Making Abortion Safe

RCOG's global initiative to advocate for women's health

Royal College of Obstetricians & Gynaecologists

Best practice in post-abortion care

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Introduction to RCOG Best Practice Papers

The Royal College of Obstetricians and Gynaecologists (RCOG) Best Practice Papers are peer-reviewed, easy-to-use, adaptable documents that set out the essential elements for evidence-based clinical practice.

The best practices described are drawn from current evidence-based guidance produced by organisations such as the World Health Organization (WHO), the RCOG and the National Institute for Health and Care Excellence (NICE).

To be readable and useful to people providing healthcare on a daily basis, the papers have been deliberately kept short and succinct. Therefore, the primary evidence for recommendations and the strength of that evidence have been omitted but can be found in the original source documents. Very recently published evidence has been assessed to determine whether any recommendations from current guidelines should be amended.

The Best Practice Papers may also be used as a tool to assist policy makers in improving services.

While the Best Practice Papers may be used for reference in any country, local legal, regulatory, policy and service-delivery contexts may require adaptation of some recommendations; however, it is important to ensure that evidence-based practice is maintained.

For support on adapting the document while still maintaining good practice, please contact cfwgh@rcog.org.uk.

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This paper was updated as part of the RCOG's Making Abortion Safe programme – a three-year programme working to increase healthcare providers' capacity to address the barriers to safe abortion care and/or post-abortion care, globally. For more information, visit www.rcog.org.uk/en/global-network/centre-womens-global-health/our-work/making-abortion-safe.

Language note

Globally, most abortions are provided to women; however, trans men and non-binary people also experience pregnancy and abortion. Therefore, this paper refers to 'women' and 'pregnant people' to reflect a range of identities.

RCOG guidelines disclaimer

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians/gynaecologists and other relevant health professionals.

The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

Background

An estimated 25 million unsafe abortions occur every year, making it one of the leading causes of maternal mortality and morbidity worldwide. Most of these are in settings where abortion is illegal or severely restricted by law. In some countries, induced abortion is only permissible by law to prevent significant harm or save the life of the pregnant person (medically indicated abortion).

Abortion-related deaths and morbidity can be reduced by providing safe post-abortion care (performed in line with clinical best practice). Post-abortion care aims to reduce deaths and injury from either incomplete or unsafe abortion by:

- evacuating the uterus
- treating infection
- addressing physical, psychological and contraception needs
- referring to other sexual health services as appropriate.

Safe post-abortion care should be available and accessible to everyone who needs it.

Denying, delaying or restricting access to safe post-abortion care and medically indicated abortions may lead to violations of the right to life, the right to health and the right to privacy, and can in some cases amount to cruel, inhumane or degrading treatment.

As with many other medical procedures, adherence to best practice standards will ensure that the most effective and the safest services are delivered. This *Best Practice Paper* is designed to be used by health workers delivering post-abortion care and/or providing medically indicated abortions.

The methods for managing incomplete abortion and medically indicated abortion are:

- **medical abortion:** the use of medications to end a pregnancy; the most commonly used medications are misoprostol alone or misoprostol in combination with mifepristone
- **surgical abortion:** the use of transcervical procedures to end a pregnancy, including manual vacuum aspiration (MVA), electric vacuum aspiration (EVA) and dilatation and evacuation (D&E).

> All aspects of post-abortion care and medically indicated abortion care should be delivered in a respectful and sensitive manner that is person-centred and recognises women and pregnant people as the decision makers.

Information for health workers providing post-abortion care

Post-abortion care can reduce the morbidity and mortality associated with abortion that was performed unsafely, incomplete abortion and spontaneous abortion (miscarriage). Options for management of incomplete abortion include surgical and medical methods of uterine evacuation.

For those who wish to avoid another pregnancy, a contraception discussion should be offered and the chosen method provided.

