Guidance for the update of training modules on safe abortion care

Foreword

In 2010-2014, worldwide, 55.7 million[1] abortions occurred annually. Of those, 25.1 million (45.1%) were unsafe. Unsafe abortions result in the death of some 22,800–31,000 women each year[2] and leave millions with disabilities, most of them living in developing countries.

However, those human losses and health conditions could be avoided with the implementation, at the country level, of an environment facilitating access to safe abortion.

Like establishing supportive national laws and policies or providing affordable and quality abortion products, educating healthcare providers on safe abortion care plays a critical role in reducing unsafe abortion-related mortality and morbidity.

Medical abortion and vacuum aspiration are the two methods of abortion recommended by WHO. Healthcare providers need to be trained to perform them in compliance with WHO's medical standards.

This guidance document is a workbook intended to:

- assist academic institutions to understand the extent of WHO's latest recommendations that must be met to provide safe abortion care;
- and to provide them with the evidence-based guidelines needed to update their training modules to ensure that in-country medical staff applies current best practices for termination of pregnancy.

The document compiles in one place a summary of WHO's latest recommendations with regard to the management of abortion (listed below) and invites academic institutions to compare those with the content of their current training modules and assess how they can update them in compliance with their country's specific context and legal framework.

The recommendations summarized in the document are extracted from the following WHO's guidelines:

- **Safe abortion: technical and policy guidance for health systems - Second edition, 2012**
- **Clinical practice handbook for safe abortion, 2014**
- **Health worker roles in providing safe abortion care and post-abortion contraception, 2015**
- **Medical management of abortion, 2018**
- **WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights, 2019**

[1] Global, regional and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model. Ganatra B, Gerdts C, Rossier C, Johnson BR Jr, Tunçalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, Bearak J, Kang Z, Alkema L.Lancet. 2017 Nov 25

[2] Singh S et al., Abortion Worldwide 2017: Uneven Progress and Unequal Access, New York: Guttmacher Institute, 2018

- **Maintaining essential health services: operational guidance for the COVID-19 context, 2020**

In some places, the document also refers to other data than those provided by WHO. When it is the case, the source of information is indicated in a foot note.

It is highlighted that this document provides an overview of WHO's recommendations. For further details on each of them, it is recommended to refer to the original guidelines listed above.

TABLE OF CONTENTS

Acronyms

D&C - Dilatation and curettage

D&E - Dilatation and Evacuation

DMPA - Depot Medroxyprogesterone Acetate

ERP - Expert Review Panel

EVA – Electric Vacuum Aspiration

hCG - human Chorionic Gonadotrophin

HIV - Human Immunodeficiency Virus

HPV - Human Papillomavirus (HPV)

IM - Intramuscular

IUD - Intra-Uterine Device

LMP - Last menstrual Period

mn - minute

MNH - Maternal Newborn Health

MVA -Manual Vacuum Aspiration

POC - Inspection of the Product of Conception

RCTs - Randomized controlled trials

Rh - Rhesus

RTIs Reproductive Tract Infections

SRA – Stringent Regulatory Authority

SRH - Sexual and Reproductive Health (SRH)

STIs - Sexually Transmitted Infections

UI - Uncertainty Interval

US - Ultra-Sound

WHO - World Health Organization

Topic	WHO Recommendations	Country Curriculum (current)	Country Curriculum (updated)
Recommendations for health systems			
Access to services	Safe abortion services should be readily available and affordable to all women.		
	Services should be available at primary-care level, with referral systems in place for all required higher-level care.		
Actions to strengthen policies and services related to abortion	Should be based on the health needs and human rights of women and a thorough understanding of the service-delivery system and the broader social, cultural, political and economic context.		
National standards and guidelines for safe abortion care	Should be evidence-based and periodically updated and should provide the necessary guidance to achieve equitable access to good-quality care. New policy and programme interventions should reflect evidence-based best practices.		
Training of abortion providers	Must ensure that they have the competencies to provide good-quality care in accordance with national standards and guidelines. Ensuring good-		

	quality abortion care requires ongoing supervision, quality assurance, monitoring and evaluation.		
Financing of abortion services	Should take into account costs to the health system while ensuring that services are affordable and readily available to all women who need them. Costs of adding safe abortion care to existing health services are likely to be low, relative to the costs to the health system of treating complications of unsafe abortion.		
Successful scaling-up	Requires systematic planning, management, guidance and support for the process by which pilot interventions are both expanded and institutionalized. It also requires sufficient human and financial resources to support the process.		
Laws and policies			
Laws and policies on abortion	Should protect women's health and their human rights.		
Barriers	Regulatory, policy and programmatic barriers that hinder access to and timely		

	provision of safe abortion care should be removed.		
Regulatory and policy environment	An enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. Policies should be geared to respecting, protecting and fulfilling the human rights of women, to achieving positive health outcomes for women, to providing good-quality contraceptive information and services, and to meeting the particular needs of poor women, adolescents, rape survivors and women living with Human Immunodeficiency Virus (HIV).		
Safe abortion as a public health and human rights issue	Unsafe abortion is defined by the WHO as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both. The persons, skills and medical standards considered safe in the provision of abortion are different for medical and surgical abortion and also depend on the duration of the pregnancy. What is considered 'safe'		

	should be interpreted in line with current WHO technical and policy guidance Safe abortion: Abortions are safe if they are done with a method recommended by WHO that is appropriate to the pregnancy duration and if the person providing or supporting the abortion is trained. The immediate determinants of the risks of an induced abortion, such as the termination method used and gestational age, are influenced, in turn, by underlying social determinants: i.e. the legal context, the availability of safe abortion services, the level of stigma surrounding abortion, the degree of women's access to information on abortion, and a woman's age and socioeconomic status.		
Global/regional figures on safe/unsafe abortion[3]	35 abortions (90% uncertainty interval [UI] 33 to 44) occurred annually per 1000 women aged 15–44 years worldwide in 2010–14, which was 5 points less than 40 (39–48) in 1990–94 (90% UI for decline −11 to 0). Because of population growth, the annual number of abortions worldwide increased by 5·9 million (90% UI −1·3 to 15·4), from 50·4 million in 1990–94 (48·6 to 59·9) to 56·3 million (52·4 to 70·0)		

