection), if there are personnel available who have the skills to undertake manual vacuum aspiration (MVA) (and who do the procedure often enough to maintain these skills) *and* if the appropriate equipment is available then undertaking MVA may be a better option than using misoprostol because the uterus will be emptied more quickly. If there is no provider skilled at MVA then it will be safer to use misoprostol to empty the uterus. The dose of misoprostol depends on the gestation and on the route of administration (oral, buccal, vaginal, etc). If a woman is bleeding heavily then misoprostol may be less well absorbed if given vaginally than, for example, buccally.

If there is no suspicion of infection and uterine size is less than 14 weeks

- uterine evacuation with vacuum aspiration:
 - antibiotic prophylaxis should be given before surgical evacuation – 200 mg doxycycline within 2 hours before the procedure (with or without 200 mg doxycycline after the procedure) or a single dose of 500 mg azithromycin within 2 hours before the procedure (NB. If antibiotics are not available, the procedure should not be delayed.)

OR

- misoprostol 600 micrograms orally or 400 micrograms sublingually.

If there is no suspicion of infection and uterine size is 14 weeks or larger

- evacuation using vacuum aspiration and blunt forceps if necessary (provided that the clinician has been trained to use them):
 - antibiotic prophylaxis should be given before surgical evacuation – 200 mg doxycycline within 2 hours before the procedure (with or without 200 mg doxycycline after the procedure) or a single dose of 500 mg azithromycin within 2 hours before the procedure (NB. If antibiotics are not available, the procedure should not be delayed.)

OR

- misoprostol:
 - 14–28 weeks: 200 micrograms administered vaginally, sublingually or buccally at least 6-hourly (maximum four doses)
 - 28+ weeks: 25 micrograms vaginally 6-hourly or 25 micrograms orally 2-hourly
 - 14+ weeks if the woman has had a previous caesarean section: 25 micrograms vaginally 6-hourly or 25 micrograms orally 2-hourly.

If infection is present the uterus should be evacuated urgently

- start broad-spectrum antibiotics orally immediately if infection is mild but intravenously if infection is moderate or severe
- transfer to a unit with the facilities for undertaking surgical evacuation if it cannot be done in the facility to which the woman presents

- if the woman is in septic shock, start IV fluids (normal saline or Hartmann's). Transfer to a specialist unit for surgical uterine evacuation. Administer broad-spectrum antibiotics (such as a combination of ampicillin 0.5–1 g 6-hourly, metronidazole 500 mg 8-hourly and gentamicin 120 mg daily) intravenously prior to transfer if available.

If the skills necessary for urgent surgical uterine evacuation are not available, misoprostol can be used:

- <14 weeks: misoprostol 600 micrograms orally or 400 micrograms sublingually
- 14–28 weeks: At least 200 micrograms administered vaginally, sublingually or buccally at least 6-hourly
- 28+ weeks: 25 micrograms vaginally 6-hourly or 25 micrograms orally 2-hourly.

Information to provide after the abortion

Before leaving the facility, women should receive instructions about how to care for themselves after they go home, including:

- how much bleeding to expect
- how to recognise potential complications
- how and where to seek help if required
- women who want to try to conceive again are usually advised to wait until after having at least one normal menstrual period, longer if chronic health problems (e.g. anaemia) require treatment.

Contraception

Before they leave the healthcare facility, all women should receive contraceptive information and, if desired, the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided.

Women should be advised of the greater effectiveness of long-acting reversible methods of contraception (LARC: implants and intrauterine devices (IUDs)) and, unless they have a clear preference for another effective method (such as pills or injectables), encouraged to choose an IUD or an implant.

IUD insertion or female sterilisation should be delayed until the woman's health is restored and any infection is resolved. Interim contraception should be provided using the most effective acceptable method until an IUD can be inserted or sterilisation performed.

