

THE UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,
GENDER, ELDERLY AND CHILDREN

COMPREHENSIVE POST-ABORTION CARE GUIDELINES

August 2020

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Foreword

Globally, there has been a 44.5% reduction of maternal deaths from 532,000 in 1990 to 295,000 in 2017. Sub-Saharan Africa (SSA) carried the biggest burden that accounted for two-thirds of all global maternal deaths, while Southern Asia accounted for nearly one-fifth (3). Between 2000 and 2017, the global maternal mortality rate declined by 38%, from 342 to 211 maternal deaths per 100,000 live births, respectively (3). Routine maternal and perinatal death data in Tanzania Mainland in 2018 and 2019 showed that abortions and related complication is among the top ten causes of maternal mortality. A study by NIMR, MUHAS and Guttmacher Institute in 2013 showed that there is variation of abortion incidence in various geographical areas in Tanzania (7). The highest abortion rate was recorded in the Lake zone (51 abortions per 1,000 women of reproductive age) followed by the Southern Highlands (47 per 1,000); the lowest rate was found in Zanzibar (11 per 1,000) (7). These variations correlated with differences in rates of contraceptive use and unintended pregnancy, and the likelihood of women resorting to abortion in the event of an unintended pregnancy.

Deaths from abortion complications can be prevented by equipping health care workers at all levels with knowledge and skills to provide comprehensive Post Abortion Care (cPAC). This includes the use of recommended uterotonic drugs (Misoprostol and oxytocin), performing Manual Vacuum Aspiration (MVA) of retained products of conception for incomplete abortions for pregnancies which are below 13-weeks and other services like counselling for voluntary use on contraceptive methods. This will eventually contribute significantly towards reduction of maternal mortality.

In efforts to improve quality and availability of obstetric care in Tanzania, MoHCDGEC in collaboration with development partners developed a guideline in 2019 (Clinical Practice Guidelines on Appropriate Use of Uterotonics) (11) which highlights the use of Misoprostol in the management of missed and incomplete abortions. In view of this and other existing global and local evidences, the Ministry in collaboration with the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) and development partners reviewed the 2015 national cPAC guideline and other learning resources package to address evolution of technologies in services provision, competency capacity building and incorporating legal guidance on abortion. This guideline is intended to serve as a standard tool for capacity building in imparting cPAC knowledge and skills to health care providers in Tanzania. The guideline will also enable maternity care providers to timely diagnose, manage and refer abortions and related complications.

I recommend this guideline to be used as a standard tool for managing patients with abortion and abortion-related complication, and the Ministry, expects that all RMNCAH stakeholders will align to this guideline whenever they plan and implement trainings, mentorship and coaching on cPAC and other abortion-related interventions throughout the country.

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Acknowledgements

The Ministry of Health would like to thank the Assistant Director of Reproductive and Child Health Section (RCHS) Dr. Ahmad M. Makuwani for providing leadership and guidance during development of this guideline and for ensuring that all maternal health stakeholders are well aligned with the national plans towards improving maternal health.

This guide was developed under the contributions of individuals and stakeholders from different institutions. Special thanks to Muhimbili University of Health and Allied Sciences, Muhimbili National Hospital, Aga Khan Hospital, Njombe Regional Referral Hospital, Dodoma Regional Referral Hospital, Pathfinder International Tanzania, Thamini Uhai, JHPIEGO, Marie Stopes Tanzania, Ifakara Health Institute, Regency Hospital, Bugando Medical Centre, Kilimanjaro Christian Medical Center, Mbeya Zonal Referral Hospital, Mawenzi Regional Hospital and Tikaya Health Centre for releasing their valuable staff who provided the best evidence-based contributions during the whole process of developing these guidelines.

The Ministry would like to give sincere thanks to the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) and the World Health Organization (WHO) Country Office for the technical assistance and updates on cPAC and management of abortion and abortion-related complications.

Finally, the Ministry would also like to thank Pathfinder International Tanzania country office for their valuable financial and logistical support throughout the development of these guidelines.



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Technical Statement

Tanzania has been implementing Health Sector Strategic Plan IV (HSSP IV) and National Roadmap Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) 2016-2020 (One Plan II) (1,2) both of which are ending in 2020; with the fifth Health Sector Strategic plan (HSSP V) and One plan III in final stages of development. These documents provide a framework that demonstrates the nation's commitment to improve women and girls' welfare in line with global commitments underlined in the 2015 Global Strategy for Women's, Children's and Adolescents' Health; in line with our commitment to achieve the Sustainable Development Goals.

When discussing post-abortion care, it must be understood that about 80% of spontaneous abortions taking place in the first trimester are due to genetic abnormalities. However, we also recognize that there are cases of induced abortions. Therefore, our approach as a health care system is to prevent these abortions, but when they occur, our role and commitment is to provide treatment that meets standards of quality care and is non-judgmental.

The recently (2019) developed "Clinical Practice Guidelines on Appropriate Use of Uterotonics: for post Abortion Care, Induction of Labour, Prevention and Treatment of Postpartum Haemorrhage" recommends the use of Misoprostol in addition to MVA in provision of cPAC services. The decision to use Misoprostol or MVA may be reached by informed choice, or Misoprostol may be preferred if the provider is technically incompetent to perform MVA, MVA sets are not available or the facility has no adequate premises for provision of MVA at required standards, including Infection Prevention and Control (IPC). Provision of Misoprostol in treatment of abortions is a medical advance that enhances harm reduction, and increases access to services among underserved populations, especially in rural dispensaries, enhancing IPC, ensuring compassionate and respectful maternity care, mitigation of pain during surgical removal of retained products of conception, avoiding unnecessary anaesthesia and time reduction in receiving care.

This guideline has further, provided clarification on medical legal aspects and regulations related to termination of pregnancy on medical grounds, in line with the Tanzania Penal Code, Cap 16, Section 150, 151, 152, 219 and 230. These Penal Codes provide guidance on punishment in case of termination of pregnancy, unless it is done on medical grounds.

Integration of RMNCAH services is much emphasized in these guidelines. Comprehensive care must ensure post-abortion patients receive counseling and voluntary family planning services of their choice. The patients should also receive information and screening for Syphilis, Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV). Furthermore, patients should have access to information and services on breast and cervical cancer screening.

The Department of Preventive Services emphasizes that our goal is to prevent unintended pregnancies through health education in schools, out of schools and to the community at large on the importance and knowledge on contraception and good parental/guardian care. Learning from other guidelines, it is encouraged to invest on comprehensive engagement with school health programs on comprehensive sexual reproductive health education to support boys and girls understand bodily changes and live a healthy adolescence lives.



Dr. Leonard Subi

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Abbreviations

AGOTA	Association of Gynaecologists and Obstetricians of Tanzania
AMO	Assistant Medical Officer
ANO	Assistant Nursing Officer
BP	Blood Pressure
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHMTs	Council Health Management Teams
CO	Clinical Officer
cPAC	Comprehensive Post-abortion Care
DHIS	District Health Information System
EmONC	Emergency Obstetric and Neonatal Care
FP	Family Planning
GA	Gestation Age
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IPC	Infection Prevention and Control
IUCD	Intrauterine Contraceptive Device
MO	Medical Officer
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MVA	Manual Vacuum Aspiration
PPE	Personal Protective Equipment
RH	Reproductive Health
R&R	Report & Request
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG	Sustainable Development Goals
SNO	Senior Nursing Officer
STIs	Sexually Transmitted Infections
WHO	World Health Organization

CHAPTER

1 Introduction

1.1 Background

Tanzania has been implementing the Health Sector Strategic Plan IV (HSSP IV) (1) and National Roadmap Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) 2016-2020 (One Plan II) (2) both of which are ending in 2020; with the fifth Health Sector Strategic plan (HSSP V) and One plan III in final stages of development. These documents provide a framework that dictates the importance and emphasizes the nation's commitment to improve women and girls' welfare in line with global commitments underlined in the 2015 Global Strategy for Women's, Children's and Adolescents' Health(3), which is a fore-runner for delivery of the global Sustainable Development Goals (SDGs) (4). Cognizant of the fact that SDGs are founded on human rights and equity and are based on the recognition that we have the opportunity and responsibility to further transform the way we work from 2016 to 2030 by being efficient and effective. In line with this commitment, the Government of Tanzania in collaboration with development partners have been investing heavily on programs to improve universal availability and access of reproductive health (RH) services to women and girls.