Assessment

Incomplete abortion should be suspected when a person of reproductive age presents with vaginal bleeding or abdominal pain after one or more missed menstrual periods. Ectopic pregnancy should be suspected if the uterus is small, the cervix is closed or there is an adnexal mass or tenderness or vaginal bleeding.

Unsafe abortion

An abortion is unsafe when it is carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

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' duration
- products of conception visible at the cervix or in the vagina
- in patients with uterine injury, any of fever, significant lower abdominal pain, tenderness or abdominal distension
- the presence of a foreign body in the vagina or cervix.

Infection

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

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

Features suggestive of sepsis and indicating the need for urgent intervention include:

- hypotension
- tachycardia
- increased respiratory rate.

Management of incomplete abortion

This will depend on the patient's condition, whether infection is present, the pregnancy duration *and* on the skills of available personnel and the facilities and equipment available. When uterine evacuation is an emergency (the individual is shocked, bleeding heavily or has severe infection), if there are personnel available who have the skills to undertake vacuum aspiration (MVA or EVA), and if the appropriate equipment is available, then undertaking aspiration may be a better option than using misoprostol because the uterus will be emptied more quickly. If there is no provider skilled at vacuum aspiration then it will be safer to use misoprostol to empty the uterus. The dose of misoprostol depends on the pregnancy duration and on the route of administration (oral, sublingual, buccal or vaginal). If an individual is bleeding heavily then misoprostol may be less well absorbed if given vaginally than if given buccally, sublingually or orally.

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

- Medical management with misoprostol 400 micrograms sublingually, buccally or vaginally or 600 micrograms orally:
  - for a missed abortion (retained non-viable fetus), mifepristone 200mg orally should be administered 24–48 hours before misoprostol.

OR

- Uterine evacuation with vacuum aspiration and antibiotic prophylaxis (see below).

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

- Medical management with misoprostol:
  - 14–24 weeks: misoprostol 400 micrograms administered sublingually, buccally or vaginally every 3 hours
  - the uterus is more sensitive to misoprostol as pregnancy advances, and therefore, in pregnancies over 24 weeks, lower doses of misoprostol should be used and increased intervals between misoprostol doses may be considered, especially for people with uterine scars
  - in order to align protocols, services may use the same dosing and intervals as recommended in regimens for induced abortion
  - for a missed abortion (retained non-viable fetus), mifepristone 200mg orally should be administered 24–48 hours before misoprostol.

OR

- Surgical management with antibiotic prophylaxis (see below):
  - vacuum aspiration for removal of retained tissue when the fetus has been expelled; blunt forceps may also be needed to remove a retained placenta
  - if the fetus is retained, vacuum aspiration is suitable before 14 weeks of pregnancy; from 14 weeks and up to 16 weeks of pregnancy, forceps removal of larger fetal parts may also be required; from 16 weeks of pregnancy, a dilatation and evacuation (D&E) may be performed
  - if removal of the pregnancy requires the use of forceps, either in combination with vacuum aspiration or for a D&E, this should only be carried out by a skilled provider; if not available, medical management is recommended.

If infection is present, the uterus should be evacuated urgently

- Start broad-spectrum antibiotics immediately – intravenously if infection is severe.
- Transfer to a unit with the facilities for undertaking surgical evacuation if it cannot be done in the facility to which the individual presents.
- If the patient is in septic shock, they should be transferred immediately to a specialist unit for surgical uterine evacuation – broad-spectrum antibiotics, such as a combination of ampicillin 0.5–1g every 6 hours, metronidazole 500mg every 8 hour and gentamicin 120mg daily (with appropriate monitoring), should be administered intravenously prior to transfer if available.
- If the skills necessary for urgent surgical uterine evacuation are not available, misoprostol can be administered using the dose regimens above.

Prevention of post-treatment infection

Prophylactic antibiotics should be used before surgical evacuation as they have been shown to reduce the risk of infection. However, the procedure should not be delayed if antibiotics are not available.