Anti-D IgG

If available, anti-D IgG should be given, by injection into the deltoid muscle, to all RhD-negative women within 72 hours following abortion occurring after 12 weeks of gestation.

Medically indicated abortion

Abortion is legal in Tanzania if continuation of the pregnancy risks the life of the mother. This decision is usually made by an obstetrician and gynaecologist but all healthcare workers who provide antenatal care should be aware of the circumstances in which induced abortion may be medically indicated in order to save a mother's life. Healthcare workers at all levels should know where to refer pregnant women in whom abortion may be medically indicated and should be aware of the need to refer rapidly.

If abortion is medically indicated, it should be done safely. As with many other medical procedures, adherence to best practice standards should ensure the most effective and the safest services. Women should be provided with information and support in a sensitive manner.

Information for women in whom abortion is medically indicated

All women in whom abortion is medically indicated should be informed about their pregnancy options and the following information should be provided:

- the choice of abortion method available (if appropriate) and the advantages of each (see Table 1)
- what will be done during and after the abortion
- symptoms likely to be experienced both during and following the abortion (e.g. menstrual-like cramps, pain and bleeding)
- the range of emotions commonly experienced after having an abortion
- how long the abortion is likely to take
- what pain management will be made available
- the risks and complications associated with the abortion method
- follow-up care, including contraceptive advice and provision
- other services that are available, such as sexually transmitted infection (STI) testing and support for women experiencing sexual coercion or domestic violence
- the care that is required for the pregnancy-related condition that necessitated the abortion
- whether or not it is advisable for her to get pregnant again in the future and, if so, when
- follow-up care including contraceptive advice and provision – this is particularly important if further pregnancies are contraindicated.

Table 1 Characteristics of abortion procedures and medical and surgical management of incomplete abortion; adapted from WHO (2014) *Clinical Practice Handbook for Safe Abortion*

Medical management	Surgical management
<ul style="list-style-type: none"> ● has a higher risk of incomplete or failed abortion ● avoids surgery ● mimics miscarriage ● controlled by the woman ● takes time (hours to days) to complete abortion, and the timing may not be predictable ● women experience bleeding and cramping, and potentially some other side effects (nausea, vomiting) ● products of conception may be passed at home ● may require more clinic visits than surgical management <p><i>May be preferable in the following situations:</i></p> <ul style="list-style-type: none"> ● for severely obese women ● if the woman has uterine malformations or fibroids, or has had previous cervical surgery ● if the woman wants to avoid surgical intervention ● if a pelvic examination is not feasible or is unwanted 	<ul style="list-style-type: none"> ● quick procedure ● an intrauterine pregnancy is verified by evaluation of aspirated products of conception and a molar pregnancy may be seen ● takes place in a healthcare facility ● sterilisation of the woman or placement of an intrauterine device (IUD) may be performed at the same time as the procedure ● requires instrumentation of the uterus ● small risk of uterine or cervical injury ● timing of abortion is controlled by the facility and healthcare provider <p><i>May be necessary in the following situation:</i></p> <ul style="list-style-type: none"> ● if there are contraindications to medical management of incomplete abortion or to medical abortion

Information about the side effects of abortion should emphasise the overall safety of the procedure and should be discussed in a way that women can understand. The information should be given in a non-judgemental and supportive way.

The consultation should include the following information:

- 1 That abortion is a safe procedure for which major complications and mortality are rare at all gestations.
- 2 For women in whom abortion is medically indicated, the earlier in pregnancy an abortion is undertaken, the safer it is likely to be.
- 3 That surgical and medical methods of abortion carry a small risk of failure to end the pregnancy (1 or 2 per 100 procedures).
- 4 That there is a small risk (less than 2 in 100 for surgical abortion, and 5 in 100 for medical abortion using mifepristone and misoprostol and around 15 in 100 using misoprostol alone) of the need for further intervention to complete the procedure, i.e. surgical intervention following medical abortion or re-evacuation following surgical abortion.
- 5 That the following complications may occur:
 - severe bleeding requiring transfusion – the risk is lower for first-trimester abortions (less than 1 in 1000), rising to around 4 in 1000 at gestations beyond 20 weeks
 - uterine rupture in association with second-trimester medical abortion at late gestations – the risk is less than 1 in 1000.