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) in Assessment of Emergency Obstetric and Neonatal Care (EmONC) services in Tanzania Mainland estimated that abortion related complications contributed to 10% of all maternal deaths, which is similar to global estimates (5). Often times, abortion-related deaths are under-reported, as was observed in a MOHCDGEC-led review of 1,744 and 1,657 maternal deaths that occurred in health facilities and communities for the year 2018 and 2019, respectively(6). In this review, the observed contribution of abortion-related complications on these maternal deaths was around 3%, which sounded to be an under-estimation. Guttmacher reports released in 2016 showed that the national average rate of abortion in Tanzania was 36 per 1,000 women of reproductive age (WRA), which was similar to that of the rest of East African countries. However, the rates were considerably higher in the Lake zone (51 per 1,000 WRA) and Southern Highlands (47 per 1,000 WRA), and low in Zanzibar (11 per 1,000 WRA) (7). These variations were correlating with disparities in the use of contraceptive services, whereby regions with low contraceptive prevalence rates had higher abortion rates that may be attributed to unintended pregnancies. Tanzania has come a long way in improving availability of RMNCAH services. There has been a progressive increase in family planning (FP) users as shown by increase in modern contraceptive prevalence rate from 16% in 1991/92, 20% in 2004/5, 27% in 2010 and 32% in 2015/16 (8). Despite the increase in contraceptive use, maternal mortality has remained unacceptably high over decades, with over 90% of deaths occurring in health facilities.

Abortion, regardless of its cause may result into death. Globally, maternal deaths due to abortion are estimated to be around 10% (7). Most deaths are due to unsafe abortions which resulted from life threatening conditions. Lack of sexual health education missed opportunity for FP services, unintended interfered pregnancies and lack of post-abortion care services may all lead to bad outcomes, which include severe morbidity or death.

The Comprehensive Post-Abortion Care (cPAC) national guidelines of 2015 has done a lot in supporting the country to scale up the availability of post-abortion care services through capacity building, mentoring and coaching of health facilities and health care providers(9). However, this guideline has been superseded by events, particularly in the evolution and country assimilation of local and global evidences in provision of quality post-abortion care. The main stay for cPAC includes counselling, voluntary FP services, pain management, compassionate care and finally, evacuation of retained products of conception from the uterus. It also includes linkage with other RH services and community involvement in order to empower the community, create awareness, address stigma and mobilize resources. In the 2015 national cPAC guidelines, evacuation of the uterus was recommended to be done only by the use of Manual Vacuum Aspiration (MVA) and in some rare cases, with curettage(9). Using Misoprostol allows post-abortion care services to be delivered at lower facilities that include dispensaries where there is limited number of skilled health care providers proficient to perform MVA. Furthermore, the use of Misoprostol acknowledges major challenges in achieving ideal cPAC room with good Infection Prevention and Control (IPC) conditions and mitigating the challenge of pain management during evacuation (10). Last but not least, use of uterotonics ensures a woman from remote villages receives services without a need to travel long distances to access a hospital to meet a highly skilled health care provider to perform surgical evacuation of the uterus.

1.2 Rationale for the guidelines

The recently (2019) developed “Clinical Practice Guidelines on Appropriate Use of Uterotonics: for post Abortion Care, Induction of Labour, and Prevention and Treatment of Postpartum Hemorrhage” recommends the use of Misoprostol in addition to MVA in treatment of abortion (11). Furthermore, the 2015 national cPAC guidelines lacked clear emphasis on IPC measures, monitoring and evaluation framework for cPAC services. The recently approved Tanzania National IPC Guidelines for Health Care Services were launched in June 2018 and provide a room and emphasis for ensuring IPC measures while providing cPAC services (12). Moreover, these cPAC guidelines will also explain how to monitor and evaluate cPAC services in order to produce realistic data that can be used to inform the design and implementation of programs aimed at reducing morbidity and mortality associated with abortions and scaling up cPAC services.

1.3 Goals

These guidelines intend to bridge the gap of service provision to the grass root level by ensuring that cPAC services are provided at all levels of healthcare delivery system in Tanzania. Furthermore, the guidelines put emphasis on provision of quality services by reinforcing compassionate and respectful maternity care, strong integration to expanded access to voluntary FP services, reinforcing pain management, IPC and monitoring and evaluation.

By attaining these goals, Tanzania will be putting milestones towards addressing the program of action from the Nairobi International Conference on Population and Development (ICPD25+) commitment that commits countries to zero unmet need for FP information and services, zero preventable maternal deaths and morbidity, and zero gender-based violence and harmful practices (13).

1.4 Target audience

These guidelines are made to be used by all stakeholders/key players involved in planning, organizing, implementing, and monitoring programs and supporting health care providers who provide reproductive and adolescent health services in Tanzania. Therefore, it is to be used by policy-makers, project managers of various RMNCAH programs (from the government and non-governmental organizations) and qualified health care providers offering reproductive health services at all facility levels in Tanzania.

1.5 Methodology used to review the guideline

Once the need for review of the 2015 national cPAC guideline was identified, the MoHCDGEC commissioned AGOTA to review the existing cPAC guidelines and develop a new one. The team had an online inception meeting with the MoHCDGEC and other RMNCAH stakeholders to identify gaps in the national cPAC guidelines of 2015 and other needs for improving cPAC services. A desk review was then done, using mainly the *Tanzanian Clinical Practice Guidelines on Appropriate Use of Uterotonics: for post Abortion Care, Induction of Labour, and Prevention and Treatment of Postpartum Haemorrhage* that was launched in 2018; the *Tanzania National IPC Guidelines for Health Care Services* launched in June 2018 and the *World Health Organization's Medical management of abortion* of 2019, among others. The first draft was then written and was shared to 20 selected members of the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA) for their professional review. The improved draft 2 of the guidelines was then reviewed by stakeholders and members of the Safe Motherhood Technical Working Group in a 3-day workshop organized by MoHCDGEC. Draft 3 was shared with the MoHCDGEC for further refinement and improvement. The improved final draft was then approved for printing in August 2020.

2 Comprehensive Post Abortion Care

CHAPTER

Comprehensive Post-Abortion Care is a term used to describe a package of services as an approach of managing patients with abortion or abortion-related complications. It encompasses five core components namely:

- i. Counselling.
- ii. Treatment of the emergency condition facing the patient, including uterine evacuation.
- iii. Provision of voluntary FP methods of a patient's choice.
- iv. Linkage with other RH services (like screening and management of STIs (including HIV), breast and cervical cancer screening.
- v. Community involvement in order to raise awareness, address stigma and reduce abortions and its complications.

cPAC has the following advantages:

- i. It reduces maternal mortality and morbidity associated with abortions.
- ii. Since the counselling for FP is done immediately (before or after the management of the abortion related morbidity depending on the clinical condition of the patient), majority of women accept voluntary contraception. This increases the contraceptive prevalence rate and reduces unwanted pregnancies, unsafe abortions and maternal mortality related to it.

2.1 Counselling

Counselling is an interactive process whereby information is shared between the provider and the patient, in order to help them make informed decisions on how the patient will be managed. Counselling is integral to all the other components of cPAC, especially when guiding the patient to make informed decisions on the method of uterine evacuation and FP method.

A provider should provide information, offer emotional support and always encourage the patient to ask questions.