[3] Statistics are extracted from:

	in 2010–14. In the developed world, the abortion rate declined 19 points (–26 to −14), from 46 (41 to 59) to 27 (24 to 37). In the developing world, we found a non-significant 2-point decline (90% UI −9 to 4) in the rate from 39 (37 to 47) to 37 (34 to 46). Some 25% (90% UI 23 to 29) of pregnancies ended in abortion in 2010–14. Globally, 73% (90% UI 59 to 82) of abortions were obtained by married women in 2010–14 compared with 27% (18 to 41) obtained by unmarried women. No association was observed between the abortion rates for 2010–14 and the grounds under which abortion is legally allowed (Statistics source 1). According to another publication, of the 55· 7 million abortions that occurred worldwide each year between 2010–14, estimation shows that 30·6 million (54·9%, 90% uncertainty interval 49·9–59·4) were safe, 17·1 million (30·7%, 25·5–35·6) were less safe, and 8·0 million (14·4%, 11·5–18·1) were least		

Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends. Sedgh G, Bearak J, Singh S, Bankole A, Popinchalk A, Ganatra B, Rossier C, Gerdts C, Tunçalp Ö, Johnson BR Jr, Johnston HB, Alkema L. Lancet. 2016 Jul 16 |referred to as Statistics source 1 throughout the table]

2) Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model.

Ganatra B, Gerdts C, Rossier C, Johnson BR Jr, Tunçalp Ö, Assifi A, Sedgh G, Singh S, Bankole A, Popinchalk A, Bearak J, Kang Z, Alkema L. Lancet. 2017 Nov 25 [referred to as Statistics source 2 throughout the table]

	safe. Thus, 25·1 million (45·1%, 40·6–50·1) abortions each year between 2010 and 2014 were unsafe, with 24·3 million (97%) of these in developing countries. The proportion of unsafe abortions was significantly higher in developing countries than developed countries (49·5% *vs* 12·5%). When grouped by the legal status of abortion, the proportion of unsafe abortions was significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws (Statistics source 2). Although an induced abortion is a medically safe procedure when done in accordance with recommended guidelines, many women undergo unsafe abortions that put them at risk of physical harm. It is estimated that 6·9 million women in the developing world were treated for complications from unsafe abortion in 2012, and as many as 40% of women who need care do not obtain it (Statistics source 2). Almost all deaths and morbidity from unsafe abortion occur in countries where abortion is severely restricted in law and in practice. Where there are few restrictions on access to safe abortion, deaths and illness are dramatically reduced		

Impact of legal restrictions on access to safe abortion	Whether abortion is legally more restricted or available on request, a woman's likelihood of having an unintended pregnancy and seeking induced abortion is about the same. However, legal restrictions, together with other barriers, mean many women induce abortion themselves or seek abortion from unskilled providers. The legal status of abortion has no effect on a woman's need for an abortion, but it dramatically affects her access to safe abortion. When countries were grouped according to the grounds under which abortion was legal, there are not evidences that abortion rates for 2010–14 were associated with the legal status of abortion. The rate was 37 abortions per 1000 women (34–51) where abortion is prohibited altogether or allowed only to save a woman's life, and 34 (29–46) where it is available on request (Statistic source 1).		
Where abortion is legal	Where legislation allows abortion under broad indications, the incidence of and complications from unsafe abortion are generally lower than where abortion is legally more restricted.		
Legality = safety	In almost all countries, the law permits abortion to save the woman's life, and in the majority of countries abortion is allowed to preserve the physical and/or mental health of		

	the woman. Therefore, safe abortion services, as provided by law, need to be available. Additional barriers, that may or may not be codified in law, often impede women from reaching the services for which they are eligible and contribute to unsafe abortion. These barriers include lack of access to information; requiring third-party authorization; restricting the type of health-care providers and facilities that can lawfully provide services; failing to guarantee access to affordable services; failing to guarantee confidentiality and privacy; and allowing conscientious objection without referrals on the part of health-care providers and facilities. When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure. In the United States of America (USA), for example, the case–fatality rate is 0.7 per 100 000 legal abortions.		

Prevention of unwanted pregnancies - a way to reduce induced abortion	Meeting the unmet need for family planning is an effective intervention to reduce unintended pregnancy and induced abortion. Contraception alone, however, cannot entirely eliminate women's need for access to safe abortion services. Contraception plays no role in cases of forced sexual intercourse, which can lead to an unintended pregnancy. Also, no method is 100% effective in preventing pregnancy. Data on contraceptive prevalence and the typical failure rates of contraceptive methods, it is estimated that approximately 33 million women worldwide annually may experience an accidental pregnancy while using a method of contraception.		
Clinical care			
WHO recommended methods of abortion	The methods recommended for first and second - trimester abortion: – manual or electric vacuum aspiration, for pregnancies of gestational age up to 12–14 weeks – medical method of abortion, specifically, oral mifepristone followed by a single dose of		

	misoprostol, for pregnancies of gestational age up to 12 weeks – where mifepristone is not available: misoprostol alone, in repeated doses For pregnancies of gestational age more than 12–14 weeks, the following methods are recommended: – dilatation and evacuation (D&E), using vacuum aspiration and forceps or – mifepristone followed by repeated doses of misoprostol or – where mifepristone is not available, misoprostol alone, in repeated doses		
Dilatation & Curettage	Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods. D&C is less safe than vacuum aspiration and considerably more painful for women. Therefore, vacuum aspiration should replace D&C. The rates of major complications of D&C are two to three times higher than those of vacuum aspiration. Randomized controlled trials comparing D&C with vacuum aspiration found		

	that, for up to 10 weeks since the last menstrual period (LMP), vacuum aspiration is quicker and associated with less blood loss than D&C. Where it is still practiced, all possible efforts should be made to replace D&C with vacuum aspiration, to improve the safety and quality of care for women.		
Pre-abortion. Diagnosis of pregnancy, counseling, informed consent	Determination of the length of pregnancy is a critical factor in selecting the most appropriate abortion method and determines the content of the information and counseling to be given to women prior to abortion. Methods used: • Last Menstrual Period : The number of days or weeks since the first day of the woman's last normal menstrual period (LMP) in women with regular cycles (for women with irregular cycles, the gestational age may need to be determined by physical or ultrasound examination). Physical exam (size, position and form of the uterus, signs of sexually		

	transmitted Infections (STIs) and other reproductive tract infections (RTIs). • Ultrasound: Ultrasound scanning is not routinely required for the provision of abortion. Where it is available, a scan can help identify an intrauterine pregnancy and exclude an ectopic one from 6 weeks of gestation. History-taking should include: LMP, personal and family history of relevant diseases; obstetric and gynaecologic history, including previous ectopic pregnancy; any bleeding tendencies or disorders; history of or presence of STIs; current use of medications; known allergies; and risk assessment for violence or coercion. General exam to evaluate the health conditions, such as anaemia or malaria, that may require additional procedures or services, or referral.		
Lab testing	Routine laboratory testing is not a prerequisite for abortion services. Measuring haemoglobin or haematocrit levels to detect anaemia may be useful when initiating treatment in the rare cases of haemorrhage occurring at the time of or following the abortion procedure. Tests for Rhesus (Rh) blood		

