

Comprehensive abortion care

Guidelines and tools

Guidelines for setting up a static clinic

Providing services and support

Infection prevention and control

Clinic logistics and commodity management

Utilizing data for service delivery
and programme management

Monitoring clinics and quality of care

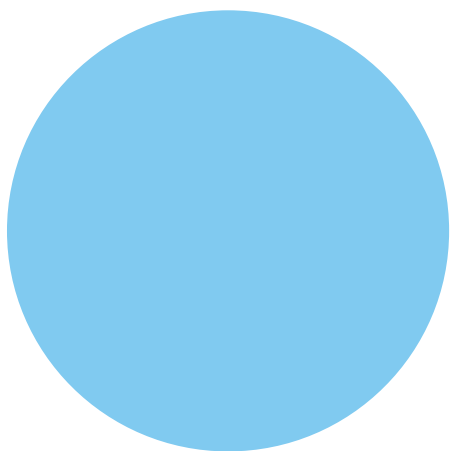
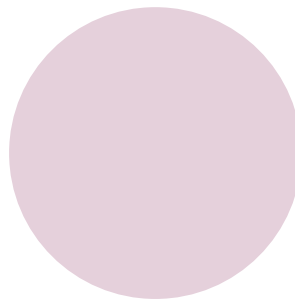


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Introduction

IPPF believes every woman and girl has the right to choose to be pregnant or not. We champion the rights of all women everywhere to access quality, person-centred abortion care and strive to ensure access to comprehensive abortion care is guaranteed as part of an integrated sexual and reproductive health package.

IPPF recognizes that, where Member Associations have clinical facilities providing sexual and reproductive health services, they have a duty to provide abortion-related care, regardless of a person's age; geographic location; religious beliefs; or socio-economic, marital and HIV status. Abortion is one of eight sexual and reproductive health service categories under IPPF's Integrated Package of Essential Services (IPES).

First developed in 2008 and updated in 2021, the Comprehensive Abortion Care Guidelines is intended to support Member Associations to provide high quality abortion and contraceptive services. It expands on existing IPPF guidelines and tools, which are grounded in IPPF core values to uphold the rights of clients and the needs of providers. This latest edition of the Comprehensive Abortion Care Guidelines has been updated to reflect the latest evidence and best practice in abortion care, taking into account the rapid development in abortion care technology and practice in the 12 years since the manual was originally published.

This manual includes guidelines and tools to support Member Associations to design, introduce and provide comprehensive abortion care and is aimed at programmes and monitoring and evaluation staff, clinic managers and clinic personnel. The manual provides guidance on setting up a clinic, the provision of abortion care, infection prevention standards, commodity management, and monitoring of quality of care in clinics and to assess clinic performance.

Organizational commitment and policies

When setting up comprehensive abortion care services, a clear written policy setting out the Member Association's commitment to abortion should be developed, in line with IPPF's 2010 Abortion Policy. Some issues that should be addressed in an abortion policy include:

- ▶ ensuring the availability of skilled staff who are committed to advancing abortion access
- ▶ prohibiting the implementation of extra-legal barriers that might hinder access to care
- ▶ ensuring that services are provided according to best practice standards and guidelines, using the latest technologies
- ▶ ensuring equitable access to abortion care for all populations, including a fair pricing, subsidization, and fee-waiver system
- ▶ the principles of person-centredness, right-based, quality of care, and inclusiveness should be integrated throughout

As with all policies, this should be reviewed regularly and updated so that an optimal service package is offered to all clients.

1 Guidelines for setting up a static clinic

1.1 Clinic space and requirements

When setting up a clinic, and before either renting or buying a building, it is important to consider the space required (Table 1). The space needed will depend on the following:

- ▶ types of clinical services provided
- ▶ client load
- ▶ plans for scaling up or introducing new services in the future

Most sexual and reproductive health (SRH) services can be provided in clinics with between 700 and 1,500 sq ft (65 to 139 sq m). Some services e.g. permanent methods of contraception and second trimester abortion, can be provided with better quality if clinic space is between 1,500 and 2,000 sq ft (139 to 186 sq m), because of higher levels of infection prevention and pain management needed.

Plan for additional space requirements in the beginning to avoid renovation expenses and disruption of ongoing services in the future.



The following people are needed to run a static clinic smoothly:

- ▶ 1 service provider (midwife, doctor or other clinician)
- ▶ 1 assistant or second service provider (e.g. a nurse)
- ▶ 1 receptionist
- ▶ 1 housekeeping staff (e.g. a cleaner)
- ▶ 1 clinic manager

Depending on client load, some clinics also employ a counsellor and a support staff such as a clinic aide or storekeeper.

24x7 electricity with back-up for failures is needed to run essential electrical equipment such as autoclaves, refrigerators and air conditioners.



Table 1 provides more information on space needed for different services, as well as type and number of fixtures and furniture, equipment and supplies needed for each service area.

Table 1: Clinic requirements for SRH services

Service Areas	Size	Fixtures and furniture	Equipment	Supplies
Reception, client registration and waiting areas	120–240 sq ft Chairs or benches to seat at least 10 clients at a time, a reception desk with chair, a filing cabinet	<ul style="list-style-type: none"> · A display screen and equipment for audio-visual IEC materials · Display shelves or racks for paper IEC materials · Computer and · Printer 	<ul style="list-style-type: none"> · Registration materials · Drinking water · Newspaper and magazines · Posters and pamphlets for IEC 	

Service Areas	Size	Fixtures and furniture	Equipment	Supplies
Counselling area	60–120 sq ft	<ul style="list-style-type: none"> • A small desk with 3 chairs • A small storage cabinet or cupboard 	<ul style="list-style-type: none"> • Family planning models e.g. uterus and penis • Contraceptive samples 	<ul style="list-style-type: none"> • Contraceptives (condoms and pills) • Contraceptive posters • Counselling flipchart • Tissues
Examination and injections area	60–150 sq ft	<ul style="list-style-type: none"> • A small desk with 3 chairs • Examination table • Sink with running water for washing hands 	<ul style="list-style-type: none"> • Blood pressure machine • Stethoscope, thermometer • Focus light • Examination instruments, trolley, surgical drum 	<ul style="list-style-type: none"> • Disposable gloves • Sterile cotton wool and gauze • Alcohol hand rub • Antiseptics • Contraceptives • Medical abortion pills
Procedure room for minor surgical procedures e.g. MVA, IUD insertion	120–200 sq ft	<ul style="list-style-type: none"> • Procedure table • Stool for provider • Foot stool for client 	<ul style="list-style-type: none"> • Focus light • 2 instrument trolleys – one for procedure instruments, and one for surgical drums containing extra sterile instruments and the emergency tray • 1-2 surgical drums • Manual vacuum aspiration equipment • Products of conception examination equipment (view box, strainer, clear bowl) • Emergency equipment: Ambu bag, blood pressure machine, stethoscope, emergency drugs tray, oxygen cylinder with mask • 3 buckets – for detergent solution, for general waste and covered bucket for medical waste (e.g. used gauze and cotton) 	<ul style="list-style-type: none"> • Disposable surgical gloves • Sterile cotton wool and gauze, alcohol hand rub, antiseptics, • Emergency drugs (see list below in section 1.2.3) • Sterile instruments
Recovery area	120–300 sq ft	<ul style="list-style-type: none"> • Sufficient beds or recliners to allow adequate recovery time for each client based on client volume, separated by screens • Small table and 2 chairs 	<ul style="list-style-type: none"> • Blood pressure machine, stethoscope, thermometer 	<ul style="list-style-type: none"> • Drinking water • IEC materials
2 toilets, with at least one easily accessible to clients, including those in recovery	60–90 sq ft	<ul style="list-style-type: none"> • Toilet fixtures, washbasin with tap 		<ul style="list-style-type: none"> • Washing soap, detergents, toilet paper, sanitary towels • Waste buckets for general and medical waste
Instrument processing area	60–120 sq ft	<ul style="list-style-type: none"> • 2 tables, cabinets for storing clean and sterile instruments • Running water 	<ul style="list-style-type: none"> • Autoclave • Surgical drums • Buckets for cleaning • Equipment for drying instruments and linen 	<ul style="list-style-type: none"> • Detergent • Disinfectants (bleaching powder/ solution) • Scrubbing brushes
Well ventilated storage area	80–200 sq ft	<ul style="list-style-type: none"> • Shelves and cabinet with lock 		<ul style="list-style-type: none"> • Medical supplies, contraceptives, spare equipment, non-clinical supplies • (See: 'Clinic logistics management')
Corridors	20–80 sq ft			