Post abortion FP counselling and voluntary service provision is an important preventive part of cPAC. It reduces future unwanted pregnancies and unsafe abortions. Women who are planning to conceive should be advised to wait for at least 6 months before becoming pregnant again. This will ensure a healthier pregnancy as it will reduce maternal anemia, recurring abortion, preterm delivery and low birth weight. Important points for counselling during cPAC include:

- i. The possible reasons (if any) that caused the abortion to occur, so that she can avoid the causative factors in the future.
- ii. The options available for managing the patient, how they will be administered or performed, their advantages, disadvantages, and side effects.
- iii. The importance of using FP immediately after the abortion, the available FP methods that she can use with respect to her condition and her reproductive goals, how they are administered, their mode of action, their side effects.
- iv. When to resume sex.
- v. When to expect resumption of fertility and menstruation

2.2 Treatment of the emergency conditions

Patients presenting to the health facility for abortion or abortion - related complications may experience vaginal bleeding or spotting, abdominal pain, damage to the internal organs, shock or sepsis. Depending on their presentation, patients may need immediate treatment of life-threatening conditions to save their lives. Therefore, it is very important for the provider to first to triage the patient by the ABCD approach (rapid clinical assessment) in order to decide whether the patient can tolerate preliminary counselling or whether it should be deferred to a later time. Counselling of a client about FP before offering treatment helps to guide to make an informed voluntary choice of FP method. For example, an Intrauterine Contraceptive Device (IUCD) can be inserted immediately after an MVA has been done before removing the speculum.

Emergency treatment provided will depend on the woman's condition, but often includes stabilization of the patient using the ABCD approach, evacuation of remaining products of conception, managing pain and treating infection.

If the patient is in shock:

- i. Shout for help, mobilize resources and apply ABCD principles of resuscitation.
- ii. Insert two large bore cannula and obtain blood for haemoglobin and X-matching.
- iii. Resuscitate with IV-Ringer's lactate OR normal saline depending on estimated blood loss (1: 3 ratio of blood loss to crystalloids replacement). If estimation of blood loss is difficult to do, give 3 litres in 1 hour.
- iv. Insert an indwelling urethral catheter and Give IV Ampicillin 2g stat.

Refer the patient if the facility does not provide Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services as the patient may need blood transfusion

2.3 Abortion and its management

Abortion is defined as the termination of pregnancy before 28 weeks of gestation. It can be spontaneous or induced. Spontaneous abortion (also known as miscarriage) is the spontaneous expulsion of products of conception while an induced abortion is defined as an abortion process that has been initiated by someone. This can be by use of medications or instruments inserted into the uterus.

i. Types of abortion and their management

There are 7 types of abortion. These are:

(a) Threatened Abortion

Definition: Vaginal bleeding or spotting before 28 weeks of gestation with a closed cervix.

Management

Investigate to establish the cause of bleeding and manage accordingly. If there is no specific cause:

- ✓ Bed rest and avoid strenuous activities and sexual intercourse until two weeks after stopping of vaginal spotting or bleeding.
- ✓ Follow up within 7 days.
- ✓ Counselling must be done to the patient.

She should come immediately if bleeding becomes heavy or she notices offensive vaginal discharge or severe abdominal pain.

If at a lower level facility, refer the patient if on the 7th day the patient still has symptoms, as she will need to be further investigated.

(b) Inevitable abortion

Definition: refers to a stage in the abortion process when it is no longer possible for the pregnancy to continue.

Management

- ✓ Apply ABCD principles of resuscitation.
- ✓ Give intravenous (IV) Ringer's lactate or normal saline if the patient is hemodynamically unstable; depending on estimated blood loss (1: 3 ratios of blood to crystalloid. If the estimation of blood loss is difficult to do, give 3 litres in 1 hour.
- ✓ Provide necessary pain medication.

- ✓ Observe for spontaneous expulsion for six hours. If the foetus is not expelled, then proceed as below:

If gestation age (GA) is 12 weeks or below

- ✓ Perform MVA and give other cPAC services.

If GA is above 12 weeks

- ✓ Augment the process of abortion by administering Oxytocin 10 IU in 500 MLs of Ringers lactate at rate 40-60 drops per minute.
- ✓ If augmentation with oxytocin is not possible, give Misoprostol 400mcg vaginally/ sub-lingual/ buccal cavity for pregnancies at 13-25 weeks and 200mcg for pregnancies at 26-27 weeks. The dose can be repeated after every 6 hours (maximum 4 doses).
- ✓ Closely monitor patients with a previous uterine scar. Manage as incomplete abortion if after augmentation, some products of conception remain in the uterus.
- ✓ Manage as complete abortion if all products of conception are expelled.

(c) Incomplete abortion

Definition: Incomplete abortion occurs when some of the products of conception are retained in the uterine cavity, while some have been expelled.

Management

- ✓ Apply ABCD principles of resuscitation.
- ✓ Give IV fluids-Ringer's lactate or normal saline if the patient is hemodynamically unstable; depending on estimated blood loss (1: 3 ratio of blood loss to crystalloids replacement). If the estimation of blood loss is difficult to do, give 3 litres in 1 hour.
- ✓ Provide necessary pain medication.
- ✓ Perform digital evacuation of any obvious reachable products of conception.

If gestation age (GA) is 12 weeks or below

- ✓ Upon counselling, you may give Misoprostol 600 mcg orally or 400mcg sub-lingual (Repeated dose may be given after six hours to achieve complete expulsion) (10). Patient may be referred to higher level facility for the second dose of Misoprostol if the time for the second dose is not feasible for the lower level facility)

OR

- ✓ Perform MVA. Then manage as complete abortion

If gestation age (GA) is above 12 weeks

- ✓ The patient should be admitted and managed at a CEmONC facility until complete evacuation has been achieved.
- ✓ Upon counselling, you may give Misoprostol 400mcg orally, in the vagina, sub-lingual/ or through the buccal cavity for GA of 13-26 weeks and 200mcg for GA of 26-27 weeks (10). The doses may be repeated at least 3 hourly apart until expulsion of remaining products of conception has been attained (A maximum of four doses)
- ✓ If Misoprostol is not available and the patient is severely bleeding, perform uterine evacuation with curettage. Then manage as complete abortion.

Curettage should only be done as a last resort when Misoprostol is not available or failed and should be done in facilities providing CEmONC services.

NB: Do not give Misoprostol or oxytocin to women with a previous uterine scar

- ✓ If Misoprostol is not available and the facility cannot provide curettage, refer the patient immediately with Oxytocin running (*Oxytocin 10 IU in 500mls of Normal saline for primigravida. For multigravida start with 5 IU. Start with 10 drops per minute. Increase 10 drops per minute after every 30 minutes to a maximum of 60 drops per minute*).

(d) Complete abortion

Definition: Complete abortion is when the products of conception are completely expelled.

Management

- ✓ Give oral antibiotics: Amoxicillin 500 mg for 5 days.
- ✓ Give Fefol 1 tablet twice daily for 3 months and reassess after every 4 weeks.
- ✓ Provide other cPAC services.

(e) Septic abortion

Definition: Septic abortion is defined as an abortion complicated by infection.

Management

- ✓ Apply ABCD principles of resuscitation.
- ✓ Insert two large bore cannula and obtain blood for haemoglobin and X-matching.

- ✓ Resuscitate with IV-Ringer's lactate OR normal saline 3 litres or more in the first hour.
- ✓ Insert an indwelling urethral catheter.
- ✓ Give Ampicillin 2gm IV AND Metronidazole 500mg IV AND Gentamicin 80mg IM stat (Or use Ceftriaxone 2g IV and Metronidazole 500mg IV stat).
- ✓ Provide necessary pain medication.
- ✓ If abortion is incomplete (products of conception in utero), manage as incomplete abortion in addition to the above measures (at least one hour after the administration of antibiotics).

Refer the patient if the facility does not provide CEmONC services, as the patient may need surgery or blood transfusion

(f) Molar abortion

Definition: Molar abortion is an abortion of a pregnancy that is characterized by abnormal proliferation of the chorionic trophoblastic villi leading to multiple grape-like vesicles usually in the absence of embryo or normal placental tissue.

Management

- ✓ Apply ABCD principles of resuscitation.
- ✓ Insert two large bore cannula (preferably size 14 or 16) and obtain blood for haemoglobin and X-matching.
- ✓ Resuscitate with IV-Ringer's lactate OR normal saline depending on estimated blood loss (1: 3 ratio of blood loss to crystalloids replacement). If the estimation of blood loss is difficult to do, give 3 litres in 1 hour.
- ✓ Insert an indwelling urethral catheter.

Refer the patient if the facility does not provide CEmONC services, as the patient may need evacuation curettage, blood transfusion and further evaluation. CEmONC facilities that cannot do B-hCG should refer the patient to a facility that can do the test.