For surgical abortions only:

- cervical trauma – the risk of damage is no greater than 1 in 100 and is lower for first-trimester abortions; trauma is less likely if cervical preparation is undertaken in line with best practice
 - uterine perforation – the risk is in the order of 1–4 in 1000 and is lower for first-trimester abortions.
- 6 That should one of these complications occur, further treatment (e.g. blood transfusion, laparoscopy, laparotomy or hysterectomy) may be required.
 - 7 That infection of varying degrees of severity is unlikely, but may occur after medical or surgical abortion and is usually caused by pre-existing infection.

There are a number of myths about the consequences of abortion. If she expresses concern, the woman can be reassured that there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia, infertility, risk of breast cancer or psychological problems.

Women for whom abortion is medically indicated may wish to get pregnant again as soon as possible. They are usually advised to wait until after at least one normal menstrual period but women with chronic medical conditions that require treatment (e.g. anaemia) or women who undergo induced abortion at late gestation should wait longer. There may be some women for whom another pregnancy would be an unacceptable risk to health.

Assessing women for medically indicated abortion

If abortion is medically indicated to save a mother's life, it may be an emergency as her condition is likely to worsen the longer that pregnancy continues. **It is important to make sure that gestation is correctly assessed and that any ongoing infection is excluded or properly managed.**

Blood tests

Pre-abortion assessment may include determination of Rhesus blood status if testing is available.

Where clinically indicated, pre-abortion assessment may also include measurement of haemoglobin concentration.

Determining gestational age

It is not necessary to determine the exact gestational age but rather to make sure that the gestation falls within the range of eligibility for a particular method of inducing abortion. The date of onset of the last menstrual period, bimanual pelvic examination, abdominal examination and recognition of symptoms of pregnancy are usually adequate after a positive pregnancy test. Table 2 shows gestation in both weeks and days of amenorrhoea.

Table 2 Weeks of gestation in terms of days since the last menstrual period (LMP); reproduced from RCOG (2011) *The Care of Women Requesting Induced Abortion*, Evidence-based Clinical Guideline Number 7

Completed weeks	0	1	2	3	4	5	6	7	8	9	10	11	12
Days since LMP	0–6	7–13	14–20	21–27	28–34	35–41	42–48	49–55	56–62	63–69	70–76	77–83	84–90
Completed weeks	13	14	15	16	17	18	19	20	21	22	23	24	
Days since LMP	91–97	98–104	105–111	112–118	119–125	126–132	133–139	140–146	147–153	154–160	161–167	168–174	

Routine pre-abortion ultrasound scanning is unnecessary but, if available, may be useful if there are concerns about complications, e.g. ectopic pregnancy.

STI screening

It is best practice to undertake a risk assessment for STIs for all women (e.g. HIV, chlamydia, gonorrhoea, syphilis), and to screen for them if appropriate and available but this should be done without delaying the abortion.

The partners of women who test positive for STIs should be informed and advised about treatment.

Ideally, a system for partner notification and follow-up or referral should be in place.

Services should make available information about the prevention of STIs, and offer condoms for STI prevention to all women undergoing abortion.

Prevention of infective complications

Routine use of antibiotics at the time of surgical abortion is best practice as it reduces the risk of infection after the abortion. However, abortion should not be delayed if antibiotics are not available.

The following regimens are recommended for perisurgical abortion antibiotic **prophylaxis**:

- 200 mg doxycycline within 2 hours before the procedure

OR

- 500 mg azithromycin within 2 hours before the procedure.