	group typing should be provided when feasible, to administer Rh-immunoglobulin when indicated. In pregnancies up to 9 weeks' (63 days') gestation, however, the theoretical risk of maternal Rh-sensitization with medical abortion is very low. Thus, determination of Rh status and the offer of anti-D prophylaxis are not considered prerequisites for early medical abortion.		
Reproductive tract infections	The presence of infection in the lower reproductive tract at the time of abortion is a risk factor for post-surgical abortion. The routine use of antibiotics at the time of surgical abortion has been reported to reduce the post-procedural risk of infection by half. However, where antibiotics are not available for prophylactic use, abortion may still be performed. Following medical abortion, the risk of intrauterine infection is very low and prophylactic antibiotics are therefore not necessary. If clinical signs indicate infection, the woman should be treated immediately with antibiotics, and abortion can then be performed. Where laboratory testing for STIs		

	is routinely performed, and if there are no visible signs of infection, abortion should not be delayed to wait for the test results.		
Information and counseling	The provision of information is an essential part of good-quality abortion services. Every pregnant woman who is contemplating abortion should receive adequate relevant information and be offered counseling from a trained health-care professional with comprehensive knowledge and experience of different methods of abortion. Information must be provided to each woman, regardless of her age or circumstances, in a way that she can understand, to allow her to make her own decisions about whether to have an abortion and, if so, what method to choose. Information, counseling and abortion procedures should be provided as promptly as possible without undue delay. Counseling to women who desire it should be voluntary, confidential, non-directive and by a trained person. In some circumstances, the woman may be under pressure from her partner, family members, health-care providers or others to have an abortion.		

	The health-care worker should also provide information and referral for antenatal care to women who decide to carry the pregnancy to term and/or consider adoption. Unmarried adolescents, women in abusive relationships and women living with HIV may be particularly vulnerable to such pressure. If health-care workers suspect coercion, they should talk with the woman alone, or refer her for additional counseling. If staff know or suspect that the woman has been subjected to sexual violence or other abuse, they should offer her referrals for other counseling and treatment services as appropriate.		
The content of the counseling	At a minimum, a woman must be given information on: – what will be done during and after the procedure – what she is likely to experience (e.g. menstrual-like cramps, pain and bleeding) – how long the process is likely to take – what pain management will be made available to her – risks and complications associated with the abortion method – when she will be able to resume her normal activities, including sexual intercourse		

	– any follow-up care – Contraception counseling: method she may use and when she can start		
Surgical methods of abortion: MVA/EVA			
Cervical preparation	Cervical preparation before surgical abortion is recommended for all women with a pregnancy of gestational age over 12–14 weeks, although its use may be considered for women at any gestational age, in particular those at high risk for cervical injury or uterine perforation. Cervical preparation (or priming) using osmotic dilators, such as laminaria, or pharmacological agents is commonly used before some first-trimester surgical abortions because it may make the abortion procedure quicker and easier to perform by reducing the need for mechanical cervical dilatation. Cervical preparation before surgical abortion is especially beneficial for women with cervical anomalies or previous surgery, adolescents and those with advanced pregnancies, all of whom have a higher risk of cervical injury or uterine perforation that may cause		

	haemorrhage. It may also facilitate the abortion procedure for inexperienced providers In first-trimester surgical abortion, research suggests that administration of 400 mcg misoprostol either vaginally 3–4 hours or sublingually 2–3 hours prior to the procedure is effective in preparing the cervix. Another effective pharmacological regimen is 200 mg mifepristone taken orally 36 hours before a vacuum aspiration procedure. For cervical priming prior to D&E, misoprostol is inferior to overnight dilatation with laminaria		
Manual Vacuum Aspiration (MVA)/ Electric Vacuum Aspiration (EVA) **Safety** **Efficacy** **Advantages** **Indications** **Special considerations**	The recommended surgical technique for abortion up to gestational age less than 15 weeks is vacuum aspiration. The high efficacy of vacuum aspiration has been well established in several randomized controlled trials. Complete abortion rates between 95% and 100% are reported. Electric and manual vacuum technologies appear to be equally effective; however, the use of manual vacuum aspiration is associated with less pain in pregnancies under 9 weeks' gestation and with more procedural difficulty over 9 weeks' gestation.		

	Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration (EVA) employs an electric vacuum pump. With manual vacuum aspiration (MVA), the vacuum is created using a hand-held, hand-activated, plastic 60 ml aspirator (also called a syringe). Available aspirators accommodate different sizes of plastic cannulae ranging from 4 mm to 16 mm in diameter. For each procedure, the appropriately sized cannula should be chosen based on the gestational age and the amount of cervical dilatation present; generally, the diameter of the cannula corresponds to the gestational age in weeks. Some cannulae and most aspirators are reusable after being cleaned and high-level disinfected or sterilized. Depending on the duration of pregnancy, abortion with vacuum aspiration takes from 3 to 10 minutes to complete and can be performed on an outpatient basis, using analgesics and/or local anaesthesia. The completion of abortion is verified by examination of the aspirated tissue. In very early pregnancy, the cannula may be inserted without prior dilatation of the cervix. Usually, however, dilatation using		

	mechanical or osmotic dilators, or pharmacological agents such as misoprostol or mifepristone, is required before insertion of the cannula. Generally, vacuum-aspiration procedures can be safely completed without intrauterine use of curettes or other instruments. No data suggest that use of curettage after vacuum aspiration decreases the risk of retained products. Most women who have a first-trimester abortion with local anaesthesia feel well enough to leave the health-care facility after observation for about 30 minutes in a recovery room. Longer recovery periods are generally needed for abortions performed later in pregnancy and when sedation or general anaesthesia has been used. Vacuum aspiration is a very safe procedure. A study of 170 000 first-trimester abortions conducted in New York City by vacuum aspiration reported that less than 0.1% of the women experienced serious complications requiring hospitalization. Though rare, complications with vacuum aspiration can include		

	pelvic infection, excessive bleeding, cervical injury, incomplete evacuation, uterine perforation, anesthetic complications and ongoing pregnancy. Abdominal cramping and menstrual-like bleeding occur with any abortion procedure.		
MVA/EVA equipment and technique	There are two types of vacuum aspiration. – Manual vacuum aspiration (MVA) uses a hand-held aspirator to generate a vacuum. The aspirator is attached to cannulae ranging from 4 to 14 mm in diameter and can be used in multiple settings, including those without electricity – Electric vacuum aspiration (EVA) uses an electric pump to generate a vacuum and can accommodate cannulae up to 14–16mm in diameter, with larger-diameter tubing (for cannulae >12 mm) – The abortion procedure is performed similarly, regardless of the type of vacuum used.		
Prior to the start of the procedure	• Refer the woman to an appropriate facility, as needed, if conditions are detected that may cause complications. • Perform cervical preparation, if needed. • Provide antibiotic prophylaxis to reduce post-procedure infection. • Confirm that the woman has received her pain medications.		