NB: Patient with molar pregnancy may progress to chorio-carcinoma. For this reason, remember all patients with molar pregnancy need to be followed up for at least one year to monitor serum β -HCG titers returning to normal. During this period, patients should be informed that they must avoid conception and must be counselled for voluntary contraceptive use.

Patients with molar abortion should not be given Misoprostol as this may precipitate sudden death due to embolism

(g) Missed abortion

Definition: This occurs when the embryo/foetus dies despite the presence of a viable placenta (with disappearance of signs and symptoms of pregnancy), and the sac is retained as the cervix remains closed. The mother's body fails to recognize this foetal demise.

Management (only at a CEmONC facility)

Refer the patient if the facility does not provide CEmONC services, as the patient may need further evaluation and management.

- ✓ An Ultrasound is needed to confirm embryo/foetal death
- ✓ Check the bed side clotting time and full blood picture before attempting evacuation.

If the GA is 12 weeks or less

- ✓ Upon counselling, Misoprostol 800mcg sub-lingual, in the buccal cavity/vaginally may be given, stat dose. This dose may be repeated after 6 hours.

OR

- ✓ Perform MVA. A 200mcg vaginal misoprostol dose may be inserted 12 hours before the MVA procedure in order to ripen the cervix, and therefore reduce the trauma associated with cervical dilatation.

If the GA is 13-26 weeks

- ✓ Misoprostol 200mcg sub-lingual or vaginally may be given for every 4-6 hours until complete expulsion of the products of conception (maximum 4 doses). Once the cervix has dilated, oxytocin may be continued as management of inevitable abortion.

If the GA is 27 weeks

Administer Misoprostol 100mcg vaginally/sub-lingual/ or through the buccal cavity every 4-6 hours (maximum 4 doses). Once the cervix has dilated, oxytocin may be continued as management of inevitable abortion.

- ✓ Provide any necessary pain medication.
- ✓ If there are any retained products after this, curettage should be done.
- ✓ Manage as complete abortion if all products of conception are expelled.

ii. Intra-abdominal injury

Patients who have induced abortions and sustained uterine and/or bowel perforations should be managed as explained below:

- i. Apply ABCD principles of resuscitation.
- ii. Insert two large bore cannula and obtain blood for haemoglobin and X-matching.
- iii. Resuscitate with IV-Ringer's lactate OR normal saline 2 litres or more in the first hour.
- iv. Insert an indwelling urethral catheter.
- v. Give Ampicillin 2gm IV AND Metronidazole 500mg IV AND gentamicin 80mg IM stat (Or use Ceftriaxone 2g IV and Metronidazole 500mg IV stat).
- vi. Provide necessary pain medication.

Refer the patient if the facility does not provide CEmONC services, as the patient may need surgery or blood transfusion.

Table 1: Management of abortions at different levels of health care

Condition	Dispensary	Health Centre	District and other Hospitals
Threatened abortion	YES	YES	YES
Inevitable abortion	Stabilize the patient and REFER	' YES ' for facilities providing cPAC services, otherwise stabilize the patient and REFER	YES
Incomplete abortion	' YES ' for facilities providing cPAC services, otherwise stabilize the patient, give first dose of an antibiotic and REFER	' YES ' for facilities providing cPAC services, otherwise stabilize the patient and REFER	YES
Septic abortion	Stabilize the patient, give first dose of antibiotic and REFER	' YES ' for facilities providing CEmONC services; otherwise stabilize the patient, give first dose of antibiotic and REFER	YES
Molar abortion	Stabilize the patient and REFER	' YES ' for facilities providing CEmONC services; otherwise stabilize the patient and REFER	YES
Missed abortion	Stabilize the patient and REFER	' YES ' for facilities providing CEmONC services; otherwise Stabilize the patient and REFER	YES

iii. Guidance on evacuation of retained products of conception

(a) Guidance on treatment options in evacuating retained products of conception

Medical treatment of incomplete and missed abortions using a uterotonic drug Misoprostol needs counselling to enhance compliance to treatment. When skills to use MVA are absent treatment using Misoprostol is highly recommended, especially at Primary Health Facilities. Patients must be informed of treatment options available according to their GA; including medical treatment using Misoprostol and surgical treatment using MVA; and in rare circumstances curettage may be used. Patients must be informed and encouraged to make follow-up consultations after a week to evaluate the progress of treatment.

(b) Use of Misoprostol to evacuate retained products of conception

The use of Misoprostol in evacuation of retained products of conception has been very well elaborated in the *Clinical Practice Guidelines for Appropriate Use of Uterotonics: For Post-Abortion Care, Induction of Labour, Prevention and Treatment of Postpartum Haemorrhage*. The guideline recommends various uterotonics for use at different GA when abortion has occurred.

Misoprostol must be prescribed by a service provider who has been trained to treat abortions using Misoprostol.

NB: Various routes of Misoprostol administration are described hereunder

- ✓ **Oral:** Tablets are swallowed directly
- ✓ **Buccal:** Tablets are placed between the cheek and gums and swallowed after 30 minutes
- ✓ **Sub-lingual:** Tablets are placed under the tongue and swallowed after 30 minutes
- ✓ **Vaginal:** Tablets are placed in the vaginal fornices (deepest portions of the vagina) and the individual is instructed to lie down for 30 minutes.

(c) Use of Manual Vacuum Aspiration to evacuate retained products of conception

This procedure is performed as follows:

- ✓ MVA is only recommended to evacuate the uterus of retained products conception for an abortion that has occurred within the first trimester (below 13 weeks). This is a simple, cost-effective procedure involving the use of aspirator to remove retained tissues and blood from the uterus through a cannula and into a syringe.

- ✓ Although the procedure does not require a general anaesthesia and can be performed in an MVA procedure room, it still carries some significant pain that require mitigation.
- ✓ All premises, equipment and MVA set must always be sterile and adhere to IPC measures.
- ✓ Although there are no known contraindications of MVA use for treatment of incomplete abortion for uterine size below 12 weeks, it is important to screen for medical conditions before the procedure. Health care providers need to be aware of shock, severe haemorrhage, perforation and cervical or pelvic infections that may necessitate a change in the approach of managing the patient.
- ✓ Remember to examine the tissues at the end of procedure. If the evacuate is scanty, the operator needs to think of incomplete evacuation or an ectopic pregnancy.
- ✓ If ectopic pregnancy is suspected, the woman should be stabilized and referred without delay to a facility where the necessary emergency care is available.
- ✓ MVA due to incomplete abortion may be performed at all levels of health care delivery from dispensary to hospital, while all missed, septic and molar abortions should be managed in CEmONC health facilities.
- ✓ When performing an MVA all measures for privacy, confidentiality and respectful care must be adhered to, including minimal exposure of the body, especially private part.

(d) Use of curettage in evacuation of retained products of conception

The World Health Organization (WHO) does not recommend routine use of curettage for uterine evacuation because its use is associated with high rates of complications, even when used by experienced operators. Curettage may be recommended for evacuation of the uterus for a pregnancy that has aborted above the first trimester. Use of this procedure may be considered in rare circumstances when other medical means to evacuate the uterus such use of MVA, Misoprostol or oxytocin have failed, or when there is severe active haemorrhage (in this case, using the medical means to evacuate the uterus threatens the life of the patient, as she will lose a lot of blood).

Curettage use needs the operator to have additional skills in order to prevent dangers such as the ones shown below from happening:

- ✓ **Perforation of the uterus:** Perforation of the uterus occurs when a surgical instrument pokes a hole in the uterus and injuring the large intestine. Some perforations heal on without an intervention. However, if a blood vessel or other organ is damaged, a second procedure (laparotomy) may be necessary to repair it.

- ✓ **Damage to the cervix:** The cervix may be torn during the procedure especially with cervix holder.
- ✓ **Scar tissue on the uterine wall:** Rarely, curettage of the uterus may result in development of scar tissue in the uterus, a condition known as Asherman's syndrome. Asherman's syndrome happens most often when overzealous curettage is done after a miscarriage or delivery. This can lead to abnormal, absent or painful menstrual cycles, future miscarriages and infertility.
- ✓ **Infection:** Infection after curettage is possible, but rare. However, when it involves perforation may lead to pelvic peritonitis.

