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Inside the New Zimbabwe Comprehensive Abortion Care (CAC) Guidelines

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ACKNOWLEDGEMENTS

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Making Abortion Safe

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OUTLINE

- BACKGROUND
- ABORTION LAW AND POLICY
- STAGES OF ABORTION
- ELEMENTS OF CAC
- MEDICAL MANAGEMENT
- SURGICAL MANAGEMENT

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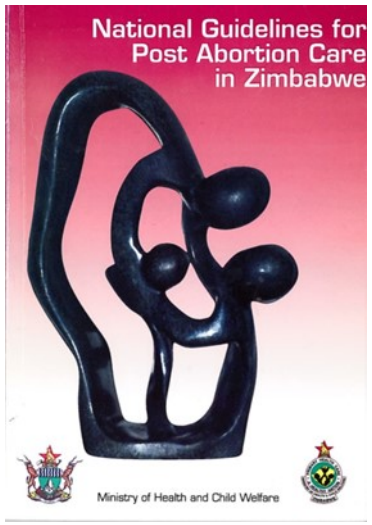
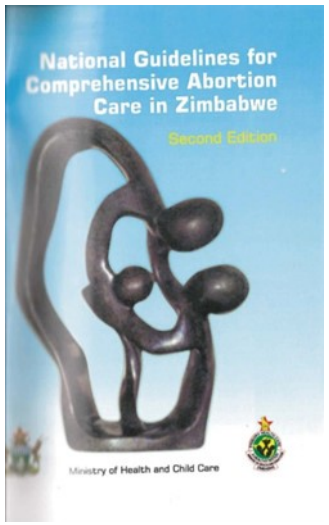
THE JOURNEY

2001



2014



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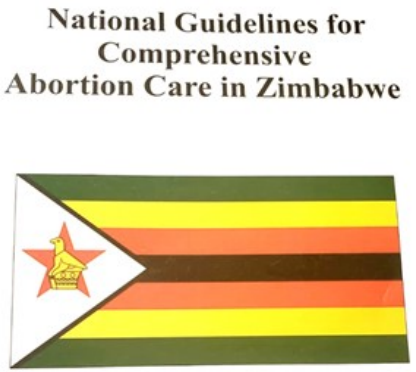

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BACKGROUND

- In Africa, nearly half of all abortions that occur are unsafe and about 10 % of maternal deaths in East and Southern Africa region are related to unsafe abortion
- WHO includes comprehensive abortion care in the list of essential health care services.
- In Zimbabwe the vast majority of CAC is provided in public health facilities. Half of these cases are treated at district hospitals and one-third at larger, central hospitals.

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BACKGROUND

- A previous community-based study in Zimbabwe showed that abortion complications are a major cause of maternal deaths in both rural (15%) and urban (23%) settings.
- Many women suffering from unsafe abortion or miscarriage face delays/challenges in obtaining post-abortion care and may have to seek care from more than one facility to get complete treatment.
- A substantial proportion of first trimester post abortion cases are being treated using surgical procedures.

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What is this Guideline?

- National Guidelines for Comprehensive Abortion Care in Zimbabwe is an updated, consolidated guideline which replaces the Second Edition 2014 Guidelines.
- This updated guideline provides evidence based recommendations related to abortion care in Zimbabwe on Service Delivery, Abortion and Post Abortion Care Clinical Management and a brief background on Zimbabwean abortion law and policy
- It contains a few updated recommendations and sections, however most areas of the 2nd Edition remain unchanged.
- Provides clear recommendations on task sharing and decentralization of Abortion services at all levels to increase access for women and girls.

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Abortion law and policy in Zimbabwe

- The Termination of Pregnancy Act (No. 29 of 1977) permits the legal termination of pregnancy under any of the following conditions:

    a) Where the continuation of the pregnancy so endangers the life of the woman concerned or so constitutes a serious threat of permanent impairment of her physical health that the termination of the pregnancy is necessary to ensure her life or physical health.

    b) Where there is a serious risk that the child to be born will suffer from a physical or mental defect of such a nature that he will permanently be seriously handicapped.

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Abortion law and policy in Zimbabwe

- c)Where there is a reasonable possibility that the fetus is conceived because of unlawful intercourse.

- “Unlawful intercourse" means rape, incest, or unlawful intercourse in contravention of paragraph (d) of section 3 of the Criminal Law Amendment Act, and
- A magistrate must certify that the conception resulted from unlawful intercourse.
- Two physicians must certify to the superintendent of a designated hospital that the conditions exist, and a pregnancy may only be terminated by a medical practitioner in a designated institution with the permission in writing of the superintendent thereof.