	• Ensure that all necessary equipment is gathered and available for use. o If using MVA, make sure to check that: – the aspirator holds a vacuum before starting the procedure; – back-up aspirators are readily available; in case the first aspirator has technical problems.		
MVA/EVA Procedural steps	1) Ask the woman to empty her bladder 2) Wash hands and put on protective barriers 3) Perform a bimanual examination 4) Place the speculum 5) Perform cervical antiseptic preparation 6) Perform paracervical block (or proceed to Step 7) 7) Dilate the cervix 8) Insert the cannula 9) Aspirate the uterine contents 10) Inspect the tissue 11) Perform any concurrent procedures 12) Recovery and discharge from the facility		
Infection prevention, **Standard precautions (universal precautions) - the no-touch technique**	Abortion procedures and care involve contact with blood and other body fluids, standard precautions for infection prevention and control should be applied, for both their own protection and that of their patients.		

	Standard precautions: – should be applied in all situations where health-care workers anticipate contact with: blood; any body fluid other than perspiration; non-intact skin; and mucous membranes; – should always be followed, regardless of a person's presumed infection status or diagnosis; – minimize or eliminate transmission of disease from patient to health-care worker, health-care worker to patient, or patient to patient. I**nclude:** – Hand-washing; hand washing with soap and running water should be routine before and after each contact, including after contact with potentially contaminated items, even if gloves are worn; – gloves should be worn and replaced between contacts with different clients and between vaginal (or rectal) examinations of the same woman. After completing care of one woman and removing gloves, the health-care provider should always wash their hands, as gloves may have undetected holes in them.		

	– Wearing barriers such as gowns, gloves, aprons, masks, protective eyewear and footwear: it should be noted that use of auxiliary supplies, such as sterile booties, does not make a significant difference in infection rates, although it increases costs. – Aseptic technique: prior to any surgical abortion procedure, the woman's cervix should be cleaned with an antiseptic (e.g. betadine). – Proper handling and disposal of sharp instruments ("sharps") – blades and needles. – Proper handling and processing of instruments and materials. – *Aspirators, cannulae and adaptors are not safe to handle with bare hands until cleaned.* – Reducing infection after vacuum aspiration is accomplished by using appropriately disinfected or sterilized instruments, administering prophylactic antibiotics, and using the no-touch technique. – MVA instruments processing steps. **The no-touch technique** means that the parts of instruments that enter the uterus should not touch objects or surfaces that are not sterile, including the vaginal walls, before being inserted.		

<table>
<tr>
<td></td>
<td>Thus, during the aspiration procedure, the provider:

▪ grasps and touches only the midportion of dilators, avoiding the tips;
▪ attaches the cannula to the vacuum source without touching the tip of the cannula;
▪ keeps used instruments away from sterile instruments remaining on the tray.

Underlying this technique is the recognition that, even with application of antiseptic solution to the cervix, it is impossible to sterilize the vagina.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selecting the cannula size for aspiration abortion</td>
<td>
<table>
<tr><th>Uterine size (weeks since LMP*)</th><th>Suggested cannula size (mm)</th></tr>
<tr><td>4–6</td><td>4–7</td></tr>
<tr><td>7–9</td><td>5–10</td></tr>
</table>
</td>
<td></td>
<td></td>
</tr>
</table>

	9–12	8–12	
	12–14	10–14	
Tissue exam after the procedure	Inspection of the Product of Conception (POC) is important to ensure a complete abortion. To inspect the tissue, empty the uterine aspirate into an appropriate container (do not push aspirated contents through the cannula, as it will become contaminated). Look for: • the quantity and presence of POC: villi, decidua and sac/membranes in appropriate quantities based on gestational age; after 9 weeks' gestation, fetal parts are visible; • the presence of grape-like hydropic villi, which suggest a molar pregnancy. • If the visual inspection is inconclusive, the tissue should be strained, placed in a transparent container, immersed in water or vinegar, and viewed with light from beneath. If indicated for abnormal findings, the tissue		

	specimen may also be sent to a pathology laboratory. If no POC are visible, less tissue than expected was removed from the uterus, or the tissue sample is inconclusive, this may indicate: • incomplete abortion: the uterine cavity still contains POC, even if it appeared to be empty at the end of the procedure; • a spontaneous abortion that completed prior to the procedure; • a failed abortion: all POC remain within the uterine cavity; • ectopic pregnancy: when no villi are seen, ectopic pregnancy is a possibility and should be investigated; • anatomical anomaly: in a bicornuate or septate uterus, the cannula may have been inserted into the side of the uterus that did not contain the pregnancy. • If it is not absolutely clear that sac/membranes and villi are present on tissue evaluation, then assume none are present and attempt re-aspiration and/or evaluate for ectopic pregnancy.		

Pain management principles General anaesthesia is not routinely recommended for vacuum aspiration Medications used for general anesthesia are one of the few potentially life-threatening aspects of abortion care. Any facility that offers general anesthesia must have the specialized equipment and staff to administer it and to handle complications	• Respectful, non-judgmental communication • Verbal support and reassurance • Gentle, smooth operative technique • Advance notice of each step of the procedure (if the woman desires it) • The presence of a support person who can remain with her during the process (if the woman desires it) • Encouraging deep, controlled breathing • Listening to music • Hot water bottle or heating pad The following medicines are usually used if woman prefers local anesthesia: 1) Analgesia (non-steroidal anti-inflammatory drugs [NSAIDs], e.g. ibuprofen 400–800 mg) 2) Anxiolytics/sedatives (e.g. diazepam 5–10 mg)		

	3) Local anaesthetic (paracervical block using lidocaine (usually 10–20 mL of 0.5 to 1.0%) Conscious sedation or general anaesthesia can be used in some cases, not routinely, if it is woman's choice		
Paracervical block	• Inject 1–2 mL of anaesthetic at the cervical site where the tenaculum will be placed (either at 12 o'clock or 6 o'clock, depending on the preference of the provider or the presentation of the cervix). • Next, stabilize the cervix with the tenaculum at the anaesthetized site. • Use slight traction to move the cervix and define the transition of smooth cervical epithelium to vaginal tissue, which delineates the placement for additional injections. • Slowly inject 2–5 mL lidocaine into a depth of 1.5–3 cm at 2–4 points at the cervical/vaginal junction (2 and 10 o'clock, and/or 4 and 8 o'clock).		