(e) Use of antibiotics after evacuation of the uterus

All patients who underwent evacuation of products of conception shall receive antibiotics after the procedure regardless of the method used, as follows;

- ✓ Antibiotics will be given when there is no obvious sepsis. This will include oral Amoxycillin 500 mg 8 hourly for 7 days.
- ✓ Suspicious infection with normal temperature, pulse rate and breathing rate but with suspected induced abortion, or if the patient stayed for days without evacuation. In this scenario provide oral Amoxycillin 500mg 6 hourly for 7 days and oral Metronidazole 500 mg 8 hourly for 7 days.
- ✓ Obvious symptoms and signs of infection are observed. In this scenario admit the patient to receive IV Ampicillin 1g 6 hourly for 72 hours or IV Ceftriaxone 2g 12 hourly for 72 hours and iv Gentamycin 80mg 12 hourly for 72 hours and IV Metronidazole 500mg 8 hourly for 72 hours; and thereafter continue with oral medication up to 7 - 10 days.

iv. Methods of uterine evacuation

The following methods of uterine evacuation may be used to evacuate the uterus, which are Medical and Surgical evacuation.

(a) Medical methods

Misoprostol can be used for evacuation of the uterus. The dose and route of Misoprostol use will depend on the type of abortion as explained in section above. Contraindications to the use of Misoprostol include:

- ✓ Women with a previous uterine scar (previous caesarean section or myomectomy in which the uterine cavity was entered).
- ✓ Women with incomplete abortion who are bleeding severely. These women should have an MVA done (if the pregnancy is less than 13 weeks) or curettage done (if the pregnancy is more than 13 weeks) immediately.

- ✓ Women with signs and symptoms of hemodynamic instability or shock (light-headedness, fainting attacks, BP < 90/60 mm Hg, PR >100 beats/minute, cold extremities).
- ✓ Women with signs of pelvic infection and/or sepsis (fever, foul smelling vaginal discharge/ bleeding, abdominal pain/ tenderness) that requires immediate action.
- ✓ History of allergy to Misoprostol or other Prostaglandins.
- ✓ Suspicion of ectopic pregnancy.
- ✓ Women with an IUCD in situ (remove the device immediately and then offer misoprostol).

(b) Surgical methods

Surgical methods should be used when the use of Misoprostol is contraindicated, or when the patient prefers surgical methods. There are two surgical methods that can be used to evacuate the uterus namely Manual Vacuum Aspiration (MVA) and evacuation by curettage.

✓ **Manual Vacuum Aspiration**

Manual Vacuum Aspiration is a simple, cost-effective procedure involving the use of an aspirator to remove remaining products of conception from the uterus for pregnancies that are less than 13 weeks through a cannula and into a syringe. It does not require a general anaesthesia and can be performed in the MVA procedure room, rather than in an operating theatre.

✓ **Evacuation curettage**

Evacuation curettage is a surgical method of evacuating a uterus that is 13 weeks or more. For this procedure to be done well, the patient needs to be anaesthetized. Therefore, it must be done in an operating theatre. It carries a higher risk of uterine perforation in unskilled hands, even when used by experienced operators. For this reason, the World Health Organization (WHO) does not recommend routine use of curettage for uterine evacuation.

v. Follow up of patients after evacuation

All patients who have undergone removal of products of conception shall be followed up at the clinic on the 7th day. During follow-up following should be enquired:

- ✓ Vaginal bleeding.
- ✓ Abdominal/pelvic pain.
- ✓ Fever.

- ✓ Resumption of menstrual bleeding.
- ✓ Counselling and psychosocial support
- ✓ Counseling for voluntary use of contraception methods.

NB: A thorough but focused physical examination should be performed in case of presentation of symptoms suggestive of complications at a follow-up visit

2.4 Provision of Family Planning services

Women who had an abortion or its related complications should be educated and counsellor on a full range of contraceptive methods for informed choice and voluntary use. All contraceptive methods should be available, accessible and if the patient accepts, FP methods should be offered to the patient before she leaves the health facility.

i. Key Points for Service Providers and patients for Post-abortion Care

- ✓ Fertility returns quickly (within two weeks) after abortion.
- ✓ Patients should be counselled on the importance of starting using a family planning method of their choice almost immediately to avoid unwanted pregnancy.
- ✓ Patients who have just been treated for post-abortion complications need easy and immediate access to voluntary FP services. Combined oral contraceptives, progestin-only pills, progestin-only injectables, implants and male and female condoms can be started immediately in every case; even if the woman has injury to the genital tract or has a possible or confirmed infection.
- ✓ IUCDs and female sterilization methods can be started once infection is ruled out or resolved, or once any injury to the genital tract has healed.

ii. Special considerations:

- ✓ IUCD insertion immediately after a second-trimester abortion requires a specifically trained provider.
- ✓ Voluntary female sterilization must be decided upon in advance, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention all available reversible methods, because sterilization is permanent.
- ✓ Fertility awareness methods: A woman can start symptoms-based methods once she has no infection-related secretions or bleeding due to injury to the genital tract. She can start calendar-based methods with her next monthly bleeding, if she is not having bleeding due to injury to the genital tract.

Table 2: Post-abortion medical eligibility recommendations for contraceptive methods (14)

	CONTRACEPTIVE METHOD	POST-ABORTION CONDITION		
		FIRST TRIMESTER	SECOND TRIMESTER	IMMEDIATE POST SEPTIC ABORTION
1	Combined Oral Contraceptives	1	1	1
2	Progestosterone Only Pills	1	1	1
3	Depot Medroxyprogesterone acetate	1	1	1
4	Implants	1	1	1
5	Copper bearing intrauterine device	1	2	4
6	Barrier methods eg male and female condoms	1	1	1

Green colour: Safe to use, Red colour: Not safe to use

Definition of Categories

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

NB: For those with other medical conditions to refer to the WHO Medical eligibility criteria

Source: Medical Eligibility Criteria for contraceptive use, 2015

2.5 Linkage with other Reproductive Health services

Patients who had abortion or its complications may also have other reproductive health conditions or diseases; therefore it is important to link them to other RH services so that they can get tested and treated for STIs, HIV, and any other condition they may have. If left untreated, STIs may lead to spontaneous abortions in the future. Clients who are HIV positive should be linked to HIV care and treatment centres for further evaluation and treatment.

At these visits patients should also be counselled and linked to cervical and breast cancer screening services in order to reduce morbidity and mortality associated with cervical and breast cancer.

2.6 Community involvement

In efforts to reduce maternal mortality due to unsafe abortions, it is important for the health care system to work with the community to create awareness and to mobilize community professionals to work together for this cause. The community is where Gynaecologists, nurse midwives, family physicians, general practitioners, clinical officers, clinical assistants, traditional birth attendants/ traditional healers and community health workers reside. The political, administrative and influential leaders and other community members should be equipped with basic knowledge in reproductive health. These cadres can be mobilized to:

- i. Educate the community on recognition of signs and symptoms of abortions, particularly unsafe abortion and its complications; and the importance of voluntary use of FP.
- ii. Emphasize on the importance of timely health care seeking, including referral to the nearby health facility.
- iii. Perform emergency care when needed.
- iv. Advocate on Adolescent and Reproductive Health services.
- v. Address the issue of violence against women.
- vi. Increase community awareness on availability of cPAC services
- vii. Address abortion-related stigma

Guiding Legal Framework of Abortion in Tanzania

3.1 Introduction and understanding of the legal aspects of abortion in Tanzania

Procuring abortion in Tanzania is restricted. However, under the Penal Code, Cap 16 R, E 2002 of the Tanzanian Laws, the law which provide punishments for criminal offences, has provisions which deal with abortion issues.

Section 219 provides for a situation where a person can be guilty of an offence for child destruction. Child destruction is performed when a child is capable of being born alive as it can exist independent of its mother (at gestation age of 28 weeks or more). Further to that, Sections 150 and 151 provide for offences to any person who attempts to procure abortion or procuring own miscarriage. Section 152 goes further by creating an offence to any person who supplies drugs or instruments to procure abortion. From these provisions, it can safely be said that, performing abortion in Tanzania is unlawful (15).