The optimal regimen is not known but nitroimidazoles (e.g. metronidazole), tetracyclines (e.g. doxycycline) and penicillins have been shown to be effective.

The following regimen can be considered before surgical evacuation:

- oral doxycycline 100mg twice a day for 3 to 7 days, starting within 2 hours of the procedure (there is evidence that a 3-day course is as effective as a 7-day course).

STI screening

It is best practice to undertake a sexually transmitted infection (STI) risk assessment for everyone and conduct screening if appropriate, e.g., for chlamydia and gonorrhoea, which might be implicated in post-abortion infection, and for blood-borne viruses such as HIV and syphilis if such testing is available. This should be done without delaying the provision of post-abortion care.

Administer treatment doses of antibiotics to those with signs or symptoms of an STI. Partners of individuals with an STI also require treatment; ideally, a system for partner notification and follow-up or referral would be in place.

Blood tests

Pre-care assessment does not automatically require routine blood tests. Measurement of haemoglobin concentration or other blood tests is not required unless there are good clinical indications for doing so, such as for those with heavy bleeding, persistent significant bleeding and/or with symptomatic anaemia.

A determination of Rhesus blood status may be considered if the duration of pregnancy is over 12 weeks and anti-D is available.

Contraception

Discussions about contraception should be sensitively initiated. Not all people will want to discuss contraception at the time of post-abortion care. Those who do should be offered information about all their contraceptive options, without any pressure to choose a particular method.

Advice can be given on the greater effectiveness and duration of long-acting reversible contraception (LARC) methods (implants and IUDs) and of their safety, but no pressure should be put on clients to accept these methods.

All contraceptive methods can be started at the time of a surgical evacuation, unless sepsis is present, in which case an IUD should not be inserted (see appendix on post-abortion contraception).

All contraceptive methods except for IUDs can be started at the time mifepristone and/or misoprostol is taken. An IUD can be inserted following expulsion of the pregnancy.

Additional contraceptive precautions are not required if contraception is initiated immediately or within 5 days of an abortion.

If sterilisation is requested, this should ideally only be performed after some time has elapsed after post-abortion care. Individuals who request that tubal occlusion be performed at the time of an abortion should be advised of the increased failure rate and risk of regret.

If a client's chosen method is not available, they should be provided with an interim, bridging method that they can start immediately and they should be referred to a service where the preferred method can be provided.

Anti-D

If available, anti-D should be offered to non-sensitised RhD-negative individuals from 12 weeks of pregnancy and provided within 72 hours of a surgical evacuation.

Information to provide after post-abortion care

People can experience a range of emotions after an abortion. Health workers should provide information on how to access emotional support after an abortion in case this is needed.

Health workers should ensure that individuals know what to expect following the procedure and where to get help if necessary. They should also ensure that everyone who wants a method of contraception is able to leave with their method of choice or know how and where to access it.

Clients should receive instructions about signs and symptoms that might indicate a complication that requires urgent medical help, including if they:

- soak through two or more maxi-size sanitary towels per hour, for 2 hours in a row
- develop an unusual, unpleasant-smelling vaginal discharge
- develop a fever or flu-like symptoms after 24 hours
- develop worsening pain, including that which might indicate an undiagnosed ectopic pregnancy (for example, if lower abdominal pain is one-sided, under the ribs, or goes up to the shoulders).

Health workers should also provide information on signs and symptoms that might indicate an ongoing pregnancy for which clients should seek medical attention, including if they:

- have no bleeding or only spotting or smearing of blood on sanitary towel or underwear in the 24 hours after misoprostol for medical abortion
- still feel pregnant 1 week after the abortion.

Medically indicated abortion

The decision to provide a medically indicated abortion is usually made by an obstetrician and gynaecologist but all health workers who provide antenatal care should be aware of the circumstances in which abortion may be medically indicated in order to prevent significant harm and/or to save a person's life. Health workers at all levels should know where to refer women and pregnant people for whom abortion may be medically indicated and should be aware of the need to refer rapidly.