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Clinical stages of abortion

Diagnosis	Stage of Abortion			
	Bleeding	**Cervix**	**Uterine size**	**Other signs**
Threatened Abortion	Slight to moderate	Closed	Equal to gestational duration by LNMP	-Soft uterus -Positive pregnancy test -Cramping
Inevitable abortion	Moderate to heavy	Dilated (open)	Less than or Equal to gestational duration by LNMP	-Tender uterus -Cramping
Incomplete abortion	Slight to heavy	Dilated and soft	Less than or Equal to gestational duration by LNMP	-Tender uterus -Cramping -Partial expulsion of POC
Complete abortion	Little or none	Soft (Dilated or closed)	Less than gestational duration by LNMP	-Firm uterus -Less or no cramping -Expulsion of POC
Missed Abortion	Slight to moderate Brownish blood	Closed	Less than gestational duration by LNMP	-Absence of pregnancy symptoms -Pregnancy test negative

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Comprehensive abortion care program aims:

1. Provide safe, high-quality services, including abortion, post abortion care and family planning.
2. Understand each woman's particular social circumstances and individual needs and tailor her care accordingly.
3. Address the needs of young women.
4. Reduce the number of unintended pregnancies and abortions.
5. Identify and serve women with other sexual or reproductive health needs.

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ELEMENTS OF COMPREHENSIVE ABORTION CARE

- **Emergency treatment of incomplete abortion and life-threatening complications**
- **Post abortion family planning (PAFP) counseling and services**
- **Post abortion reproductive health counseling**
- **Links to other sexual and reproductive health services**
- **Community Mobilization and participation**

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- The CAC guidelines covers abortion across the continuum of care including and general pathways for both abortion and post abortion care in terms of:
    i. Where abortion and post abortion care services and information can be obtained (Community, Primary Health Care Facilities, Secondary and Tertiary Level facilities)
    ii. Who can safely carry out an abortion or post abortion care and disseminate information on SA/PAC (VCW,VHW, Trained Nurses, Midwives, Clinical Officers, Trained GPs, Obs and Gynae Specialist.
    iii. Specific guidelines on the interventions needed

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What's New or Updated

- Informed consent and Counseling for CAC- the previous edition did not provide comprehensive information on Informed Consent and comprehensive counseling steps for CAC clients.
- Informed consent implies that clients make free choices after being given full information about the nature, risks and benefits of the available options of the procedure or method being provided.
- The Guideline emphasizes that the provider must secure an informed consent for the procedure using a standard consent form and the concept of emancipated minor.

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What's New or Updated

- The guideline elucidates the components of comprehensive abortion care.
- There are additional Regimens for Medical Abortion- Mifepristone and Letrozole. The 2nd Edition recommended the use of Misoprostol, Ergometrine and Oxytocin for Medical Abortion
- The Guideline strongly discourages Surgical methods for pregnancies less than 14 weeks of gestation

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What's New or Updated

Comprehensive abortion. care services appropriate for each level of health care

Table 2: Provision of comprehensive abortion care appropriate by level of health care facility and staff

Provision of comprehensive abortion Care by level of health care facility and health care provider			
Healthcare facility level	**Healthcare provider**	**Comprehensive abortion Care Services**	**PostAbortion Contraception**

Community	Community residents with basic health care training. W, **Community based health workers including village health workers**	Recognition of signs and symptoms of abortion and serious post abortion complications. Referral to facilities where treatment is available.	-Provision of pills, condoms, diaphragms, and spermicides. -Referral and follow up for these and other methods of counseling
Primary care facilities -Family	Trained: -Nurses - Midwives -Clinical	All primary care facilities: - Above activities, plus: Diagnosis based on medical history and physical and pelvic examination. - Resuscitation/preparation for treatment or	• Provision of above methods plus IUDs, injectables

Obs/Gynae specialist	• Uterine evacuation as indicated for all types of abortion. • Treatment of most post abortion complications including septic incomplete/inevitable abortion. • Second trimester safe abortion using MA or D&E • Local and general anesthesia • Laparotomy and indicated surgery as needed including for ectopic pregnancy/hysterectomy/hysterotomy • Treatment of severe complications (including bowel injury, peritonitis, severe sepsis, renal failure) with other departments. • Treatment of bleeding/clotting disorders/DIC

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ABORTION METHODS

- MEDICAL
  - PROSTAGLANDINS
  - ANTIPROGESTRONES
  - AROMATASE INHIBITORS
- SURGICAL
  - MVA
  - D&E
  - D&C

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INCOMPLETE AND INEVITABLE ABORTION

- For incomplete and inevitable abortion at < 14 weeks either
  - Use 600 µg misoprostol orally or 400 µg misoprostol administered sublingually can be used or
  - Vacuum aspiration depending on clinical condition of the patient.