	• Move the needle while injecting OR aspirate before injecting, to avoid intravascular injection. • The **maximum** dose of lidocaine in a paracervical block is 4.5 mg/kg/dose or generally 200–300 mg (approximately 20 mL of 1% or 40 mL of 0.5%).		
Recovery	• Reassure the woman that the procedure is finished and that she is no longer pregnant. • Offer to address any emotional needs the woman might have immediately following her abortion. • Monitor her for any complications and provide management as needed. • She may leave the facility when she is stable and meets the criteria for discharge. • Ensure that the woman has all necessary information and medications prior to leaving the facility, including the family planning information and method (ideally) • Document all outcomes of the treatment, including any adverse events.		
Discussing contraceptive options	– A woman's acceptance of a contraceptive method must never be a		

	precondition for providing her an abortion. – Immediate initiation of contraception following abortion has been shown to both improve adherence and reduce the risk of unintended pregnancy – Inform all women that ovulation can return within 2 weeks following abortion, putting them at risk of pregnancy unless an effective contraceptive method is used. – If the woman is interested in contraception, she requires accurate information to assist her in choosing the most appropriate contraceptive method to meet her needs. – Understand that some women prefer to discuss options for contraception after the abortion is completed. – If a woman is seeking an abortion following what she considers to be a contraceptive failure, discuss whether the method may have been used incorrectly and how to use it correctly, or whether it may be appropriate for her to change to a different method.		

	– Ultimately, the final decision about whether to use contraception, and identification of a method to use, is the woman's alone.		
Medical method of abortion			
Medical method of abortion **Differences between medical and surgical abortion**	The availability of safe and effective medical methods of inducing abortion has expanded due to the increased registration and use of mifepristone and misoprostol (global maps of registration of mifepristone and misoprostol are available at: www.gynuity.org). Medical methods of abortion have proved acceptable in many settings, including low-resource settings. The medications are increasingly available globally, and the combination of mifepristone and misoprostol for medical abortion is now included on the *WHO model list of essential medicines*[4]. As these medications become increasingly available, programme managers should be aware of what is		

[4] https://www.who.int/medicines/publications/essentialmedicines/en/

	required to introduce medical methods of abortion into existing health services – The knowledge of and correct use of these drugs, including that of misoprostol alone when mifepristone is not available, is important for programme planners, managers, health-care workers and pharmacists, as these drugs are introduced into health systems. – Medical abortion is a multistep process involving two medications (mifepristone and misoprostol) and/or multiple doses of one medication (misoprostol alone). – Mifepristone with misoprostol is more effective than misoprostol used alone and is associated with fewer side-effects. – Comparison between surgical and medical abortion. Medical method: Avoids surgery Mimics the process of miscarriage Controlled by the woman and may take place at home (< 9 weeks) 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) May require more clinic visits than VA Vacuum aspiration: Quick procedure Complete abortion easily verified by evaluation of aspirated POC Takes place in a health-care facility Sterilization 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 controlled by the facility and provider		

History, mechanism of action of the MA pills.	– First clinical studies and approval of MA – The global/regional availability and access of MA		
Quality of medical products	The quality of medicines used is an important factor that can influence the process and overall success of a medical abortion. Substandard mifepristone and/or misoprostol products that do not contain the right active ingredients in the right dosages, and those that are not manufactured, transported or stored under the specified conditions, can affect the outcomes of a medical abortion. It is critical that mifepristone and misoprostol used for medical abortion are properly manufactured in line with specifications and are handled appropriately through the supply chain until use at the point of care. Ensuring use of quality-assured[5] mifepristone and misoprostol that have been transported and stored correctly according to the specified conditions can contribute to the overall quality of a medical abortion process.		

[5] Based upon the international definition used by the United Nations and most international procurement organizations and funders, quality assurance is evidenced by prequalification of a product by WHO, recommendation of a product from the Expert Review Panel (ERP) coordinated by WHO or a marketing authorization issued by a Stringent Regulatory Authority (SRA).
The updated list of products prequalified by WHO can be found through the following link: https://extranet.who.int/prequal/content/prequalified-lists/medicines.

How mifepristone and misoprostol work	**Mifepristone:** Mifepristone is an anti-progesteron which connects itself to the progesterone receptors and inhibits progesterone from working. Affinity for progesterone receptors 5 times higher than for progesterone. Weak antiglucocorticoid effect. No affinity for estrogen and mineralocorticoid receptors. -**Mifepristone pharmacokinetics:** • Peak serum level in 2 hours • Decreases by half between 12 and 72 hours, followed by half-life elimination after 18hours. • Same pharmacokinetics for all doses 100 mg or greater • Total serum concentration same during first 72 hours for 200-mg and 600-mg dosing • Same peak concentration with 100-, 400-, 600-, and 800-mg doses – **Misoprostol:** Prostaglandin F2α et PGE2 strongly influence uterine and intestinal contraction. Mifepristone potentiates the effect of the low dose of prostaglandins on the contractility of the myometrium. Misoprostol: vaginal, sublingual or oral administration – Vaginal, oral, sublingual and rectal use – **Misoprostol pharmacokinetics:** **Oral**: level peak 30mn after administration and drop off sharply within 2h		

	<u>Vaginal:</u> level peak 80mn after administration and remain relatively high for 4 hours **<u>Buccal:</u>** Later, lower peak, sustained levels (similar to vaginal) **<u>Sublingual</u>**: Rapid absorption, high peak, sustained levels **<u>Rectal:</u>** Lower peak but higher levels longer than oral Mechanism of Action: Mifepristone + Misoprostol = abortion • Progesterone Blockade • Decidual Necrosis • Rhythmic Uterine Contractions • Cervical Ripening • Detachment • Expulsion • Abortion		
Pre-requisites, indications, contraindications	**Pre-requisites:** - A pregnant woman requesting an abortion - A well-informed woman		