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

Information for individuals having a medically indicated abortion

All women and pregnant people for whom abortion is medically indicated should be informed about their options so that they can make an informed choice about their preferred course of action. Their choice should be respected without any unnecessary delay, as the earlier in pregnancy an abortion is undertaken the safer it is likely to be.

The following information should be provided in a clear, understandable, non-judgemental and respectful way:

- The choice of abortion methods available.
- What will happen during and after the abortion (see Table 1).
- What pain management options are available.
- Side effects, risks and complications of abortion methods (see Table 2).

- **How to identify the need to seek urgent medical attention during or after the abortion.**
- **The range of potential emotions experienced after an abortion.**
- **Other available services, such as STI screening, counselling for those who need it and support for those experiencing, for example, sexual coercion or domestic violence and abuse.**
- **What contraception options are available and how they can be accessed.**
- **Any care required for any pregnancy-related condition that necessitated the abortion.**

Table 1 What abortion methods entail; adapted from the WHO (2014) ***Clinical Practice Handbook for Safe Abortion*** and the NICE (2019) patient decision aids published with the ***Abortion Care*** guideline

Medical abortion	Surgical abortion
• Avoids surgery. • Mimics miscarriage. • May take place at home (depending on stage of pregnancy). • Takes time (hours to days) to complete and the timing may not be predictable. • The medications can cause nausea, vomiting, diarrhoea, chills and fever (1 in 10). • Will experience abdominal cramping and bleeding while passing the pregnancy (worse than during a period). • Abdominal cramping can last, on and off, for a week and bleeding for two to three weeks. • May see the pregnancy as it passes. • Serious complications are uncommon (see Table 2). • All contraceptive methods can be started at the time of the medical abortion, except intrauterine devices (IUDs), which can be inserted immediately after the pregnancy is expelled.	• Takes place in a healthcare facility. • Will experience some discomfort during procedures conducted with sedation and/or local anaesthetic. • Will experience no discomfort during procedures conducted under general anaesthetic. • The medications used to prepare the cervix cause cramps and bleeding and can cause nausea, vomiting, diarrhoea, chills and fever (1 in 10). • Will experience some pain and bleeding for one to two weeks afterwards. • Will not usually see the pregnancy, unless wishes to do so. • Requires a pelvic examination and insertion of surgical instruments into the uterus. • Serious complications are uncommon (see Table 2). • All contraceptive methods can be started at the time of the procedure, including the IUD.

Table 2 Complications and risks of abortion; adapted from the NICE (2019) ***Abortion Care*** guideline and the RCOG (2011) ***Care of Women Requesting Induced Abortion*** guideline

Complication/risk	Medical abortion	Surgical abortion
Continuing pregnancy	1–2 in 100	1 in 1000 Higher in pregnancies <7 weeks
Need for further intervention to complete the procedure	<14 weeks: 70 in 1000 >14 weeks: 13 in 100	<14 weeks: 35 in 1000 >14 weeks: 3 in 100
Infection*	Less than 1 in 100	Less than 1 in 100
Severe bleeding requiring transfusion	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000	<20 weeks: less than 1 in 1000 >20 weeks: 4 in 1000
Cervical injury from dilation and manipulation**	–	1 in 100
Uterine perforation	–	1–4 in 1000
Uterine rupture	Less than 1 in 1000 for second-trimester medical abortions***	–

* Upper genital tract infection of varying degrees of severity is unlikely but may occur after abortion and is usually associated with pre-existing infection. Infection after surgical abortion is reduced with use of prophylactic antibiotics.
** Cervical injury is less likely if cervical preparation is undertaken in line with best practice.
*** The presence of a uterine scar (e.g. following a previous caesarean) is a risk factor.