- For incomplete and inevitable abortion at ≥ 14 weeks either
  - Repeat doses of 400 µg misoprostol administered sublingually, vaginally or buccally every 3 hours or
  - Evacuation by sponge or ring forces followed by vacuum aspiration or
  - Dilatation and evacuation can be used depending on the cervical status and clinical condition of the patient.

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MISSED ABORTION

Medical abortion

For missed abortion at ≥14 weeks, for individuals preferring medical management:

- Use 200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered sublingually or vaginally every 4–6 hours.
- Letrozole 10mg once daily for 3 days can also be used instead of mifepristone followed by misoprostol.

For missed abortion at < 14 weeks, for individuals preferring medical management:

- Use 200 mg mifepristone administered orally, followed by 800 µg misoprostol administered by any route (buccal, sublingual, vaginal).
- Alternative regimen: 800 µg misoprostol administered by any route (buccal, sublingual, vaginal).
- Letrozole 10mg once daily for 3 days can also be used instead of mifepristone followed by misoprostol.

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SUMMARY OF DRUG REGIMENS FOR MEDICAL

Gestational age and abortion types	Combination regimen (standard of care)		Misoprostol alone (Alternative)
	Mifepristone	Misoprostol	
Induced abortion <12 weeks	200 mg PO once	800 µg once B, PV or SL*	800 µg B, PV or SL*
Induced abortion ≥12-22 weeks	200 mg PO once	400 µg B, PV or SL every 3 hours**	400 µg B, PV or SL every 3 hours**
Missed abortion < 14 weeks	200 mg PO once	800 µg once B, PV or SL*	800 µg B, PV or SL*¥
Missed abortion ≥14-22 weeks	200 mg PO once	400 µg B, PV or SL every 4-6 hours*	400 µg B, PV or SL every 4-6 hours*

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SURGICAL MANAGEMENT

- MVA
- D&E
- D&C

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Vacuum Aspiration

- MVA is the surgical method of choice for evacuation of a uterus of less than 14 weeks in size.
- MVA is more commonly used and more likely to be used in primary care settings provided adequately trained health personnel are available.

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Advantages of MVA over Sharp Curettage

- Low cost and effective technique
- Simple and portable procedure which can be done at primary health care facilities.
- It is safer: less risk of bleeding, perforation, infection and Asherman syndrome.
- Has a variety of pain management options and does not require general anaesthesia.
- Does not require operating theatre facilities.