	Indication: A pregnancy under or equal to 63, 71, 77 or 84 days of amenorrhea, depending on local protocol **May be preferred in the following situations:** - For severely obese women, presence of uterine malformations or fibroids, or previous cervical surgery - If the woman wants to avoid surgical intervention - If a pelvic exam is not feasible or unwanted (Pregnancy with hymen intact, etc) * Breastfeeding is not a contraindication to medication abortion with mifepristone and misoprostol. Patients should be informed that breastfeeding can continue uninterrupted without concern for side effects in infants. **Contraindications** to the use of mifepristone and a prostaglandin analogue include:		

	– chronic or acute adrenal or hepatic failure, – inherited porphyria – allergy to any of the drugs used – Mifepristone is not an effective treatment for ectopic pregnancy; suspicion of ectopic pregnancy demands further investigation and, if confirmed, immediate treatment – Caution and clinical judgement are required for women using corticosteroids long term, and for those who have bleeding disorders, severe anaemia, pre-existing heart disease or cardiovascular risk factors. An intra-uterine device (IUD) in place would need withdrawal before Mifepristone administration		
How to determine eligibility	Through patient evaluation: 1. Contraceptive and obstetric history 2. Confirmation of an intra-uterine pregnancy and its duration Pertinent history Physical examination +/- Pregnancy testing Ultra-sound (US) +/-		

	Pinpoint indications, treatment precautions and possible rare contraindications to use of the drugs and the method.		
Side effects, complications	*Side effects:* effect of the treatment, other than the intended outcome, that might include physiological or psychological consequences. Most of them are minor, and require little or no intervention *Complications;* Effects of treatment that have potentially serious clinical consequences and require medical intervention *Side effects and their management (in details)* • Bleeding : create reasonable expectations about amount and duration of bleeding • Gastrointestinal side effects Self-limiting. Reassure, provide antidiarrhoeal medication if desired, Encourage oral hydration		

	• Fever, chills Antipyretic drugs, such as paracetamol • Dizziness, headache • Pain, cramping: **Pain management** Respectful, non-judgmental communication Verbal support and reassurance Thorough explanation of what to expect The presence of a support person who can remain with her during the process (if the woman desires it) Hot water bottle or heating pad Analgesia (NSAIDs, e.g. ibuprofen 400–800 mg) Anxiolytics / sedatives (e.g. diazepam 5–10 mg)		

	Paracetamol is not recommended to decrease pain during abortion. To ensure that oral medications will be most effective at the time of the procedure, administer them 30–45 minutes before the procedure. Adjuvant medications may also be provided, if indicated, for side-effects of misoprostol **Complications** **Heavy bleeding** – Heavy or prolonged bleeding causing a clinically significant change in hemoglobin concentration is uncommon approximately, 1%, similar to surgical abortion – May happen in a week following MA Difficulty in determining amount of bleeding requires informing woman to consult a doctor in emergency:		

	If she soaks through 2 maxi pads per hour for 2 consecutive hours; If she experiences signs of severe anemia • Importance of accessibility to an emergency care • Management: – If caused by incomplete abortion - misoprostol (see below) Methergine, Ergometrin, 0.2 mg, Aspiration to stop bleeding (0.4-2%, depends on the gestational age) – Transfusion (0.1%-0.2%) – No reports of hysterectomy for hemostasis after MA **Infection** Endometrial and/or pelvic infection is very rare (0.09-0.5%), (Surgical Abortion: 0.2 – 5.4%) Clinical signs and clinical examination: -pelvic pain, bleeding, fever +/-, normal uterus or softened, sensitive, foul vaginal discharge Diagnosis: pelvic exam/Ultrasound: empty uterus or retained products		

	Management: Large spectrum antibiotic therapy, Aspiration in case of retained products **Incomplete Abortion:** Incomplete abortion is defined by clinical presence of open cervical os and bleeding, whereby all products of conception have not been expelled from the uterus. Common symptoms include vaginal bleeding and abdominal pain. Incomplete abortion should also be suspected if, upon visual examination, the expulsed tissue is not consistent with the estimated duration of pregnancy. -Clinical Sign: Vaginal bleeding or spotting -Diagnosis: Clinical examination, Ultrasound and ßHCG Management: Depending on woman's condition and preferences If the woman is clinically stable (no signs of infection, heavy bleeding): Provide reassurance, clinical exam and reevaluation following next menstrual cycle,		

	Provide repeat doses of Misoprostol: 600 mcg misoprostol administered orally or 400 mcg misoprostol administered sublingually Surgical evacuation due to woman's choice (Antibiotic therapy +/-) If bleeding too heavy or detection of infection: Emergency aspiration **Ongoing Pregnancy** Necessity of informing woman during check-up visit on teratogenic risk of Misoprostol Clinical signs: None or little spotting after treatment, Presence of pregnancy symptoms: Observance of enlarged uterus upon clinical examination during check-up visit 2 weeks after MA Diagnosis: Clinical examination/ Ultrasound/ Significant increase in ßHCG Management: repeating the entire protocol or aspiration		

	Additional doses of misoprostol with or without mifepristone may be given for persistent gestational sac or continuing pregnancy.		
1st and 2nd trimester evidence-based protocols, **Self-managed abortion, telemedicine MA**	**Medical management of induced abortion < 12 week** – Mifepristone is always administered orally. – Misoprostol can be administered by different routes, including oral, vaginal, buccal and sublingual. Side-effects and instructions for use differ (see above – Pharmacokinetics of different routes of misoprostol administration.) Antibiotic prophylaxis is not necessary for medical abortion The decision about abortion management should be based on the individual's preference for treatment. The WHO guideline, *Safe abortion: technical and policy guidance for health systems* (2012), recommends manual or electric vacuum aspiration, dilation and evacuation, or medical management, either using a combination regimen (mifepristone followed by misoprostol) or misoprostol alone. Mifepristone followed by a prostaglandin		

	analogue has been shown to be safe and effective. Limited evidence also suggests that a regimen with repeated doses of misoprostol between 9 and 12 weeks of gestation is safe and effective; however, use of misoprostol alone is less effective than its use in combination with mifepristone. **WHO recommends the use of 200 mg mifepristone administered orally, followed 1–2 days later by 800 mcg misoprostol administered vaginally, sublingually or buccally. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.** **For the misoprostol-only regimen, WHO recommends the use of 800 mcg misoprostol administered vaginally, sublingually or buccally.** **Notes to the recommendations above**: • There is limited evidence to suggest that simultaneous dosing of mifepristone and misoprostol is efficacious		