However, as a matter of law, there is no general rule without exceptions. Section 230 of the same Penal Code provides for situations whereby abortion can be performed. The section states that a person cannot be held criminally responsible for performing in good faith and with reasonable care and skill, a surgical operation upon any person for her benefit, or upon an unborn child for the preservation of mother's life if the performance of operation is reasonable having regard to the patient's state at the time and all the circumstances of the case.

From the foregoing, it is apparent that abortion can only be performed where it is only necessary to save the life of the mother. However, experience has shown that, even though abortion is restrictive in Tanzania, it is one of the methods used commonly in averting unwanted pregnancies. Being restrictive, it is normally done in secretive manner and mostly done by unqualified personnel, outside formal health care settings, hence placing the life of the victims at risk.

Health care providers should note that it is their responsibility to provide cPAC services irrespective of the nature of abortion, bearing in mind the fact that the prime role of health care providers is to preserve the lives of patients. What this means is, provision of cPAC is always legal.

3.2 Penalties for procuring an abortion

Unlawful abortion in the Tanzanian legal context is defined as a process of terminating pregnancy before 28 weeks of gestation. (Penal Code, Cap 16 Section 150-152; Sec 219(3)).

Penal Code, Cap 16 Section 150: Any person who with intent to procure miscarriage of a woman, whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony, and is liable to imprisonment for fourteen years.

Penal Code, Cap 16 Section 151: Every woman being with child who with intent to procure her own miscarriage unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatsoever, or permits any such thing or means to be administered or used to her, is guilty of a felony, and is liable to imprisonment for seven years.

Penal Code, Cap 16 Section 152: Any person who unlawfully supplies to or procures for any person anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, is guilty of a felony, and is liable to imprisonment for three years.

Attempting to procure an abortion after 28 weeks of gestation, carries a charge of child destruction as at this gestation age the delivered foetus is capable of leading an independent life outside the mother's womb.

Penal Code, Cap 16 Section 219(3): For the purpose of this section, evidence that a woman had at any material time been pregnant for a period of 28 weeks or more shall be prima facie proof of that she was at the time pregnant of a child capable of being born alive.

3.3 Clinical indication for an abortion

For the purpose of these guidelines, an abortion shall be indicated if it is necessary to save the woman's life; the Penal Code Cap 16 Section 230.

Penal Code, Cap 16 Section 230: A person is not criminally responsible for performing in - good faith and with reasonable care and skill a surgical operation benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case.

Who should certify for an abortion?

A skilled person who is convinced that an abortion would preserve the life of the mother shall carry a responsibility of certifying an abortion (Penal Code, Cap 16 section 230).

Where to perform an abortion?

When a decision for an abortion is made, the procedure to terminate the pregnancy must be carried out in a health facility that can provide reasonable health services without endangering the life of the mother.

NB: Depending on the type of abortion, the procedure may need to be carried out in a facility that can offer CEmONC or other services as explained in chapter 2.

Conditions to be fulfilled before performing an abortion

For any abortion to be carried out, the following must be fulfilled:

- National guidelines for management of the condition must be followed
- Providers are advised to seek a second opinion from another health care provider whenever it is necessary.
- Counselling of the client/couple must be done
- Obtain a signed informed consent or assent. (See annex 1 for consent form)
- Document the process in the patient's file.

4.1 Organization of post-abortion care services

Having a strategic approach in setting up post-abortion care services results in good utilization of services, the benefits of which will reach everyone in the community.

Comprehensive post-abortion care services have mainly three goals which are:

- i. Sustainable reduction in maternal mortality due to unsafe abortions, by providing access to information and emergency treatment of abortion on site and at referral centres
- ii. Sustainable reduction of unwanted pregnancies by providing counselling on a full range of contraceptive methods so that patients may decide and select a FP method of their choice
- iii. Sustainable reduction in STIs (including HIV) transmission through discussion of sexuality issues, preventing more complications, treatment, counselling and education.

When the goals above are attained, then cPAC will be able to contribute towards reduction of maternal deaths, improving access and coverage of services to marginalized populations, encouraging women with abortion complications to come early to seek cPAC services and aligning the country to improve Sexual Reproductive Health and Rights in line with international instruments such as the Global RMNCAH Strategy 2016-2020, ICPD, etc.

Guidance for organizing cPAC services

(a) Address factors that hinder provision of cPAC services

Abortion is almost always associated with some level of stigmatization. Therefore, it is important whenever organizing cPAC services to address the following issues in order to mitigate for stigma:

- ✓ Negative reactions by service providers towards abortion patients.
- ✓ Work overload as a result of inadequacy of skilled personnel.
- ✓ Inadequate essential equipment and supplies for cPAC services.
- ✓ Misconceptions about “abortion vs miscarriage” by providers due to the stigma attached to the word “abortion” and not miscarriage.
- ✓ Restrictive professional regulations.
- ✓ Community and health care stigma to patients who have induced abortion.
- ✓ Inadequate primary health care awareness among the community members on the availability, legality and accessibility of post-abortion care services as part of RH services.

(b) Take on board facilitating factors for promoting utilization of cPAC services

This may be achieved by integrating cPAC services with other services, policy environment and community participation as follows:

- ✓ Integration of cPAC services into other existing RH services.
- ✓ Supportive and explicit policies and service standards.
- ✓ Willingness of the community or health facility to establish cPAC services.
- ✓ Breaking barriers such as stigma.
- ✓ Facilities should be encouraged to perform value clarification and attitude transformation exercises in order to reduce stigma associated with abortions.

(c) Ensure availability of all required services at all times

Instruments and medications required for cPAC services should always be available at all times in the designated areas. It is important for the premises offering cPAC services to be able to provide FP methods as well. The provider in charge of the room should make sure there are no stock-outs and that there is enough method mix to fit all kinds of patients.

(d) Abide with clients' rights and need of receiving quality services

This can be done by:

✓ **Working in line with contextual framework of Sexual and Reproductive Health Information**

The 1994 International Conference for Population and Development (ICPD) states that it is the right of young boys and girls, women and men to be informed and have access to sexual and RH services of their choices; which are safe, effective, affordable and acceptable. Clients have right to information, express their opinion, access to services, informed choice, safety, privacy, confidentiality, dignity, comfort and continuity of care.

✓ **Health care providers to provide respective care**

While the topic on respectful maternity care is well covered in specific national guidelines, it is fair to emphasize here that health care providers should respect women's informed decision making, autonomy, confidentiality and privacy at all times.

✓ **Paying special attention to vulnerable groups**

Attention should be given to the special needs of particular populations such as adolescents and youth, women with disabilities, survivors of rape and other forms of sexual violence, poor and marginalized women.

- ✓ **Informing the community**

All members of the community have a right to information on the benefits of RH for themselves and their families. They also have a right to know where and how they can obtain more information and services for planning or caring for their families.
- ✓ **Ensuring access of services**

All members of the community have a right to receive services from RH programs, regardless of their social status, economic situation, political belief, ethnic origin, marital status or geographical location. Access includes freedom from barriers such as policies, standards and practices that are not scientifically justifiable.
- ✓ **Giving one freedom of choosing family planning services**

cPAC services are highly integrated with FP services as shown above. Below is some guidance to enable patients to choose a FP method:

 - i. Individuals and couples have the right to decide freely whether or not to practice FP.
 - ii. When seeking RH services, patients should be given the freedom to choose which method of contraception or RH service to use.
 - iii. Patients should be able to make informed decisions, free from discrimination, inducement or coercion.
 - iv. Decision making should be autonomous and free of third-party involvement.
- ✓ **Ensuring there is safety in provision of cPAC services**

Patients have the right to safety while receiving cPAC services, using FP and other RH services.
- ✓ **Ensuring privacy**

When a patient is undergoing a physical examination or receiving service, it should be carried out in an environment in which her right to bodily privacy is respected.
- ✓ **Maintaining confidentiality**

The patient should be assured that any information she provides, or any details of the services received will not be communicated to third parties without her consent.
- ✓ **Ensuring women's dignity**

Reproductive health patients have the right to be treated with courtesy, consideration, and attentiveness with full respect of their dignity regardless of their age, level of education, social status or any other characteristic that would single them out or make them vulnerable to abuse. Adolescents' RH rights should be respected alongside the provision of Youth Friendly Services.