Further treatment (e.g. blood transfusion, laparoscopy, laparotomy or hysterectomy) may be required, should any serious complications occur.

There are several myths about the consequences of abortion. Individuals who express concerns can be reassured that there are no proven associations between having an abortion and subsequent ectopic pregnancy, placenta praevia, infertility, breast cancer or mental health problems.

It is best practice to invite a discussion about contraception at the initial consultation. If a contraceptive method is chosen, that method should be provided, where possible, at the time of the abortion.

Young people
Adolescents deserve the same amount of respect as everyone else accessing abortion care. It's important to remember how vulnerable a young person might feel when requesting an abortion, especially if it's their first time seeking healthcare. If the law requires an adult to consent to their procedure, this should be clearly explained to the young person at the start of the consultation. While all adolescents should be encouraged to involve a trusted adult in their decision, if possible, do **not** insist on parents' authorisation unless it is a legal requirement.

Information for health workers assessing individuals before a medically indicated abortion

If abortion is medically indicated to save a pregnant person's life, it may be an emergency as her condition is likely to worsen the longer that pregnancy continues.

Communicate information in a clear, understandable way. Providers should not impose personal values or beliefs on clients but focus on their needs and show empathy and respect for their decisions about treatment.

Whenever possible, women and pregnant people should be offered a choice of abortion method.

Clinical history taking should identify any health conditions that might affect eligibility for a particular method of abortion and any extra considerations that might affect the location of care and/or pre-treatment planning, including individuals with serious medical conditions who need to be referred for specialist care.

Health workers should ask about sexual and domestic violence and abuse (physical and emotional) and be able to refer the person to appropriate support services. If the assessment is being conducted by telephone, video call or online, the provider should be confident that the person is able to speak privately without risk of being overheard.

Health workers should be aware of the anxiety that clients may have about perceived negative and judgemental attitudes from healthcare providers.

Health workers can help relieve anxiety, create a safe and respectful environment, and counteract abortion-related stigma by:

- using welcoming words when they first meet the patient, making eye contact and smiling
- introducing themselves, explaining what the consultation will entail
- giving clear, concise and accurate information and encouraging questions
- trying not to make assumptions and by using value-neutral, unbiased language
- conveying how common abortion is.

> It is important that abortion eligibility by pregnancy duration is determined, that any contraindications to methods are identified and that post-abortion contraception is offered.

Determining pregnancy duration

The duration of the pregnancy will influence the method of abortion and whether the abortion can take place at home or should take place in a clinical facility. Pregnancy duration can be assessed from the first day of the last menstrual period (LMP). Most people can determine the duration of their pregnancy with reasonable accuracy by LMP alone.

Routine pre-abortion ultrasound scanning is unnecessary but, if available, should be used if there is clinically relevant uncertainty about the pregnancy duration or if there is a suspected ectopic pregnancy.

In circumstances where the pregnancy duration cannot be assessed by reliable LMP and where ultrasound scanning is not available, an abdominal examination can help determine pregnancy duration when it is over 12 weeks. A bimanual examination can be performed if the practitioner is still not sure of pregnancy duration after an abdominal examination and the information gained would change clinical management.

Contraindications and extra considerations

Medical abortion

There are few **contraindications** to medical abortion:

- known or suspected ectopic pregnancy
- previous allergic reaction to mifepristone or misoprostol
- severe uncontrolled asthma*
- chronic adrenal failure*
- inherited porphyria.*

* Mifepristone should not be used as there is a theoretical risk of exacerbation of the underlying condition, but use of misoprostol alone could be considered.