Service Areas	Size	Fixtures and furniture	Equipment	Supplies
Minor operating theatre (if required for tubal ligation and/or non-scalpel vasectomy)	180–250 sq ft	<ul style="list-style-type: none"> · Operating table, foot stool, stool for provider · Operating table · Focus light 	<ul style="list-style-type: none"> · Blood pressure machine, stethoscope · 2 instrument trolleys (as in procedure room) · 1-2 surgical drums · Tubal ligation and non-scalpel vasectomy equipment and instruments · Emergency equipment (as in procedure room) · Buckets and waste bins (as in procedure room) 	
Staff room	80–150 sq ft	<ul style="list-style-type: none"> · 4–6 chairs · 1 small table · Locker 		
Admin/clinic Support	100–150 sq ft	<ul style="list-style-type: none"> · Desk · 3 chairs · 1 filing cabinet 	<ul style="list-style-type: none"> · Computer and printer 	

*1 square foot = 0.0929 square metres

1.2 Setting up a Static Clinic

Review the following to ensure quality, optimal utilization and sustainability of services:

- ▶ location and accessibility
- ▶ clinic design and client flow mechanism
- ▶ equipment and supplies
- ▶ competency and attitude of the providers
- ▶ infection prevention and control
- ▶ clinic logistics management

1.2.1 Location and accessibility

- ▶ The clinic should be easily accessible by public transport, preferably less than a 20-minute walk from the nearest bus stop, train station or other public transport.
- ▶ Clearly visible sign boards in good condition must be placed outside the clinic, displaying opening times and services provided. The timings should be convenient for women, young people and those travelling long distances.
- ▶ The entrance to the clinic should be clean and without any obstructions.
- ▶ The area must be safe for women to come and go on their own during clinic hours.
- ▶ Ensure security for safety of clients and providers during clinic hours, and have security measures in place to prevent unwanted people entering the clinic.
- ▶ Make the clinic accessible for people with physical disabilities, with ramps and handrails to allow clients easy passage into and out of the clinic.

Location and accessibility of clinics



Clinic is well signposted, and the entrance is well maintained.

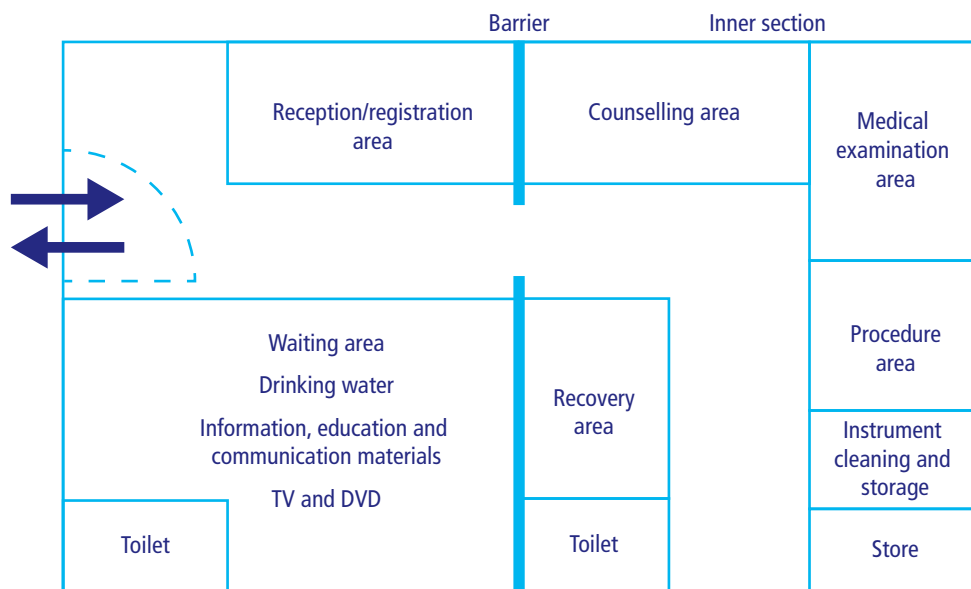


Poorly signposted, and badly maintained entrance

1.2.2 Clinic design and client flow mechanism

The most efficient way to design a clinic and the client flow is to tailor these according to the services provided. Figure 1 shows what a good static clinic design may look like.

Figure 1: Example of a good clinic set-up



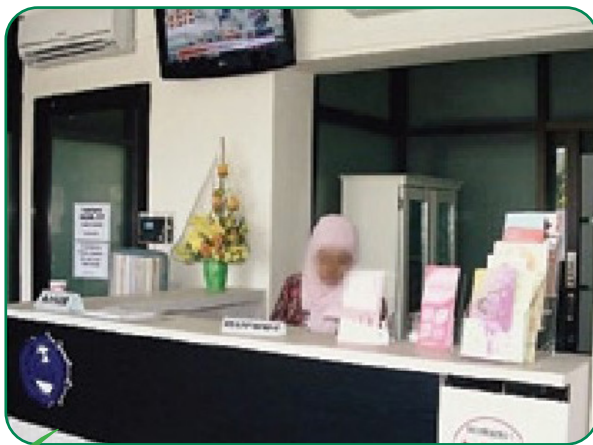
All electrical items should be wired securely to ensure safety.

Client Flow: Clearly demarcated outer and inner sections help ensure privacy, confidentiality and infection prevention. Client flow should be one-way so that clients do not have to go back to the waiting area except to exit the clinic. A separate exit is preferable if the clinic provides abortion services and/or services for young people.