	• This updated recommendation applies to pregnancies up to 12 weeks of gestation, whereas in the prior guidance, different regimens were recommended for pregnancies up to 7 weeks, 9 weeks and 12 weeks. For the recommended misoprostol-only regimen, buccal route of administration has been added and the maximum number of doses has been removed. Interval dosing has been removed and a note has been added that repeat doses of misoprostol can be considered to achieve success of the abortion process. • Studies comparing the different routes of misoprostol administration revealed the vaginal and sublingual routes to be more effective. In the few studies that compared misoprostol dosages in misoprostol-only regimen, 800 mcg of misoprostol had lower rates of ongoing pregnancy and higher rates of successful abortion. • A systematic review revealed that medical abortion is effective in the late first trimester (> 63 days and up to 84 days of gestation). A combination regimen is significantly more effective than a misoprostol-only regimen. Success rates were higher with repeat		

	dosing of misoprostol both in combination regimens and when misoprostol was used alone, and they were also higher with vaginal rather than oral administration for repeat dosing. • Studies addressing outpatient versus inpatient medical abortion, showed no significant difference in effectiveness, safety or acceptability between the two groups. **Medical management of induced abortion >= 12 week** WHO suggests the use of 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 mcg misoprostol administered vaginally, sublingually or buccally every 3 hours. The minimum recommended interval between use of mifepristone and misoprostol is 24 hours.		

	For the misoprostol-only regimen, WHO suggests the use of repeat doses of 400 mcg misoprostol administered vaginally, sublingually or buccally every 3 hours. **Notes to the recommendations above**: : • The use of a loading dose of misoprostol is not necessary. There is no advantage to the use of moistened over dry misoprostol. Recommendations have been updated from the WHO 2012 *Safe abortion* guidance. For this recommendation, the combination regimen (mifepristone and misoprostol) does not have the loading dose of 800 mcg misoprostol as in the prior guidance. For both the combination regimen and the misoprostol-only regimen, the buccal route has been added as an option. • Maximum number of doses has been removed and the time period between mifepristone and misoprostol dosing is given in days.		

	• Combination regimen is recommended because it is more effective. • Evidence suggests that vaginal route is the most effective. Consideration for patient and provider preference suggests the inclusion of all routes, including buccal administration. • Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. In the guidelines, no maximum number of doses of misoprostol is provided. • Health - care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine		

	rupture must be considered with advanced gestational age. • Systematic reviews showed that the combination regimen had higher rates of successful abortion and lower rates of ongoing pregnancy than the misoprostol-only regimen. • In the studies comparing misoprostol doses and interval of misoprostol administration in the combination regimen, there were higher rates of successful abortion and lower rates of ongoing pregnancy with 800 mcg of misoprostol and an interval of at least 24 hours between use of mifepristone and misoprostol. • One of the systematic reviews, on induced abortion at ≥ 12 weeks, showed that combination regimens had lower rates of ongoing pregnancy at 24 and 48 hours when compared with misoprostol-only regimens. Dosing of mifepristone 24 hours before misoprostol had lower rates of ongoing pregnancy when		

	compared to simultaneous dosing of both medications. In misoprostol-only regimens, dosing intervals of 3 hours had lower rates of ongoing pregnancy at 24 and 48 hours compared to other dosing intervals. For both combination and misoprostol-only regimens, sublingual and vaginal misoprostol routes of administration had better efficacy and lower rates of side-effects than the oral route.		
Who can be an abortion provider? **Self-managed MA**	Given the nature of the medical abortion process when using the combination regimen, it is possible for individuals to play a role in managing some of the components by themselves outside of a health-care facility. Where there is access to a source of accurate information and to a health-care provider (should one be needed or wanted at any stage of the process), the abortion process can be self-managed with pregnancies <12 weeks of gestation without the direct supervision of a health-care provider. For provision of medical abortion of pregnancies < 12 weeks, the following cadres have been recommended: auxiliary nurses, auxiliary nurse midwives, nurses, midwives, associate/advanced		

	associate clinicians, and non-specialist and specialist doctors. Doctors of complementary systems of medicine can be providers of this service in health system contexts with an established mechanism for the participation of such doctors in other tasks related to maternal and reproductive health. Alongside non-specialist and specialist doctors, the following cadres can provide medical abortion for pregnancies ≥ 12 weeks in contexts where appropriate surgical backup and proper infrastructure is established and easily accessible to address incomplete abortion or other complications: nurses, midwives, associate/advanced associate clinicians.		
Follow-up care **Post-abortion care, family planning**	**Mifepristone and misoprostol** – There is no medical need for a mandatory routine follow-up. Women should be able to have a follow-up visit if they desire. If a follow-up visit is scheduled, it should be between 7 and 14 days. **Misoprostol alone** – Clinic follow-up to ensure complete abortion is recommended. (This regimen is less effective than the combined regimen.)		

	Assessing for completed abortion: The use of clinical signs and symptoms with bimanual examination, human chorionic gonadotrophin (hCG) levels or ultrasonography (if available) can confirm abortion completion. Further evaluation for completed abortion is needed if: – a woman reports ongoing symptoms of pregnancy and/or has only minimal bleeding after taking the abortifacient medications as directed: – ongoing pregnancy should be suspected, and further evaluation could include pelvic examination, demonstrating a growing uterus, or an ultrasound scan, demonstrating an ongoing pregnancy; – offer vacuum aspiration or repeat administration of misoprostol to complete her abortion; – a woman reports prolonged or excessive bleeding and cramping, and ongoing		

	intrauterine pregnancy (see above) is not suspected: • consider a diagnosis of ectopic pregnancy and manage appropriately; • offer repeat misoprostol or vacuum aspiration to complete the abortion; • a woman reports lighter than expected bleeding or no bleeding, and ongoing intrauterine pregnancy is not suspected: • consider a diagnosis of ectopic pregnancy and manage appropriately. Routine follow-up is not necessary following an uncomplicated surgical or medical abortion using mifepristone and misoprostol. However, an optional follow-up visit 7–14 days after their procedure may be offered to provide further contraceptive counselling and services, further emotional support, or to address any medical concerns. A routine follow-up visit is recommended only in the case of medical abortion using		