Extra consideration and additional care planning might be necessary for those:

- on **long-term steroid therapy** – theoretically, since mifepristone is a glucocorticoid receptor antagonist, it might inhibit the action of the steroid therapy and exacerbate the underlying condition; seek specialist input on whether dose adjustments to a corticosteroid regimen are required
- on **anticoagulant medication** – anticoagulants may need to be stopped before abortion medications are administered and then restarted after the abortion
- with a **bleeding disorder**, who may need care in a hospital setting
- with **symptomatic anaemia**, where the haemoglobin concentration should be measured and who may need additional care in a hospital setting.
- with an **IUD in place** – the IUD should ideally be removed in advance of treatment; if the IUD cannot be retrieved, it is important to confirm that it is expelled during the procedure, by using imaging such as an abdominal X-ray after the abortion.

Surgical abortion

Surgical methods of abortion are contraindicated if the pregnancy cannot be removed through the cervix, for example due to an obstructing tumour.

In the very rare case that a medical abortion is also not suitable in these circumstances, hysterotomy or gravid hysterectomy may be undertaken.

Medical (or other) conditions and considerations can affect the choice of anaesthetic, indicate a need for the abortion to be undertaken in hospital, or require additional or specialised equipment. These include bleeding disorders and abnormal placentation, use of anticoagulant medication, and severe cardiopulmonary disease. A very high body mass index (BMI), distortion of the uterine cavity by fibroids or another anomaly, previous cervical surgery or type 3 female genital mutilation (FGM)† can also make access to the cervix or pregnancy challenging. Procedure planning can include variations in patient positioning, use of longer instruments for evacuation, ultrasound guidance, and cervical preparation.

See the post-abortion care section above for prevention of post-abortion infection, STI screening, blood tests, contraception, anti-D and information to provide after an abortion.

† Type 3 FGM is the removal of external genitalia and the narrowing of the vaginal opening through the creation of a covering seal, also known as infibulation and/or being closed.

Information for health workers providing medically indicated abortions

Medical abortion

Before 12 weeks of pregnancy

If mifepristone is available, it is best practice to use it in combination with misoprostol as it is more effective than misoprostol alone, shortens the time taken to complete the abortion (the induction-to-abortion interval), reduces side effects and decreases the rate of ongoing pregnancy. There is no lower limit of pregnancy duration at which medical abortion can be performed. Medical abortion in the first 12 weeks can be safely managed by most people at home, is as safe and effective as in-facility treatment, and can be more convenient and private for people.

The most effective regimen is mifepristone 200mg orally, followed 24–48 hours later by misoprostol 800 micrograms taken by the vaginal, buccal or sublingual route.

- If expulsion of the pregnancy has not occurred within four hours, then a further 400 micrograms of misoprostol should be taken by the vaginal, buccal or sublingual route.
- If misoprostol is provided for use at home, additional doses should be provided in case they are required. This is especially important to consider for pregnancy durations of over 9 weeks as the effectiveness of a single dose of 800 micrograms of misoprostol starts to decline from then onwards.

If mifepristone is not available, use misoprostol 800 micrograms taken by the vaginal, buccal or sublingual route, followed by misoprostol 400 micrograms every 3 hours until the pregnancy has passed.

12–24 weeks of pregnancy

At 12 weeks or more, medical abortion is usually undertaken in a medical facility. However, there is no evidence indicating that out-of-facility medical abortion is unsafe.

If mifepristone is available, it should be used in combination with misoprostol as it shortens the induction-to-abortion interval, reduces side effects and decreases the rate of ongoing pregnancy.

The most effective regimen is mifepristone 200mg orally, followed 24–48 hours later by misoprostol 800 micrograms vaginally*, buccally or sublingually†, followed by misoprostol 400 micrograms vaginally, buccally or sublingually every 3 hours until abortion occurs.

Where mifepristone is not available, use misoprostol 800 micrograms followed by misoprostol 400 micrograms every 3 hours until abortion occurs.

The uterus is more sensitive to misoprostol as pregnancy advances, and therefore, in pregnancies over 24 weeks lower doses of misoprostol should be used and increased intervals between misoprostol doses may be considered, especially for people with uterine scars.