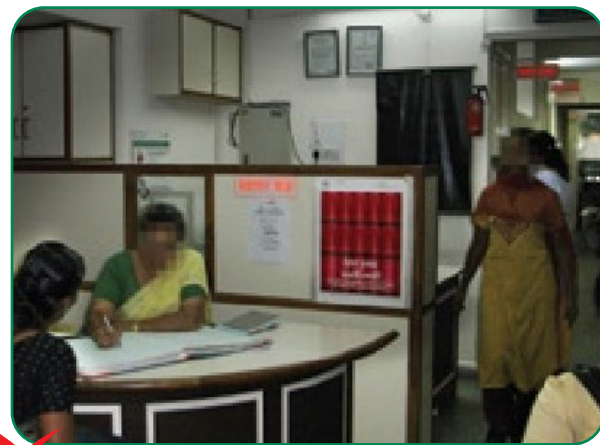
- ▶ The outer section includes the reception/registration area and the waiting area.
- ▶ The barrier prevents non-essential movement into the inner section of the clinic. Ideally, this is a permanent partition that ensures audio-visual privacy for the inner section.
- ▶ The inner section has the counselling area, the examination room, procedure room, recovery room and a toilet for clients.

Registration and waiting areas

- ▶ The registration area should ensure privacy. Clients should not be asked for detailed personal information which can be overheard by those in the waiting room.
- ▶ Client registers and records must not be left unattended. They must be filed securely when not in use, preferably in a locked cabinet. Records of referred clients and those needing follow-up should be filed separately for easy retrieval.
- ▶ A list of services and their prices should be displayed clearly.
- ▶ The waiting area should have adequate seating, good ventilation, access to safe drinking water and a clean toilet.
- ▶ Accurate and pro-choice sexual and reproductive health messaging should be displayed using posters, leaflets or TV visuals. Messaging should be simple and accessible for clients with disabilities (for example large print leaflets).



A pleasant and welcoming reception desk



Insufficient privacy at the registration desk; other clients can easily overhear the conversation.



The door separates the waiting area from the examination area, ensuring privacy. The waiting area is comfortable and clean.



The waiting area is situated outside the clinic. There is no privacy or comfort, and no information, education and communication materials are displayed.

Counselling area

The counselling area should be set up in a way that clients can speak freely without being overheard or seen by others. If there is no separate room, partitions or curtains should be used to ensure audio and visual privacy. No one should enter the room during counselling, and there should be no disruption to the counselling session.



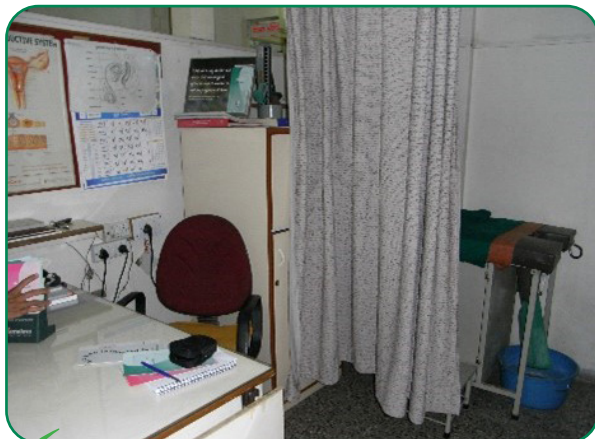
✓ Ideally, the client and the provider should sit at an equal level.



✗ The large table between the client and provider acts as a barrier. Other clients' records are easily visible, which compromises confidentiality.

Medical examination room

Complete privacy is mandatory during examination. The door must be closed when a client is inside, and staff needing to enter must knock before doing so. All clients who are being examined should be offered a chaperone. The examination room should be well ventilated, comfortable and clean, with access to hand washing facilities, necessary fixtures, instruments, equipment and supplies.



✓ Clean room, ensuring privacy and meeting quality of care standards

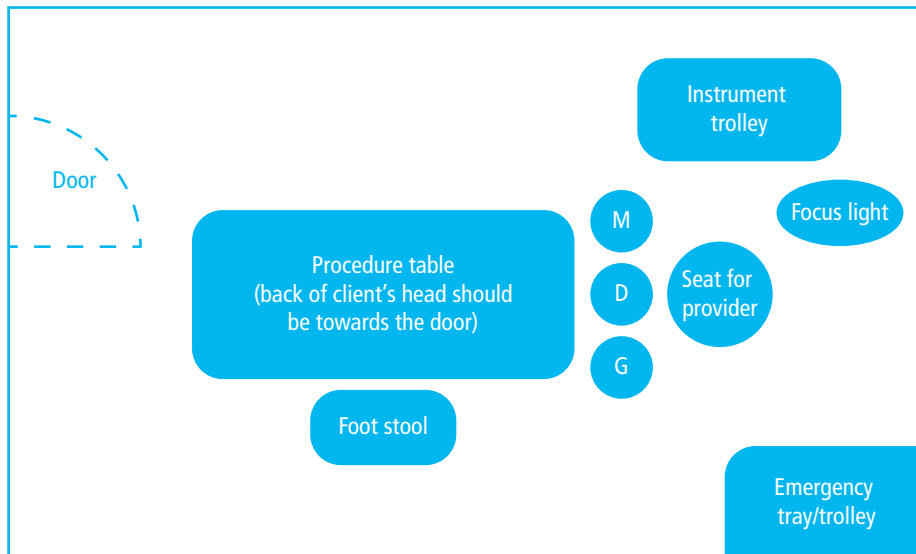


✗ The recovery room is being used for check-up and treatment of other clients, leading to lack of privacy and increasing risk of infection for clients who have just undergone a procedure.

Procedure room

The procedure room should not be accessible to outsiders or waiting clients. It should be located in a secure, quiet part of the inner section and have enough space for the procedure table, two surgical trolleys and free movement of two to four staff members. The room must have hand washing facilities, and be located close to the recovery room, toilet and instrument processing area (Figure 2). It should not be used to store extra equipment or supplies.

Figure 2: Set-up of a procedure room



M = bucket for medical waste; D = bucket for detergent solution; G = bucket/bin for general waste



✓ Well-organized and maintained procedure room, meeting quality of care guidelines



✗ The procedure room is very cluttered and also used for storage.

Recovery room

The recovery room should be located close to the procedure room in a quiet part of the inner section. It should have easy access to a toilet and no or minimum access for outsiders. The room should be well ventilated with drinking water and curtains or screen separating the beds for privacy.