	misoprostol alone, to assess success of the abortion. At the follow-up appointment: ➢ assess the individual's recovery and inquire about any signs or symptoms of ongoing pregnancy; ➢ review an available medical records and referral documents; ➢ ask about any symptoms experienced since the procedure; ➢ perform a focused physical examination in response to any complaints; and ➢ assess the individual's fertility goals and need for contraceptive services. If no method was started prior to discharge from the facility, provide information and offer counselling and the appropriate contraceptive method, if desired by the client. If a contraceptive method was already started, assess the method used and note any concerns – where there are no concerns, resupply as needed; where		

	there are concerns, help with selection of another appropriate method. Contraception can be initiated at the time of administration of the first pill of the **medical abortion** regimen or after assessment of successful medical abortion. All contraceptive options may be used. Criteria laid out in the WHO publications *Medical eligibility criteria for contraceptive use* and *Ensuring human rights in the provision of contraceptive information and services*[10] should be adhered to. All individuals who can become pregnant should be informed that ovulation can return within two weeks following abortion, putting them at risk of pregnancy unless an effective contraceptive method is used. Those who are interested in contraception should be provided with accurate information to assist them with choosing the most appropriate contraceptive method to meet their needs. Some prefer to discuss options for contraception after the abortion is completed. For those seeking an abortion following a reported contraceptive failure, it is important to discuss whether the method may have been used incorrectly and how to use it correctly, or whether it		

[10] https://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/

	may be appropriate to change to a different method. Ultimately, the final decision about whether to use contraception, and which method to use, is up to the individual alone. **Acceptance of a contraceptive method must never be a precondition for providing an abortion!** **Timing of post-abortion hormonal contraception initiation, except for intrauterine device (IUD)** **HORMONAL CONTRACEPTION -** Immediately after the first pill of the medical abortion For individuals undergoing medical abortion with the combination mifepristone and misoprostol regimen or the misoprostol-only regimen who desire hormonal contraception (oral contraceptive pills, contraceptive patch, contraceptive ring, contraceptive implant or contraceptive injections), it is suggested that they be given the option of starting hormonal		

	contraception immediately after the first pill of the medical abortion regimen. Notes for the recommendations above: • All individuals who can become pregnant should be provided with all of the necessary information to make an informed decision regarding the use of contraception. Immediate initiation of intramuscular (IM) depot medroxyprogesterone acetate (DMPA) is associated with a slight decrease in the effectiveness of medical abortion regimens. However, immediate initiation of DMPA should still be offered as an available contraceptive method after an abortion. • Indirect evidence was used as a basis for decision-making on initiation of hormonal contraception as an option for individuals undergoing medical abortion with misoprostol alone. • No data were available on the use of combined hormonal contraception (pills or		

	injections) by those undergoing medical abortion. Three systematic reviews served as the evidence base for the timing of post-abortion contraception. The first systematic review assessed the efficacy and safety of non-IUD hormonal contraception initiation after abortion (including medical abortion). Three randomized clinical trials (RCTs) and one cohort study compared immediate versus delayed initiation of implants or DMPA after medical abortion with mifepristone and misoprostol. No studies assessed hormonal contraception initiation after medical abortion with a misoprostol-only regimen. Another systematic review assessed the effectiveness and safety of initiation of IUD after abortion. In this review, three studies compared immediate versus delayed IUD insertion after medical abortion with mifepristone and misoprostol. The included studies assessed copper-bearing and levonorgestrel-releasing IUDs. No studies assessed IUD initiation after medical abortion with a misoprostol-only regimen.		

	Timing of post-abortion intrauterine device (IUD) placement Placement of an IUD at the time the abortion process has been deemed successful leads to lower rates of contraceptive failure and higher continuation rates at 6 and 12 months. The 6-month continuation rates are based on moderate certainty of evidence while the contraceptive failure rates are based on low certainty of evidence and the continuation rates at 12 months are based on very low certainty of evidence. There is no difference in the number of women requiring further intervention post-IUD placement due to retained tissue or bleeding, but the certainty of the evidence was low. There is no difference in the side-effect of pain at IUD insertion between the two groups, based on moderate certainty of evidence. Serious adverse events are rare and there was no difference between the two groups for uterine perforation or death, but this was based on very low certainty of evidence. Acceptability and feasibility of immediate placement of the IUD was high.		
Maintaining essential health services: operational guidance for the COVID-19 context			

Ensuring access to safe abortion and contraception services	During such outbreaks access to sexual and reproductive health (SRH) services can be severely disrupted, disempowering individuals – particularly women and girls – and exposing them to preventable health risks. Reductions in the availability of essential SRH and maternal newborn health (MNH) services will result in many thousands of maternal and newborn deaths due to millions of additional unintended pregnancies, unsafe abortions and complicated deliveries without access to essential and emergency care. Even a 10% reduction in these services could result in an estimated 15 million unintended pregnancies, 3.3 million unsafe abortions and 29 000 additional maternal deaths during the next 12 months. When facility-based provision of SRH services is disrupted, WHO recommends prioritizing digital health services, self-care interventions, task sharing and outreach to ensure access to medicines, diagnostics, devices, information and counselling. This prioritization should include ensuring access to contraception, abortion to the full extent allowed by law, and prevention and treatment services for sexually transmitted		

	infections (STIs), including HIV and human papillomavirus (HPV).		
Access to contraception	If a woman's regular contraceptive method is not available, other contraceptive options (including barrier methods, fertility awareness-based methods and emergency contraceptives) should be made more readily available. Relax requirements for a prescription for oral or self-injectable contraception and emergency contraception and provide multimonth supplies with clear information about the method and how to access referral care for adverse reactions. Enable pharmacies and drugstores to increase the range of contraceptive options they can provide and allow for multimonth prescriptions and self-administration of subcutaneous injectable contraceptives if available. Plan for clients to return to longer-term methods (such as IUDs, implants) and permanent methods (tubal ligation and vasectomy) if these services were disrupted Assess inventory and maintain data related to procurement of medications for contraception to avoid potential stock outs. Monitor and communicate about where services can be accessed.		

Safe abortion to the full extent of	**Access to safe abortion** Consider reducing barriers that could delay care and therefore increase risk for adolescents, rape survivors and others particularly vulnerable in this context. Consider the option of using noninvasive medical metho managing safe abortion and incomplete abortion. Minimize facility visits and provider–client contacts through the use of telemedicine and self-management approaches, when applicable, ensuring access to a trained provider if needed. Adjust forecasting for commodities and supplies to meet the anticipated increase in need for medical methods of abortion. Regularly assess inventory data related to medications and supplies for abortion and post-abortion care to avoid potential stock-outs when normal services resume. Consider expanding telemedicine mechanisms for medication delivery in contexts where it is proven effective.		