* Avoid vaginal misoprostol if there is significant bleeding as it may not be absorbed as effectively.
† Oral misoprostol is less effective than misoprostol administered vaginally, buccally or sublingually.

Pain management for medical abortion

Analgesia (pain relief) should **always** be offered.

- Nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended either prophylactically or at the time that cramping begins.
- Non-pharmacological pain management measures (e.g. hot water bottle/heat pad) may be helpful.
- Pain increases with pregnancy duration so narcotic analgesics may be required when other pain management measures are insufficient. Epidural anaesthesia can also be used, where available.

Surgical abortion

Before 14 weeks of pregnancy

Surgical abortion before 14 weeks can be performed using **vacuum aspiration** (electrical (EVA) or manual (MVA)).

Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. EVA employs an electric vacuum pump. With MVA, the vacuum is created using a hand-held, hand-activated, plastic 60 ml aspirator (also called a syringe).

- MVA aspirators accommodate 4–12 mm cannulas.
- There is no lower limit of pregnancy duration for surgical abortion.
- It is best practice to inspect aspirated tissue at all durations of pregnancy, to confirm that the pregnancy has been fully removed.
- During vacuum aspiration, the uterus should be emptied using only a suction cannula (and forceps if required). The procedure should **not** be routinely completed by sharp curettage.

14–24 weeks of pregnancy

Surgical abortion between 14 and 24 weeks can be performed using dilatation and evacuation (D&E).

D&E requires preparation of the cervix using osmotic dilators or pharmacological agents, and evacuating the uterus using long forceps and vacuum aspiration with cannulas. It is the safest and most effective surgical technique after 14 weeks, as long as skilled, experienced providers are available.

Vacuum aspiration can be used up to 15–16 weeks of pregnancy with larger bore suction tubing and cannulas up to 16 mm in diameter.

> Dilatation and sharp curettage (D&C) is an obsolete method of surgical abortion and should not be used.

Cervical preparation before surgical abortion

Cervical preparation should be used for all patients as it reduces the risk of incomplete abortion and makes dilation easier. It may cause some bleeding and pain before the procedure. If osmotic dilators are used, consider inserting them the day before the abortion, especially if pregnancy duration is 19 weeks or greater.

Before 12 weeks of pregnancy:

- mifepristone 200mg orally, 24–48 hours before the procedure, or
- misoprostol 400 micrograms sublingually, 1–2 hours before the procedure, or
- misoprostol 400 micrograms vaginally or buccally, 2–3 hours before the procedure.

12–18^{+6} weeks of pregnancy:

- combination of mifepristone and misoprostol* (using above regimens), or
- osmotic dilators plus either mifepristone or misoprostol, or with both mifepristone and misoprostol (using above regimens in all cases).

19–24 weeks of pregnancy:

- osmotic dilators plus either mifepristone or misoprostol, or with both mifepristone and misoprostol (using above regimens in all cases).

Pain management for surgical abortion

Analgesia should **always** be offered.

- In most cases, analgesics, such as NSAIDS, local anaesthesia and/or conscious sedation, supplemented by verbal reassurance, are sufficient.
- General anaesthesia is not recommended for routine use in pain management for abortion procedures, as it has been associated with higher rates of complications, and with longer hospital stays, than local anaesthesia.
- Local anaesthesia, such as lidocaine given as a paracervical block, can be used to alleviate discomfort from mechanical cervical dilatation and uterine evacuation.
- Where conscious sedation is available, it should be offered with a cervical block.
- If general anaesthesia is used, consider intravenous propofol and a short-acting opioid (such as fentanyl) rather than inhalational anaesthesia.
- NSAIDS can be used to alleviate abdominal cramping caused by misoprostol given for cervical preparation.

See the post-abortion care section above for prevention of post-abortion infection, STI screening, blood tests, contraception, anti-D and information to provide after an abortion.

Follow-up

There is no need for routine follow-up after an uncomplicated medically indicated abortion. Rather, individuals should be given clear information on when to seek medical help, as outlined above.