Good privacy and comfort

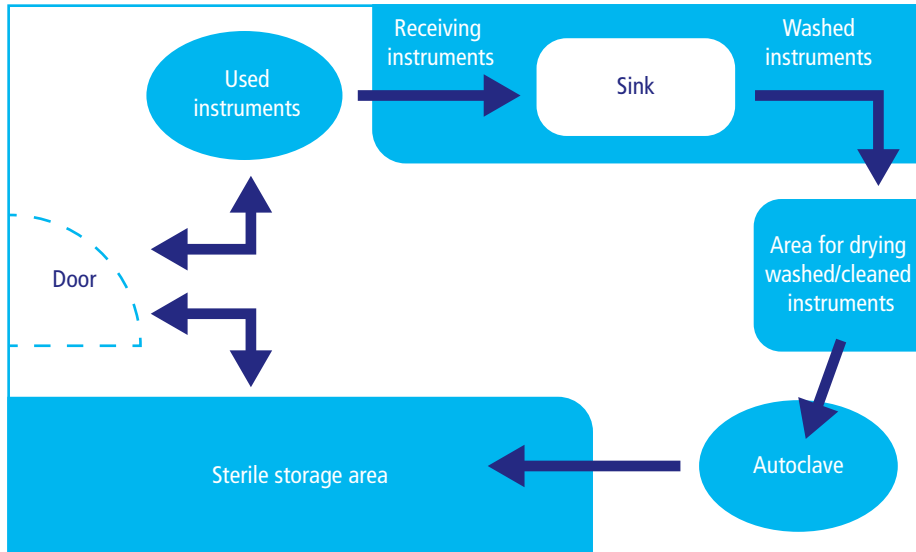


Limited privacy and comfort

Instrument processing room

The instrument processing room should ideally be adjacent to the procedure room. The room should have clean, running water. The flow of instruments should be one-way to prevent contamination of processed and sterile instruments, as shown in Figure 3. For more information, see 'Chapter 3: Infection prevention and control'.

Figure 3: Example of the correct flow of instruments



✓ Well organized area according to quality of care guidelines



✗ Poor and disorganized processing area

Storage

- ▶ The central storeroom or storage facility must be in a secured part of the clinic and kept locked. The room should be well ventilated, well lit, at a suitable temperature (15–30°C), and with no signs of dampness on the floor, walls or ceiling.
- ▶ A week's supply of daily use items (contraceptives, disposable gloves, etc.) can be kept in the consultation or medical examination room.
- ▶ Adequate shelves should be kept to ensure proper storage of supplies.
- ▶ One staff member should be given responsibility for general upkeep, dispersing and stock-taking of supplies. This should be monitored quarterly by the clinic manager. An annual audit of the store should be undertaken by the clinic team.
- ▶ Supplies should be stocked and labelled as listed in the stock register.

- ▶ All drugs and supplies are arranged on FEFO (first-expire, first-out) basis with clearly displayed expiry dates.
- ▶ Drugs, especially contraceptives and medical abortion supplies, must be stored away from direct sunlight.
- ▶ Expired drugs and commodities should be disposed of immediately (See Chapter 3: 'Infection prevention and control').
- ▶ Broken equipment and fixtures should not be stored on the clinic premises.
- ▶ A buffer stock of at least three months' supply should be maintained based on the average number of clients served (see Chapter 4: 'Clinic logistics and commodity management').



Well organized storage area



Poorly organized storage area

Toilets

- ▶ There must be toilets for both clients and staff – ideally, one toilet in the waiting area, a mandatory toilet with or near the recovery room and one toilet for staff in the inner section. In case of space constraints, two toilets – one in the waiting area and another near the recovery room – will suffice.
- ▶ Toilets should be clean, and have running water, toilet paper and soap/detergents.

1.2.3 Equipment, drugs and supplies

Uterine evacuation procedure with Ipas MVA Plus

- ▶ Personal protective barriers such as gloves and face protection
- ▶ Examination table with stirrups
- ▶ Step-up stool for client
- ▶ Stool for provider
- ▶ Strong focus light
- ▶ Two instrument trolleys
- ▶ Ipas MVA Plus aspirator
- ▶ Lubricant for aspirator
- ▶ Selection of Ipas EasyGrip cannulas
- ▶ Speculum
- ▶ Atraumatic forceps/tenaculum
- ▶ Small cup with sponge clamp and gauze
- ▶ Tapered mechanical dilators (Pratt or Denniston) or cannulas of increasing sizes
- ▶ 10 - 20cc syringe
- ▶ #20 - 23 gauge spinal or hypodermic needle or needle from IV insertion set
- ▶ Sponge stick with gauze
- ▶ Medium basin
- ▶ Smooth forceps
- ▶ Strainer
- ▶ Clear basin
- ▶ View box
- ▶ Sanitary towels
- ▶ Buckets for decontamination, general and medical waste
- ▶ Sharps disposal box
- ▶ Betadine® or other non-alcohol based antiseptic
- ▶ Lidocaine 1% or 2% without epinephrine (for para-cervical block)
- ▶ Analgesics (acetaminophen, ibuprofen, non-steroidal anti-inflammatory drugs)
- ▶ Sedatives (Diazepam, Lorazepam), if available
- ▶ Misoprostol for cervical preparation
- ▶ Emergency tray with emergency drugs and supplies (see below)

Dilatation and evacuation (D&E)

- ▶ Non-perforated stainless steel instrument tray
- ▶ Stainless-steel instrument tray without cover
- ▶ Vaginal Speculum- Klover
- ▶ Ipas MVA Plus aspirator
- ▶ Sponge holding forceps
- ▶ Atraumatic angled tenaculum
- ▶ Bierer forceps 13" size- small and large slightly curved,
- ▶ Sopher uterine evacuation forceps 11" Size –Small and large, slightly curved
- ▶ Sopher Ovum Forceps
- ▶ Set of Pratt and Ipas Denniston dilators
- ▶ Cheshire Medical Vacuum Curette Straight, 14 mm.
- ▶ Long needle holder
- ▶ 60 cc Foley Catheter

Source: *Ipas Second Trimester Abortion – A Toolkit for Service Delivery and Ipas Women Centred Comprehensive Abortion Care Reference Manual*

Emergency equipment, drugs and supplies

Equipment and supplies:

- ▶ Blood glucose monitor with test strips
- ▶ IV cannulation Equipment – a range of large bore cannula (sizes 16-22), syringes, saline flush, tape, cannula fixing dressing, tourniquet, sharps box
- ▶ Oxygen cylinder size D/E with non-rebreathe mask (with oxygen reservoir) or portable oxygen kit
- ▶ Pocket mask
- ▶ Portable Pulse oximeter
- ▶ IV infusion sets
- ▶ Syringes (2, 5, 10 ml)
- ▶ Needles – 21 G
- ▶ Clean and sterile gloves – different sizes
- ▶ Sterile gauze pack
- ▶ Urine catheter (Foley) and bag (adult size catheter)
- ▶ Large scissors
- ▶ Crepe bandage

Drugs:

- ▶ IV fluids – Normal Saline (0.9%), Ringer Lactate Solution
- ▶ Sterile water for injection/IV flush
- ▶ Inj. hypertonic glucose solution, 25%, 50%,
- ▶ Inj. Adrenaline, 1:1000
- ▶ Inj. Atropine, 1mg/ml
- ▶ Salbutamol inhaler
- ▶ Inj. Chlorpheniramine
- ▶ Inj. Oxytocin
- ▶ Inj. antibiotics (IV/IM)
- ▶ Inj. Tetanus toxoid/tetanus antitoxin
- ▶ Aspirin tablets (81 mg)

If sedation is provided in the clinic, the procedure room also needs to be equipped with:

- ▶ Suction machine and apparatus
- ▶ Oropharyngeal Airways, sizes 2, 3, 4
- ▶ Self-inflating Bag Valve Mask (BVM) with Oxygen Reservoir
- ▶ Inj. Diazepam, 5mg/ml

2 Providing services and support

2.1 Introduction

Abortion care must be person-centred keeping in mind that all people have a right to reproductive and sexual healthcare and choices, and a right to safe abortion and treatment of complications of an unsafe abortion. Services must satisfy each woman's individual needs and situation, including those of young women.