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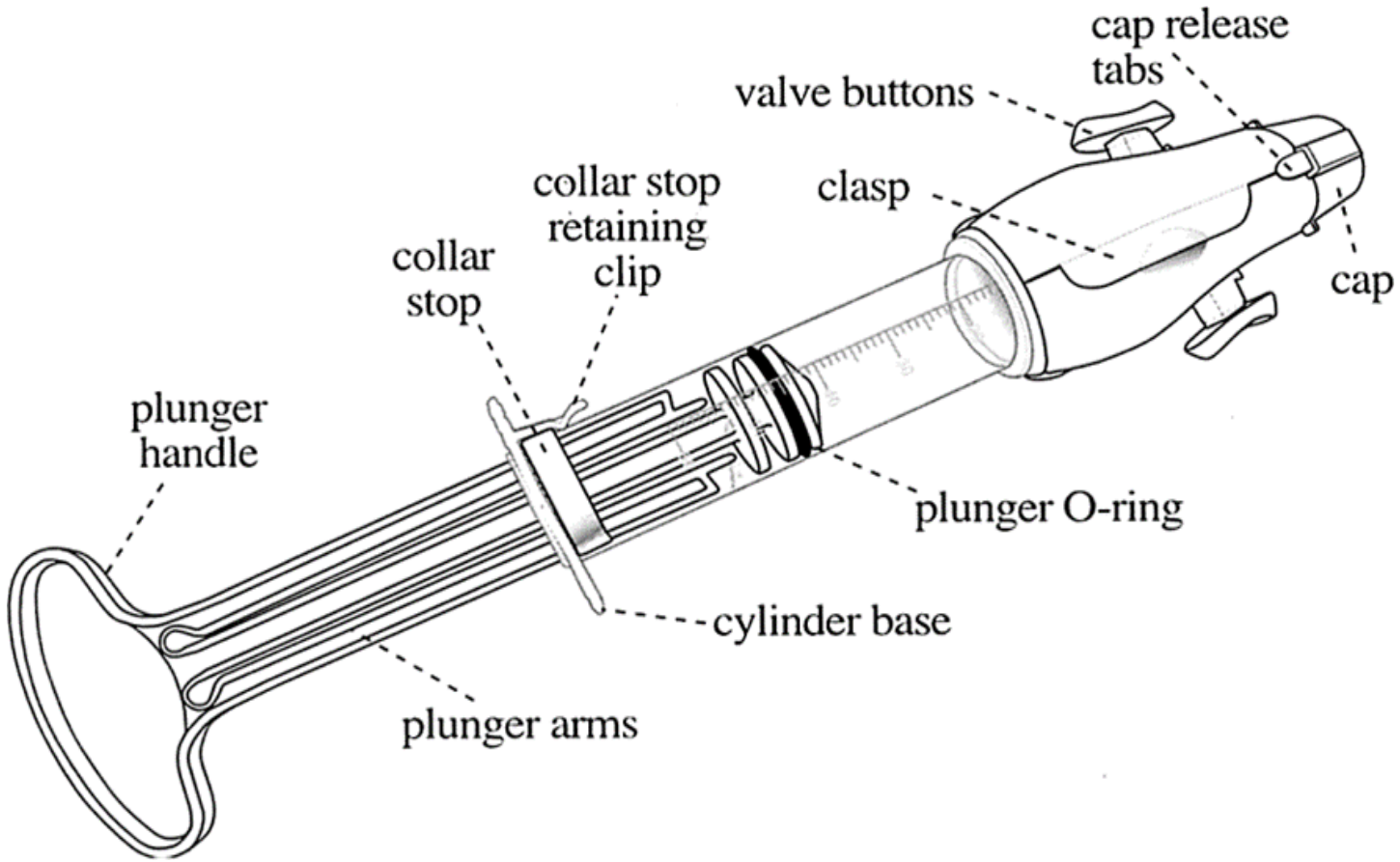
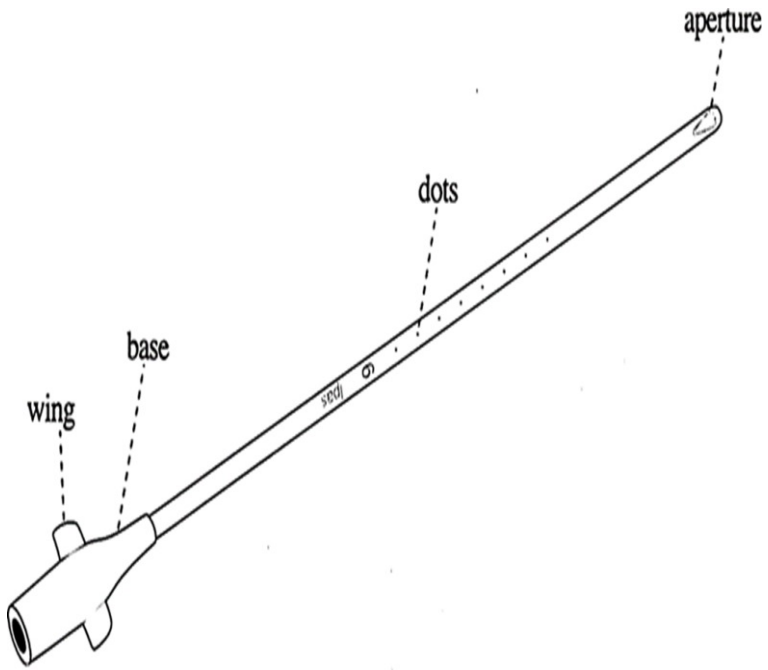
MANUAL VACUUM ASPIRATOR





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SUMMARY

- Most of the sections of the CAC guidelines remain unchanged.
- Informed consent is very important.
- Advocate for medical management for abortions.
- MVA > D&E > D&C
- It's possible to increase the availability and access to CAC services in Zimbabwe.
- Guidelines clear on **Who, Where and What CAC** services can be provided

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THANK YOU

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