Contraception

Effective methods of contraception should be discussed with women at the initial assessment and a plan agreed, and documented, for contraception after the abortion. Before they leave the healthcare facility, all women should receive the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided.

Women should be advised of the greater effectiveness of implants and IUDs (long-acting reversible (LARC) methods)) and encouraged to choose them unless they have a clear preference for another effective method. Immediately after surgical abortion is an optimal time for insertion of an IUD (and is safe after both first- and second-trimester surgical abortions). Contraceptive implants can be provided at any time once the abortion procedure has started.

Providing abortion when medically indicated

The most appropriate abortion methods/regimens (surgical or medical) should be determined and discussed with the woman (see Table 1).

Dilatation and sharp curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods.

For pregnancies of less than 14 weeks of gestation

Surgical abortion

Either manual or electric vacuum aspiration:

- There is no lower limit of gestation for surgical abortion.
- It is best practice to inspect aspirated tissue at all gestations to confirm complete evacuation; this is essential following vacuum aspiration before 7 weeks of gestation.
- During vacuum aspiration, the uterus should be emptied using the suction cannula and forceps (if required) only. The procedure should **not** be routinely completed by sharp curettage.
- Use of medications containing either oxytocin or ergometrine are **not** recommended for prophylaxis to prevent excessive bleeding either at the time of vacuum aspiration or afterwards.
- Sharp curettage should not be performed.

OR

Medical abortion

- If mifepristone is available, it is best practice to use it in combination with misoprostol as it shortens the induction–abortion interval, reduces side effects and decreases the rate of ongoing pregnancy; mifepristone 200 mg should be administered orally 24–48 hours before misoprostol.
- Misoprostol 800 micrograms given by the vaginal, buccal or sublingual route, followed by misoprostol 400 micrograms every 3 hours until abortion occurs.

For pregnancies of 14 weeks of gestation or more

Surgical abortion

Surgical abortion can be performed by trained providers using:

- vacuum aspiration using large bore cannulae
- dilatation and evacuation (D&E).

OR

Medical abortion

- misoprostol 800 micrograms followed by misoprostol 400 micrograms every 3 hours until abortion occurs.

Cervical preparation before surgical abortion

Cervical preparation should be used for all women with a pregnancy over 14 weeks. Suitable preparations include:

- osmotic dilators 12–24 hours before the procedure

OR

- misoprostol 400 micrograms vaginally, sublingually or buccally 3 hours before the procedure.

Cervical preparation may be considered for women before 14 weeks if there is a high risk for cervical injury or uterine perforation. The following regimen is recommended:

- misoprostol 400 micrograms administered vaginally or buccally 3 hours before the procedure or sublingually 2 hours before the procedure.

Medication for pain management

For both medical and surgical abortions, analgesia (pain relief) should **always** be offered and provided without delay, if requested.

- In most cases, analgesics (e.g. nonsteroidal anti-inflammatory drugs (NSAIDs)), local anaesthesia and/or conscious sedation supplemented by verbal reassurance are sufficient.
- The need for pain management increases with gestational age and narcotic analgesia may be required.
- Prophylactic NSAIDs may reduce the need for narcotic analgesia during MVA.
- Prophylactic paracetamol (oral or rectal) is ineffective in reducing pain during both surgical and medical abortion.

Local anaesthesia, such as lidocaine, will alleviate discomfort from mechanical cervical dilatation and uterine evacuation during surgical abortion and should be routinely offered if available.

General anaesthesia is not recommended for routine abortion procedures, as it has been associated with higher rates of complications than analgesia and local anaesthesia.

Contraceptive provision

If a woman has chosen a contraceptive method that can be provided as part of or during the abortion procedure (e.g. IUD insertion once vacuum aspiration is completed), it is important to

be sure that this has been done. IUDs can be inserted at the time of the abortion in both the first and second trimesters. Contraceptive implants can be inserted at any time once the abortion procedure has started.