A **person-centred approach** requires providers to recognize and separate their own beliefs and values from those of the client. They must respect her needs and preferences and treat her with empathy, irrespective of age, marital status, sexual and reproductive behaviours and decisions.



Comprehensive abortion care (CAC) is an approach to abortion services that focuses on the woman's individual needs, be it an induced abortion; treatment of incomplete, missed or unsafe abortion; compassionate counselling; providing abortion through supported self-care or a harm reduction model; contraceptive services; or related sexual and reproductive health services (on site or via referral).

CAC can be provided through various pathways, including through in-clinic care, via digital health interventions, home provision of care, other out-of-clinic care, or a mix of different pathways. The guidance provided in this chapter will mainly focus on the provision of abortion care through a clinic-based model; however, the content can be adapted for different models of care accordingly.

2.2 Principles

Person-centred – Providing options relevant to the individual's needs, preferences, and lived experiences supports people's self-efficacy to control their lives and decisions.

Rights-based – People's right to make autonomous decisions about their own bodies and reproductive functions is at the core of their fundamental rights to life, health, equality and non-discrimination.

Quality and dignity of care – Care delivered should be in line with the available evidence and the needs, values, and preferences of the clients, free of stigma and with compassion and empathy.

Privacy and confidentiality – Audio and visual privacy during counselling and examination should be guaranteed, as should ensuring confidentiality of client information.

Inclusiveness – All individuals who may need an abortion must have access to care that considers their unique needs, irrespective of visible or invisible differences.

2.3 Registration

Registration is the first service provided to the client by a receptionist or counsellor. Privacy and confidentiality are critical as are a friendly and non-judgemental attitude. The receptionist:

- ▶ provides information on services available
- ▶ registers client requests and schedules appointments

- ▶ opens a new client record or locates existing client folder (manually or using eCMIS)
- ▶ records socio-demographic client data
- ▶ explains what to expect (where to sit, where to go, waiting time, etc.)
- ▶ triages clients for urgent consultation, for example heavy bleeding in incomplete abortion

2.4 Counselling

This is the next service on a woman's abortion care pathway after registration.

a) Pregnancy options counselling – This counselling should not act as a barrier. Most women will have already made the decision to terminate their pregnancy prior to their visit. The purpose of this session is to help her with any questions she may have about her pregnancy options, including whether to:

- ▶ Continue the pregnancy to term and parent
- ▶ Continue the pregnancy and place for adoption, where relevant and available
- ▶ Terminate the pregnancy

b) Information provision – If she decides to end the pregnancy, discuss her options for abortion methods and pathways to care including:

- ▶ The advantages, disadvantages, benefits and risks of the different methods of abortion available, both surgical and medical (See Table 1)
- ▶ Details about all methods available to enable her to make an informed decision, including:
 - ▶ What will happen before, during and after the abortion
 - ▶ What she is likely to experience – cramps, bleeding, nausea, etc.
 - ▶ How long the abortion will take
 - ▶ What pain management options she has
 - ▶ Possible side effects and risks
 - ▶ What aftercare and follow-up will be needed
- ▶ Information, including advantages and disadvantages, about the different pathways to abortion care available. This may include, for example, telemedicine options (for specific aspects of the service or all), supported abortion self-care (in-part or entirely), home provision of medical abortion, in-clinic care, or a mix of different pathways.

c) Informed consent – Discuss and confirm that she understands:

- ▶ The benefits and risks of her chosen method of abortion and pathway to care

Table 1: Surgical and medical abortion up to 12–13 weeks' gestation

	Vacuum aspiration	Medical abortion using mifepristone and misoprostol	Medical abortion using misoprostol only
What is it?	Evacuation of the pregnancy from the uterus by suction. Takes 2 to 10 minutes. Completion is immediately confirmed	Two medicines taken together cause the uterus to expel the pregnancy. Mifepristone is taken by mouth (swallowed). One or two days later, misoprostol is put either under the tongue (sublingual), inside the cheek (buccal) or in the vagina. After taking the misoprostol, the abortion usually takes 4-6 hours, but can take longer.	One medicine that causes the uterus to expel the pregnancy. Misoprostol is put under the tongue (sublingual), inside the cheek (buccal) or in the vagina. The abortion usually occurs within 24 hours, but can take longer.
How does it work?	The pregnancy is removed through a plastic tube attached to a manual or electric aspirator	Mifepristone detaches the pregnancy from the wall of the uterus. Misoprostol causes cramps to expel the pregnancy.	Misoprostol causes cramps/contractions to expel the pregnancy
Where can it be used?	At a health care site/clinic	Mifepristone (first pill) is usually given at the clinic but can safely be provided to women to take at home if local laws and regulations allow. Misoprostol (second set of pills) may be taken at clinic or at home if pregnancy is < 12 weeks. If pregnancy > 12 weeks, misoprostol is given in the clinic and it is generally recommended that women stay in clinic until the abortion is complete.	Misoprostol may be taken at the clinic or home for women if pregnancy < 12 weeks. If pregnancy > 12 weeks, misoprostol should be given in the clinic.
How effective is it?	97% to 99.5% effective	95% to 98% effective	80% to 85% effective
What are the side effects?	Bleeding and cramping	Bleeding and cramping. Other possible side effects include nausea, vomiting, diarrhoea, fever/chills and dizziness.	Bleeding and cramping. Other possible side effects include nausea, vomiting, diarrhoea, fever/chills and dizziness.
What are the possible complications?	Rare complications include injury to the uterus or cervix, excessive bleeding, infection, blood collecting in the uterus, incomplete abortion	Rare complications include excessive bleeding and infection. Continuing pregnancy occurs in less than 2% of women.	Rare complications include excessive bleeding and infection. Continuing pregnancy occurs in 3%–10% of women
Contraindications	Inability to visualize or dilate the cervix	<ul style="list-style-type: none"> • Previous allergic reaction to mifepristone or misoprostol • Known or suspected ectopic pregnancy • Inherited porphyria • Chronic adrenal failure 	<ul style="list-style-type: none"> • Previous allergic reaction to misoprostol • Known or suspected ectopic pregnancy
Precautions (weigh risk vs. benefit or additional procedures/assessment needed)	Uterine abnormalities including bicornuate uterus or fibroids	<ul style="list-style-type: none"> • Intrauterine device (IUD) in place (remove prior to initiating medical abortion) • Serious/unstable health problems e.g. haemorrhagic disorders, heart disease and severe anaemia • Severe uncontrolled asthma or long-term corticosteroid therapy 	<ul style="list-style-type: none"> • Intrauterine device (IUD) in place (remove prior to initiating medical abortion) • Serious/unstable health problems e.g. haemorrhagic disorders, heart disease and severe anaemia



Tips for an effective counselling session

- ▶ Keep an open mind and remain non-judgemental
- ▶ Ask open-ended questions and use encouraging words
- ▶ Help the woman to talk freely before you provide her with information
- ▶ Ask her about her feelings and circumstances surrounding the pregnancy; think whether these have any implications for her care or referral for other services
- ▶ Support her to make a decision about this pregnancy and her future sexual and reproductive health
- ▶ Help her to explore her own feelings about abortion
- ▶ Provide answers to her questions, using words and language that she understands
- ▶ Do not provide information that is not relevant to her situation
- ▶ Do not tell her what you think is best for her or try to influence her beliefs and decision
- ▶ Help her decide if she needs and where she should go for social support
- ▶ Provide referrals for additional services if necessary
- ▶ Follow appropriate protocols (if any) if the client is a minor.

d) Closing the counselling session

- ▶ Summarize the important points discussed.
- ▶ Ask her if she has any other questions.
- ▶ Confirm that she has understood all the information and instructions.
- ▶ Obtain informed consent, where necessary.
- ▶ Give written or pictorial instructions if possible, and provide referrals if indicated.
- ▶ Explain what to expect during the remainder of the clinic visit.