- ✓ **Providing services with comfort**
Patients have the right to feel comfortable when receiving services. This right of the patient is intimately related to adequacy of service delivery facilities and quality of services.
- ✓ **Maintaining continuity of services given**
Patients have the right to receive RH services and supply of contraceptives and other services for as long they need them.
- ✓ **Allowing patients to have the right to give an opinion**
Patients have the right to express their views on the services they receive.

Table 3: Roles of National, Regional, District and Health Facilities on cPAC

	Level	Explanation	Roles
1	National Level	Overall overseer of all cPAC activities in the country.	Provide normative and strategic guidance, policy formulation, and programmatic support to Regions in implementing cPAC
2	Regional Health Management teams	Will provide guidance to the Council Health Management Teams as they design and implement cPAC services	▪ Mobilize resources ▪ Disseminate and provide guidance on implementation of the cPAC guidelines to lower facilities ▪ Provide coordination, strategic guidance and programmatic support to District Health Management Teams (CHMTs) ▪ Identify a Regional focal person who will provide leadership and overall coordination of clinical mentorship in the province
3	Council Health Management Teams	Will be overseeing implementation of cPAC activities in their facilities and communities	▪ Mobilize resources ▪ Disseminate and provide guidance on implementation of the cPAC guidelines to lower facilities ▪ Provide coordination, strategic guidance and programmatic support to CHMTs ▪ Identify a district focal person who will provide leadership and overall coordination of clinical mentorship in the province
4	Health Facilities	They will be actual implementers of cPAC services	▪ Facility manager will coordinate all activities. This person should: ▪ Maintains communication with the district in order to ensure cPAC implementation ▪ Ensure availability of space for providing cPAC ▪ Ensure availability of equipment and supplies for cPAC ▪ Ensures that all evaluation tools are completed at the proper time

4.2 Infection Prevention and Control

Patients with abortion or its related complications are at an increased risk of acquiring infections during the process of examination and when evacuating the uterus if infection prevention measures are not adhered to. Those who get septic abortion are at increased risk of death. Due to this, it is important for health care providers to practice proper infection prevention measures in order to avoid transmitting microbes to and from the patients and vice versa.

It is important to apply the following infection prevention measures/standard precautions when offering cPAC services:

- ✓ Proper hand hygiene
- ✓ Use of Personal Protective Equipment (PPE)
- ✓ Appropriately dispose equipment and sharps
- ✓ Appropriate decontamination of instruments/equipment and surfaces
- ✓ Environmental cleaning

i. Proper hand hygiene

The provider should wash hands with soap and running water or use alcoholic hand rub/sanitizer before and after touching the patient and any procedure. Hands should also be washed before wearing PPE and after removing PPE.

ii. Personal Protective Equipment

When performing procedures like MVA and curettage, it is important for the provider to wear personal protective equipment (PPEs), including

- ✓ Goggles to protect the eyes
- ✓ A face mask to cover the nose and the mouth
- ✓ Sterile gloves to cover the hands
- ✓ An apron to cover the rest of the body
- ✓ Boots to cover the feet

When these protective gears are used properly they will inhibit micro-organisms from the provider to reach the patient, but also will prevent micro-organisms in the body fluids of the patient to get contact into the provider.

iii. Appropriate disposal of sharps and instruments

All sharps and disposable instruments used on a patient should be put on a designated sharps box and dust bins respectively and appropriately disposed of.

iv. **Appropriate decontamination of instruments/equipment**

All instruments used for MVA should be cleaned, disinfected, high level disinfected or sterilized before they can be re-used in another patient as per instruction in the manufacturers guide (Performing uterine evacuation with the Ipas MVA Plus Aspirator and Ipas EasyGrip cannula (Instructional Booklet page 19-26)

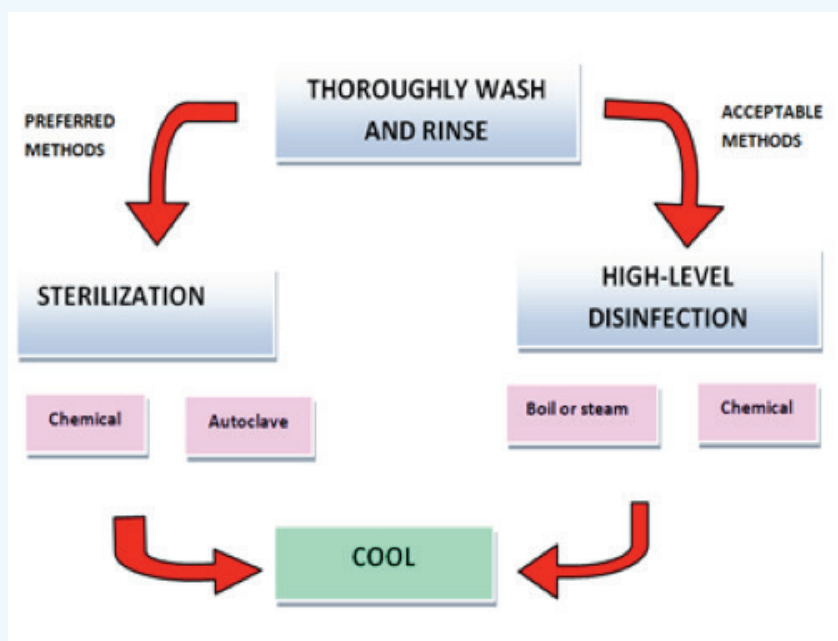
Table 3: Levels of Decontamination

Cleaning	The physical removal of body materials, dust or foreign material. Cleaning will reduce the number of micro-organisms as well as the blood, therefore allowing better contact with the surface being disinfected or sterilized and reducing the risk of blood being fixed to the surface. Removal of blood will reduce also the risk of inactivation of a chemical disinfectant and the multiplication of micro-organisms. It is the removal of contamination from an item to the extent necessary for further processing. Cleaning is accomplished by manual cleaning with cleaning chemicals (detergent) and water, brushing or flushing, or by using ultrasonic and or washer disinfectors to remove foreign material.
Disinfection	The destruction or removal of micro-organisms at a level that is not harmful to health and makes the instruments safe to handle. This process does not necessarily include the destruction of bacterial spores. General disinfection is accomplished by wiping surfaces with disinfectant solution.
High Level Disinfection	A process that eliminates all micro-organisms except some bacterial endospores from inanimate objects. Processes include boiling, steaming or the use of chemical disinfectants.
Sterilization	The complete destruction or removal of micro-organisms, including bacterial spores. Sterilization validated process is used to render a product free from viable micro-organisms. Processes include high-pressure steam (autoclave), dry heat, chemical sterilant or radiation (UV-light).

Adopted from the *National IPC guidelines for health care services in Tanzania, June 2018.*

High-Level Disinfection for MVA equipment can be done by boiling, steaming or chemically by soaking them in 0.3% ortho-phthalaldehyde (Cidex OPA) for 12 minutes.

Picture: Processing of MVA equipment



WHO Recommendation

Soaking of instruments in 0.5% chlorine solution or any other disinfectant before cleaning is *not recommended* for the following reasons:

- It may damage/corrode the metallic instruments.
- The disinfectant may be inactivated by blood and body fluids, which could become a source of microbial contamination and formation of biofilm.
- Transportation of contaminated items soaked in chemical disinfectant to the decontamination area may pose a risk to health-care providers and result in inappropriate handling and accidental damage.
- May contribute to the development of antimicrobial resistance to disinfectants.

The bed used while doing MVA should be decontaminated using chlorine before it can be used by another patient.

4.3 Monitoring and Evaluation of cPAC services

Monitoring and evaluation is an important component of cPAC services, as it helps produce data that can be used to inform service provision including resource prioritization. It is important for the statistics to be accurate, complete and be collected routinely so that programs are managed efficiently, and appropriate feedback given timely. This in turn will reduce morbidity and mortality associated with abortions.