Caring for women after medically indicated abortion

Healthcare staff involved in this aspect of providing abortion where medically indicated should ensure that the woman leaves the service knowing what to expect following the procedure and where to get help if necessary. They should also ensure that every woman is able to leave with a method of family planning to start immediately. Women should be informed of the superior effectiveness of IUDs and implants in preventing unplanned pregnancy.

Information to provide

Before leaving the facility, women should receive instructions about how to care for themselves after they go home, including:

- how much bleeding to expect in the next few days and weeks
- how to recognise potential complications, including signs of ongoing pregnancy
- when to resume normal activities (including sexual intercourse)
- how and where to seek help if required
- whether or not they can get pregnant again and when to start trying.

Contraception

Before they leave the healthcare facility, women for whom contraception is indicated should receive appropriate information and, if desired, the contraceptive method of their choice. If the chosen method is not available, they should be referred to a service where the method can be provided.

Women should be advised of the greater effectiveness and duration of LARC methods (implants and IUDs) and encouraged to choose them unless they have a clear preference for another effective method.

Sterilisation can be safely performed at the time of induced abortion although it can be more likely than interval sterilisation to be associated with regret.

Failure rates for sterilisation are slightly higher if it is performed at the same time as the abortion.

Anti-D IgG

If available, anti-D IgG should be given by injection into the deltoid muscle to all RhD-negative women within 72 hours following abortion for gestations longer than 12 weeks.

Service delivery

The provision of a safe and effective comprehensive postabortion care service, and of safe induced abortion when medically indicated, depends on everyone involved in the service ensuring that everything is done to meet the need. It is not enough for doctors and nurses to have clinical skills for postabortion care if the facilities and tools that they need are not reliably available and if the service is not organised in a way that ensures safe and effective comprehensive postabortion care

and induced abortion care when medically indicated. **Best practices for service delivery** are listed below.

Access to services

- 1 Abortion services must be available to the fullest extent that the law allows. Healthcare providers should know what the law *does* allow in their country and be clear about the circumstances for which abortion is legal.
- 2 Safe abortion is legal in Tanzania to save the life of the woman.
- 3 Healthcare providers must know the process required for induced abortion to be approved, which, in Tanzania, requires the agreement of two physicians.
- 4 Abortion is safer the sooner it is done. Services should provide the abortion at the earliest possible gestation and as close to home as possible.
- 5 All healthcare providers should be trained to provide comprehensive postabortion care, and induced abortion when medically indicated, in line with their skills and licences. This can help spread the workload and improve the skills of *all* providers of women's health care, thereby increasing the safety of all abortion and postabortion care.
- 6 Integrating postabortion, and abortion where medically indicated, services into overall maternal/women's health care minimises the stigma associated with abortion care for both women and providers.
- 7 In settings where women with incomplete abortion are likely to present but where there is no provision for emergency or specialist care, there must be robust and timely pathways for referral.

Information provision

- 1 There should be local arrangements in place for providing information to women and healthcare professionals on routes of access to postabortion care and to induced abortion when medically indicated.
- 2 Services should ensure that written, objective, evidence-guided information is available in a way that is understandable to women presenting for postabortion care and to women for whom induced abortion is medically indicated. Information should be available in a variety of languages and formats.
- 3 Women for whom induced abortion is medically indicated should have access to objective information and, if required, counselling and decision-making support about their pregnancy options.
- 4 Information for women and providers should emphasise the need for confidentiality and be sensitive to the woman's need for privacy.

Arrangements for the procedure

- 1 In order to minimise delay, service arrangements should be such that postabortion care, and induced abortion when medically indicated, can be provided as soon as possible, ideally on the same day as the assessment.
- 2 A system should be in place to ensure that the required documentation is completed accurately and soon after the procedure.

- 3 The setting for postabortion care, as well as for induced abortion when medically indicated, including the consultation room, the procedure room and the recovery room, should respect the need for women's privacy and dignity.