It is important that the Member Association protocols and/or practices of individual counsellors or providers do not add additional barriers to services for young people that are not mandated by law.

e) Counselling young clients and/or vulnerable adults

Clinics can serve young people better by becoming familiar with the laws relating to age of consent to know where there is more or less flexibility for their clients. Where allowed by law, some organizations have a team of health professionals who can consent in the place of parents.

Age is often used to establish legal age limits, but this doesn't take into account the different rates at which young people mature. Each young person gradually develops the ability to take full responsibility for her or his own actions and decisions, which is known as "evolving capacities". More information and guidance on finding the right balance between protecting young clients and enabling them to exercise autonomy can be found in the IPPF guidance document "Keys to youth-friendly services: Understanding evolving capacity".¹

2.5 Clinical assessment

Before providing an abortion, assess the woman's clinical condition and eligibility for abortion using medical or surgical methods through:

1) Client history – This helps determine the woman's gestational age from LMP, and her eligibility for a medical or surgical abortion; it also provides information about her other sexual and reproductive health needs.

¹ https://www.ippf.org/sites/default/files/key_evolving_capacity.pdf

2) Physical examination (for in-person assessments), including:

- ▶ general health assessment, including checking temperature, pulse and blood pressure; noting if there is any weakness, lethargy, pallor or malnourishment. The abdomen is also checked for masses and tenderness.
- ▶ pelvic examination, which includes a speculum and bimanual examination. Before the pelvic exam, ask the woman to empty her bladder and explain what to expect.

3) Investigations/tests only if needed – These are helpful ONLY when the history and physical examination are unable to confirm gestational age and include ultrasound examination. No investigations are required routinely for the provision of an abortion service up to 12 weeks (WHO 2012).

The clinical assessment is also an opportunity to screen for other conditions such as ectopic pregnancy, abortion complications, intra-uterine fetal death, cervical cancer and reproductive tract infections.

2.5.1 Pregnancy/abortion complications

Pregnant women who present with vaginal bleeding and/or lower abdominal pain may have early pregnancy complications like threatened abortion; missed or incomplete spontaneous abortion; or complications from a safe induced abortion, an unsafe abortion or post-abortion care. Complications can range from mild to severe including vaginal bleeding/haemorrhage, pelvic infection/sepsis and local, pelvic or intra-abdominal injury (Table 2).

Table 2: Comparison of signs, symptoms and management options of early pregnancy/abortion complications versus complete abortion

Definition and diagnosis	Signs and symptoms	Management options
Threatened abortion vaginal bleeding in woman with a viable intrauterine pregnancy	<ul style="list-style-type: none"> • Light bleeding • Slight cramping/pain • Closed cervix • Uterine size corresponds to LMP 	<ul style="list-style-type: none"> • Reassurance • Expectant management if client wants to continue pregnancy. Can proceed with medical or surgical abortion without delay if abortion is desired. • If bleeding continues or increases, reassess clinically
Incomplete abortion an abortion (spontaneous or induced) in which some pregnancy tissue passes out of the uterus but some remains	<ul style="list-style-type: none"> • Bleeding increases • Moderate cramping or pain • Open cervix, (tissue may be seen at cervical os) • Uterine size corresponds to or is smaller than LMP • On visual examination after abortion, expelled tissue is not consistent with estimated duration of pregnancy. 	Depending on clinical condition and the woman’s preference, offer: <ul style="list-style-type: none"> • Expectant management, or • Medical management (misoprostol), or • Surgical management (vacuum aspiration) • Antibiotics (if signs of infection are present) and pain control if needed
Missed abortion a type of spontaneous abortion where pregnancy ends but pregnancy tissue does not pass spontaneously from the uterus	<ul style="list-style-type: none"> • Light to no bleeding • Some cramping/pain • Closed cervix • Uterine size smaller than LMP • Diagnosis is made on ultrasound 	Depending on clinical condition and the woman’s preference, offer: <ul style="list-style-type: none"> • Expectant management, or • Medical management (misoprostol alone or mifepristone and misoprostol), or • Surgical management (vacuum aspiration) • Antibiotics and pain control
Complete abortion products of conception are completely expelled from the uterus	<ul style="list-style-type: none"> • Bleeding decreases • Cramping/pain reduces • Closed cervix • Uterine size smaller than LMP 	<ul style="list-style-type: none"> • Provide expectant management • Antibiotics if signs of infection are present and pain control if needed

Ectopic pregnancy

Ectopic pregnancy must be ruled out in pregnant women with previous history of ectopic pregnancy, tubal ligation, tubal surgery, infertility, assisted reproductive technology, pelvic infections; an IUD in the uterus; or worrying signs on physical examination such as adnexal mass, pain on examination or vaginal bleeding.

Women with a history and/or physical examination findings concerning for ectopic pregnancy need immediate diagnosis and management of the ectopic pregnancy.

- ▶ Ultrasound and serial hCG testing can confirm ectopic pregnancy.
- ▶ If the woman has undergone vacuum aspiration, strain and examine the aspirate. If products of conception (i.e. chorionic villi and/or gestational sac) are not seen, ectopic pregnancy should be considered.
- ▶ If a woman has used medical abortion and presents with the following symptoms, suspect ectopic pregnancy and treat/refer immediately:
 - ▶ Minimal vaginal bleeding after taking medical abortion medicines
 - ▶ Uterine size is smaller than expected for the gestation
 - ▶ Sudden, intense and persistent lower abdominal pain, initially one-sided then generalized, irregular vaginal bleeding or spotting and/or palpable adnexal mass
 - ▶ Fainting, shoulder pain, rapid heartbeat and light-headedness indicate internal bleeding.

Intra-uterine fetal death (IUFD)

IUFD is death of the fetus at or more than 14 weeks gestation, but the uterus has not yet expelled the pregnancy and the cervical os remains closed. Clinical findings include vaginal bleeding, absent fetal heart sounds on electronic auscultation, lack of fetal movements and a uterus much smaller than expected size. Diagnosis is made by a combination of clinical signs confirmed with an ultrasound scan. IUFD is managed expectantly, surgically or medically, depending on the woman's clinical condition and preference for treatment (see Section 2.10).

2.6 Surgical abortion up to 13 weeks' gestation: Manual vacuum aspiration (MVA)

Surgical abortion is done using vacuum aspiration up to 13 weeks.