Each health facility should monitor cPAC services by analyzing:

- ✓ Routine service statistics
- ✓ Case reviews
- ✓ Observations
- ✓ Checklists
- ✓ Maternal death and near-miss audit
- ✓ Feedback from patients

At the moment, cPAC data is collected through data on services provided during patient registration at every health facility in Tanzania. These tools are **Register Number 17**, and **Daily Tally Sheets Number 17**. At the end of the month, data collected using the Daily Tally Sheets is summarized into **Monthly Summary Form Number 17**. Information on commodity stock levels is collected daily using ledger book and summarized monthly using Reporting and Requesting (R&R) Form.

Service Delivery data elements that should be recorded in data collection tools include: Age of the patient, gestation age, history of previous pregnancies (gravidity, parity, abortions, stillbirths, early perinatal deaths, live births, age of last child, previous Caesarean section/myomectomy scar).

Key information (type of abortion, emergency treatment given, method of uterine evacuation, antibiotics given, supply of Iron/Folic Acid, FP counselling, FP method chosen, and referrals/when the patient should come back).

Indicator calculation procedure: Adhere to specific indicators' standard definition, then use numerator from among data elements in Health Management Information System (HMIS)/DHIS2; and denominator from National Bureau of Statistics projections or from among data elements in HMIS/DHIS2.

Some cPAC M&E framework indicators related to cPAC services are highlighted below:

Table 4: Some cPAC services related indicators in Tanzania

SN	Indicator	Numerator/ Denominator	Type of measure	Source of data
1	Gynecological admissions due to abortion	Number of patients with abortion/ abortion complications in a month per total number of patients admitted in the gynecology ward X 100	Percentage	DHIS
2	Abortion rate	Number of patients with abortions/ Total number of women aged 15-49 X 1000	Rate	DHIS
3	Maternal deaths attributed to abortion	Number of maternal deaths due to abortions/total number of maternal deaths from all causes X 100	Percentage	DHIS /survey (special)/vital Registration
4	Patients aged below 20 years with abortion or abortion complications	Number of patients with abortions aged <20 years/ total number of patients with abortions X 100	Percent	DHIS
5	Patients counselled for FP after an abortion	Number of patients with abortions who are counselled on FP/total number of patients with abortions X 100	Percent	DHIS
6	Patients given Iron/ Folic Acid after an abortion	Number of patients with abortions who received Iron/Folic acid per total number of patients with abortions X 100	Percent	DHIS
7	Clients referred to another facility	Number of patients with abortion complications who are referred to another facility/total number of patients with abortions X 100	Percent	DHIS
8	Patients who received a FP method	Number of patients with abortions who received a FP method/total number of patients with abortions X 100	Percent	DHIS
9	Patients who received antibiotics after an abortion	Number of patients with abortions who are received antibiotics/total number of patients with abortions X 100	Percent	DHIS
10	Patients referred to other RH services	Number of patients with abortions who are referred to other RH services/total number of patients with abortions X 100	Percent	DHIS

DHIS: District Health Information System; **FP:** Family planning; **RH:** Reproductive health

NB: All clinical records and other documentation must be maintained and filed appropriately.

Facilities should improve Maternal Death Surveillance and Response as this will help reduce the number of deaths due to abortions.

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ANNEX

1. STATEMENT OF INFORMED CONSENT FOR TERMINATION OF PREGNANCY ON MEDICAL GROUNDS

NAME OF THE HEALTH FACILITY: _____

DATE: _____

I, _____ (Name of the patient),
have been informed about the decision to terminate my pregnancy in order to save my life from
death that may be caused by my poor health.

I have been informed that;

- The medications involved in a medical abortion, how they work to complete an abortion,
and how they should be taken
- The surgical procedure that will be done in order to terminate the pregnancy, and how it
will be done
- The side effects associated with a medical abortion/ surgical abortion
- The pregnancy tissues will be disposed of as per hospital policy (appropriate for medical
abortions within the hospital setting).
- I have been fully informed of, and understand to my complete satisfaction:
- I have understood all information that has been given to me by the medical practitioner. I
have had the opportunity to ask questions about this information. I consent to a medical
/ surgical abortion of my own freewill.
- I understand all potential risks and complications associated with a medical/ surgical
abortion, some of which may require further treatment.

Name of the patient: _____

Date of birth: ____/____/20____

Address: _____

Signature: _____

Date: ____/____/20____

Parent/Guardian Name: (if required) _____

Signature: _____

Date: ____/____/20____

Name of Attending Medical Personnel : _____

Signature: _____ Date: ____/____/20____

Name of Head of Unit/Department: _____

Signature: _____ Date: ____/____/20____

2. LIST OF AGOTA MEMBERS WHO REVIEWED THE DRAFT ZERO OF THE DOCUMENT

SN	NAME	WORK PLACE	REGION
1	Prof. Andrea B. Pembe	MUHAS	Dar es Salaam
2	Dr. Belinda Balandya	MUHAS	Dar es Salaam
3	Dr. Ahmad M. Makuwani	MOHCDGEC	Dodoma
4	Dr. Sunday Dominico	Thamini Uhai	Dodoma
5	Dr. Muzdalifat Salim	Agakhan Hospital	Dar es Salaam
6	Dr. Gasper Kimaro	Njombe Regional Referral Hospital	Njombe
7	Dr. Berno Mwambe	Marie Stopes Tanzania	Dar es Salaam
8	Dr. Elias G. Kweyamba	Tanzania Training Centre for International Health	Ifakara
9	Dr. Amani Kikula	MUHAS	Dar es Salaam
10	Dr. Chetan Ramaiya	Regency Hospital	Dar es Salaam
11	Dr. Matilda Ngarina	Muhimbili National Hospital	Dar es Salaam
12	Dr. Albert Kihurnwa	Bugando Medical Centre	Mwanza
13	Dr. Peter Wangwe	MUHAS	Dar es Salaam
14	Dr. Damas Wilson	Muhimbili National Hospital	Dar es Salaam
15	Dr. Pendo Mlay	Kilimanjaro Christian Medical Centre	Moshi
16	Dr. John France	Meta Maternity Hospital	Mbeya
17	Dr. Mzee Nassoro	Dodoma Regional Referral Hospital	Dodoma
18	Dr. Godwin Macheke	Mawenzi Regional Referral Hospital	Moshi
19	Dr. Yahaya Kapon	Tikaya Health Centre	Dar es Salaam
20	Dr. Chrisostom Lipingu	JHPIEGO	Dar es Salaam

3. LIST OF MOHCDGEC STAKEHOLDERS WHO PARTICIPATED IN THE SECOND REVIEW PROCESS

SN	NAME	CADRE	WORK PLACE	REGION
1	Naibu Mkongwa	Medical Doctor	MoHCDGEC	Dodoma
2	Suzan Exaud Mdegela	Specialist midwife	Morogoro Regional Referral Hospital	Morogoro
3	George Alcard Rweyemamu	Obstetrician & Gynaecologists	Morogoro Regional Referral Hospital	Morogoro
4	Amani Samma	Medical doctor	Pathfinder International	Dar es Salaam
5	Mariam Mazengo	Nurse midwife	Morogoro Regional Referral Hospital	Morogoro
6	Mtungi Faustine	AMO	Retired cPAC trainer	Dar es Salaam
7	Joseph Komwihangiro	MO, MPH	Pathfinder International	Dar es Salaam
8	Maurice Hizza	FP trainer	MoHCDGEC FP advisor	Dar es Salaam
9	Peter Josephat	ANO	Saint Caroli Hospital	Morogoro
10	Beatus Chale	AMO	Mafiga Health centre	Morogoro
11	Ismail Mtitu	Medical Doctor	MoHCDGEC	Dodoma
12	Kalidushi Charles	SNO	PO-RALG	Dodoma
13	Domitila Masalla	CO	Pathfinder International	Dar es Salaam
14	Isihaka Mwandalima	MO, MPH	Pathfinder International	Dar es Salaam
15	Ernest Neke	Pharmacist	Morogoro Regional Referral Hospital	Morogoro
16	Jean Lyatuu	Nurse Midwife, MPH	Pathfinder International	Dar es Salaam

AMO: Assistant Medical Officer

MO: Medical Officer

SNO: Senior Nursing Officer

CO: Clinical Officer

ANO: Assistant Nursing Officer