Evidence sources

World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems*. 2nd ed. Geneva: WHO; 2012 [www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/].

World Health Organization. *Clinical Practice Handbook for Safe Abortion*. Geneva: WHO; 2014 [www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/].

Royal College of Obstetricians and Gynaecologists. *The Care of Women Requesting Induced Abortion*. Evidence-based Guideline Number 7. London: RCOG; 2011 [www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/].

Additional literature reviewed

Conde-Agudelo A, Belizan JM, Berman R, Brockman SC, Rosas-Bermudez A. Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America. *Int J Gynaecol Obstet* 2005;89 Suppl 1:S34–40.

Mark AG, Edelman A, Borgatta L. Second-trimester postabortion care for ruptured membranes, fetal demise, and incomplete abortion. *Int J Gynaecol Obstet* 2015;129:98–103.

Love ER, Bhattacharya S, Smith NC, Bhattacharya S. Effect of interpregnancy interval on outcomes of pregnancy after miscarriage: retrospective analysis of hospital episode statistics in Scotland. *BMJ* 2010;341:c3967.

Passini R Jr, Cecatti JG, Lajos JG, Tedesco RP, Nomura ML, Dias TZ, et al., for the Brazilian Multicentre Study on Preterm Birth study group. Brazilian Multicentre Study on Preterm Birth (EMIP): prevalence and factors associated with spontaneous preterm birth. *PLoS One* 2014;9:e109069.

The United Republic of Tanzania. *Standard Treatment Guidelines and Essential Medicines List*. 4th edition. Ministry of Health and Social Welfare; 2013 [www.who.int/selection_medicines/country_lists/Tanzania_STG_052013.pdf].

World Health Organization. *Report of a WHO Technical Consultation on Birth Spacing*. Geneva: WHO; 2005 [www.who.int/maternal_child_adolescent/documents/birth_spacing05/en/].

Appendix: Post-abortion contraception

(Adapted from World Health Organization (2014) *Clinical Practice Handbook for Safe Abortion*)

Generally, almost all methods of contraception can be initiated immediately following a surgical or medical abortion. Immediate start of contraception after surgical abortion refers to the same day as the procedure, and for medical abortion refers to the day the first pill of a medical abortion regimen is taken. As with the initiation of any method of contraception, the woman's medical eligibility for a method should be verified.

Post-abortion medical eligibility recommendations for hormonal contraceptives, intrauterine devices and barrier contraceptive methods

POST-ABORTION CONDITION	FIRST TRIMESTER	SECOND TRIMESTER	IMMEDIATE POST-SEPTIC ABORTION
COC	1	1	1
CIC	1	1	1
Patch & vaginal ring	1	1	1
POP	1	1	1
DMPA, NET-EN	1	1	1
LNG/ENG implants	1	1	1
Copper-bearing IUD	1	2	4
LNG-releasing IUD	1	2	4
Condom	1	1	1
Spermicide	1	1	1
Diaphragm	1	1	1

CIC, combined injectable contraceptive; COC, combined oral contraceptive; DMPA/NET-EN, progestogen-only injectables: depot medroxyprogesterone acetate/norethisterone enantate; IUD, intrauterine device; LNG/ENG, progestogen-only implants: levonorgestrel/etonorgestrel; POP, progestogen-only pill.

Definition of categories

- **1:** a condition for which there is no restriction for the use of the contraceptive method.
- **2:** a condition where the advantages of using the method generally outweigh the theoretical or proven risks.
- **3:** a condition where the theoretical or proven risks usually outweigh the advantages of using the method.
- **4:** a condition that represents an unacceptable health risk if the contraceptive method is used.

Contraception for women on antiretroviral therapy for HIV

There are potential drug interactions between some antiretroviral drugs and hormonal contraception. However, WHO has reviewed the data and concluded that the benefits of using hormonal contraception outweigh the risks (2015 MEC, Category 2).