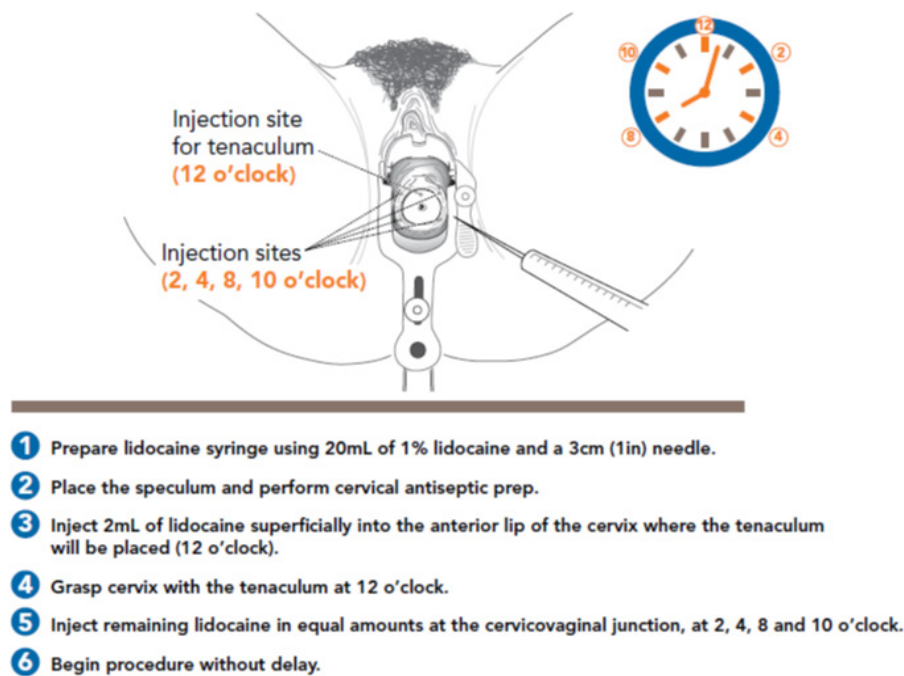
2.6.1 Pain management

- ▶ Paracervical block and nonsteroidal anti-inflammatory drugs (NSAIDs) 30 minutes before the procedure are recommended for all women.
- ▶ Narcotic analgesics, anxiolytics, non-pharmacologic measures (verbal reassurance, gentle technique, calming environment) or intravenous sedation can be offered.
 - ▶ Paracetamol is not effective for pain management of surgical abortion.
- ▶ NSAIDs relieve cramping post-procedure but pain that increases over time requires clinical evaluation.

Paracervical block

- ▶ Paracervical block is an effective method of pain management for vacuum aspiration, osmotic dilator placement and dilatation and evacuation (D&E).
- ▶ It can be safely given by all service providers who are trained in surgical abortion.
- ▶ 20mL of 1% lidocaine (or 10 ml of 2% lidocaine) is injected to a depth of 3cm, three minutes before dilating the cervix, using a two-point (4 and 8 o'clock) or a four-point paracervical injection technique (Figure 1).
- ▶ Always aspirate before injecting to avoid intravascular injection.
- ▶ Do not exceed the maximum dose of lidocaine – 4.5mg/kg or 200mg.

Figure 1: Paracervical block



Source: *Ipas*, <https://www.ipas.org/resource/paracervical-block-technique/>

2.6.2 Performing manual vacuum aspiration

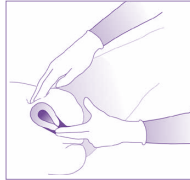
The following steps should be followed when providing an abortion using manual vacuum aspiration (MVA). Figure 2 illustrates these steps. Vacuum aspiration can also be performed utilizing electric vacuum aspiration and involves the same steps (other than preparation of the aspirator) below.

Figure 2: Steps for performing MVA²

Steps for Performing Manual Vacuum Aspiration (MVA) Using the Ipas MVA Plus[®] and Ipas EasyGrip[®] Cannulae

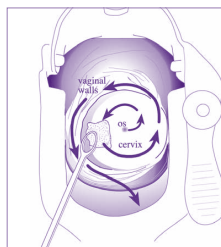
Step One: Prepare the Patient

- Administer pain medication before the procedure to have maximum effect when the procedure begins.
- Give prophylactic antibiotics to all women, or therapeutic antibiotics if indicated.
- Ask the woman to empty her bladder.
- Conduct a bimanual exam to confirm uterine size and position.
- Insert speculum and observe for signs of infection, bleeding or incomplete abortion.



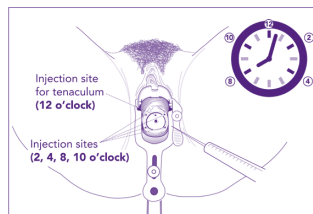
Step Two: Perform Cervical Antiseptic Prep

- Use antiseptic-soaked sponge to clean cervical os. Start at os and spiral outward without retracing areas. Repeat until os has been completely covered by antiseptic.



Step Three: Perform Paracervical Block

- Paracervical block is required prior to MVA.
- Perform paracervical block with 20cc of 1% lidocaine, or 10cc of 2% lidocaine. Inject a small amount of lidocaine (1-2cc) into the cervix at the tenaculum site (12 o'clock). Inject the remaining lidocaine in equal amounts at the cervicovaginal junction at 2, 4, 8 and 10 o'clock. Always aspirate before injecting to prevent intravascular injection of lidocaine.

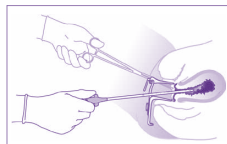


Step Four: Dilate Cervix

- Observe no-touch technique when dilating the cervix and during aspiration. Instruments that enter the uterine cavity should not touch your gloved hands, the patient's skin, the woman's vaginal walls, or unsterile parts of the instrument tray before entering the cervix.
- Use mechanical dilators or progressively larger cannulae to gently dilate the cervix to the right size.

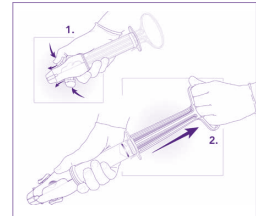
Step Five: Insert Cannula

- While applying traction to the tenaculum, insert cannula through the cervix, just past the os and into the uterine cavity.
- Do not insert the cannula forcefully.



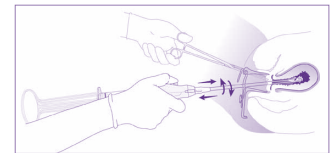
Step Six: Prepare the Aspirator

- Position the plunger all the way inside the cylinder.
- Have collar stop in place with tabs in the cylinder holes.
- Push valve buttons down and forward until they lock (1).
- Pull plunger back until arms snap outward and catch on cylinder base (2).



Step Seven: Suction Uterine Contents

- Attach the prepared aspirator to the cannula.
- Release the vacuum by pressing both buttons.
- Evacuate the contents of the uterus by gently and slowly rotating the cannula 180° in each direction, using an in-and-out motion.
- When the procedure is finished, depress the buttons and disconnect the cannula from the aspirator. Alternatively, withdraw the cannula and aspirator without depressing the buttons.