Service delivery

The provision of a safe and effective post-abortion care service, and of safe abortion care when medically indicated, depends on everyone involved in the service ensuring that everything can be done to meet the need. It is not enough for doctors, nurses and midwives to have the clinical skills for post-abortion 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 post-abortion care. **Best practices for service delivery** are listed below.

Access to services

1. Abortion services should 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.

* Sometimes more than one dose of misoprostol may be required to get adequate dilation.

2. Health workers should know the process required to fulfil the legal criteria for abortion. There should be no further restriction of access on grounds such as age, marital status or the number of previous abortions.
3. Abortion is safer the sooner it is done. Services should provide abortions as early as possible and as close to home as possible.
4. All healthcare providers should be trained to provide comprehensive post-abortion care in line with their skills and licences. This can help spread the workload and improve the skills of *all* providers of women's healthcare, thereby enhancing access to and increasing the safety of abortion care.
5. Integrating services for post-abortion care, and for medically indicated abortions, within mainstream maternity and women's health services minimises the stigma associated with abortion care for both patients and providers.
6. In settings where individuals with incomplete abortion are likely to present but 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 pregnant people and to healthcare providers on routes of access to post-abortion care and to medically indicated abortions.
2. Services should ensure that written, objective, evidence-guided information is available in a way that is understandable to all people needing post-abortion care or medically indicated abortions. Information should be available in a variety of languages and formats.
3. Women and pregnant people for whom abortion is medically indicated should have access to objective information and, if required, counselling and decision-making support about their options. However, there should be no requirement for compulsory counselling.
4. Services should identify people who may be particularly vulnerable (e.g. some adolescents, those in controlling, abusive relationships, people addicted to drugs/alcohol, people with moderate/severe mental health problems) and refer/signpost them on to appropriate support services.

Arrangements for the procedure

1. To minimise delay, service arrangements should be such that post-abortion care and medically indicated abortions can be provided as soon as possible, ideally on the same day as the assessment.
2. The setting for post-abortion care services and for medically indicated abortions (consultation rooms, procedure rooms and recovery rooms) should respect the need for clients' privacy and dignity.

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Appendix: Post-abortion contraception

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

Method of post-abortion contraception	Medical eligibility criteria (MEC) category		
	First trimester	Second trimester	Immediate post-septic abortion
CHC	1	1	1
POP	1	1	1
Progestogen-only injectable	1	1	1
Progestogen-only implant	1	1	1
Cu-IUD	1	2	4
LNG-IUD	1	2	4
Condom	1	1	1
Spermicide	1	1	1
Diaphragm	1	1	1

CHC = combined hormonal contraception (pill, patch, ring, injectable).
POP = progestogen-only pill.
Progestogen-only injectable = depot medroxyprogesterone acetate or norethisterone enanthate.
Progestogen-only implant = levonorgestrel or etonogestrel.
Cu-IUD = copper-bearing IUD.
LNG-IUD = levonorgestrel-releasing IUD.
Condom = male latex condom, male polyurethane condom or female condom.
Diaphragm = diaphragm (with spermicide) or cervical cap.

MEC categories for contraceptive eligibility	
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 which represents an unacceptable health risk if the contraceptive method is used.

Recommendations for contraceptive use among women at high risk of HIV infection

- Women at high risk of HIV infection are eligible to use all hormonal contraceptive methods without restriction (MEC category 1), including combined hormonal contraception, progestogen-only pills, and progestogen-only injectables and implants.
- Women at high risk of HIV infection are also eligible to use Cu-IUD and LNG-IUDs without restriction (MEC category 1).

Contraception for individuals on antiretroviral therapy for HIV

There are potential drug interactions between some antiretroviral drugs and hormonal contraception that may affect efficacy of some methods of hormonal contraception. Providers should advise clients on the risk so that they can make an informed choice of method.

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