Signs that indicate the uterus is empty:

- Red or pink foam without tissue is seen passing through the cannula.
- A gritty sensation is felt as the cannula passes over the surface of the evacuated uterus.
- The uterus contracts around or grips the cannula.
- The patient complains of cramping or pain, indicating that the uterus is contracting.

Step Eight: Inspect Tissue

- Empty the contents of the aspirator into a container.
- Strain material, float in water or vinegar and view with a light from beneath.
- Inspect tissue for products of conception, complete evacuation and molar pregnancy.
- If inspection is inconclusive, reaspiration or other evaluation may be necessary.



Step Nine: Perform Any Concurrent Procedures

- When procedure is complete, proceed with contraception or other procedures, such as IUD insertion or cervical tear repair.

Step Ten: Immediately After the Procedure

- Reassure the woman that the procedure is finished.
- Ensure she is escorted to the recovery area.
- Immediately process or discard all instruments, according to local protocols.



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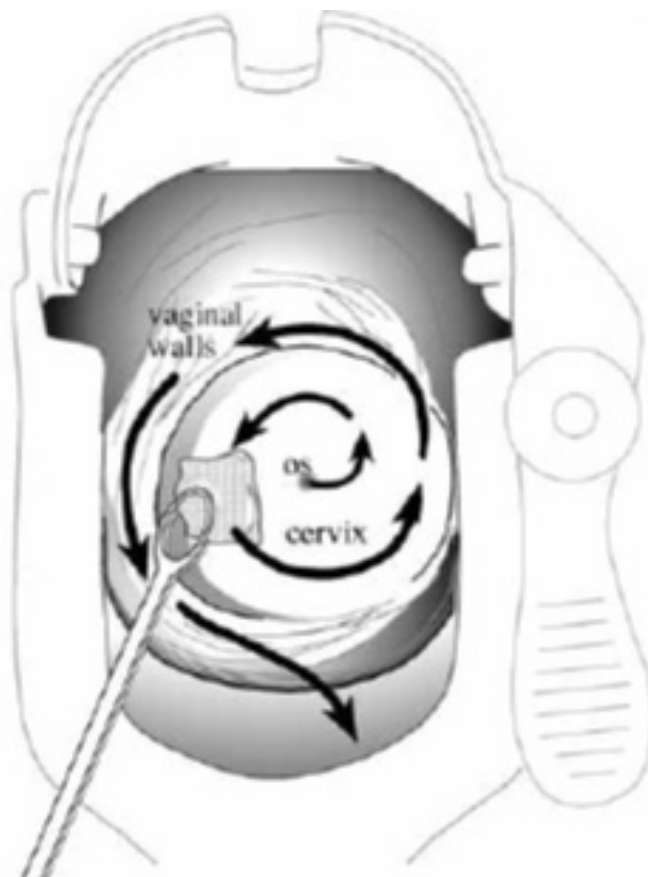
© 2014, 2017 Ipas.
U.S. Patent and Trademark Office Reg. No.
Ipas MVA Plus[®] 2,907,186 Ipas EasyGrip[®] 2,768,302

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² This can be downloaded for print at: <https://www.ipas.org/resource/steps-for-performing-manual-vacuum-aspiration-using-the-ipas-mva-plus-and-easygrip-cannulae/>

- ▶ **Prepare the instruments** – Check aspirator for vacuum retention before starting. Create a vacuum for evacuation. Keep a back-up aspirator ready. See Chapter 1, Section 1.2.3 for a list of emergency equipment, drugs and supplies to keep in the procedure room.
- ▶ **Prepare the client** – Give pain medication and prophylactic antibiotics (a single dose of doxycycline 200mg orally, OR azithromycin 500mg orally OR metronidazole 500mg orally) no more than 2 hours before the procedure. Give treatment doses of antibiotics to those with signs or symptoms of sexually transmitted infection. If antibiotics are unavailable, the procedure does not need to be delayed. Ask client to empty the bladder, help her onto the procedure table and ask for permission to proceed.
- ▶ **Perform cervical antiseptic preparation** – After washing hands and donning clean gloves, insert a speculum of appropriate size. Clean the cervical os with an antiseptic-soaked sponge, spiralling out and downwards to clean the vagina (Figure 3).

Figure 3: Cleaning the cervical os



Source: Ipas, <https://www.ipas.org/resource/steps-for-performing-manual-vacuum-aspiration-using-the-ipas-mva-plus-and-easygrip-cannulae/>

- ▶ **Perform a paracervical block** as described above.
- ▶ **Place a tenaculum on the cervix** at the 12 o'clock position.
- ▶ **Dilate the cervix** gently with progressively larger size MVA cannulas (or mechanical dilators) until a cannula of appropriate size passes snugly through the os. In general, the appropriate size cannula for an aspiration procedure is the same number in millimetres as estimated weeks of gestation (i.e. 8mm cannula for 8 week gestation).

Cervical preparation before cervical dilatation is done routinely above 12-14 weeks gestation and in other cases if indicated (Table 3). Vaginal misoprostol is preferred to sublingual misoprostol as it has fewer side-effects. Misoprostol can be repeated as needed and can be used alone or with mifepristone and osmotic dilators. Mifepristone is rarely used for cervical preparation in the first trimester due to cost and availability and the need to delay the procedure as it needs to be given 1-2 days prior.

Table 3: Cervical preparation

Dose	Dose/Route	Timing
Misoprostol	400 mcg vaginally/buccally	3–4 hours before procedure
Misoprostol	400 mcg sublingually	2–3 hours before procedure
Mifepristone	200 mg orally	1–2 days before procedure
Osmotic dilators	Placed in the cervix. The number of dilators needed will vary based on types of dilators used, gestational age of the pregnancy and experience of the provider.	6–24 hours before procedure



Use No-Touch Technique – The tip of the cannula, or the tip of any other instrument that enters the uterus, should never touch nonsterile surfaces (including the vaginal walls) prior to insertion.

- ▶ **Insert cannula** – Apply gentle traction to the cervix while slowly inserting the cannula through the os into the uterine cavity until it touches the fundus; then withdraw it slightly.
- ▶ **Suction the uterine contents** – Attach prepared MVA aspirator to the cannula, start suction and gently evacuate uterine contents by rotating the cannula 180 degrees in each direction, with an in-and-out motion till uterus is empty. Signs of a complete procedure include:
 - ▶ Red or pink foam appears and no more tissue passes through the cannula
 - ▶ A gritty sensation is felt as the cannula scrapes the surface of the empty uterus
 - ▶ The uterus contracts around (grips) the cannula
- ▶ **Inspect tissue** – Empty the contents of the aspirator into an appropriate container, strain and immerse in water and view with a light from beneath. Villi and decidua should be visible and the amount of tissue should correspond to the uterine size.

If no or less tissue (POC) than expected is seen, suspect and evaluate for the following:

- ▶ **Incomplete or failed abortion:** The uterine cavity still contains POC, as a result of using a cannula that is too small or stopping the procedure early
- ▶ **Spontaneous complete abortion** that has already completed itself
- ▶ **Suspected ectopic pregnancy:** When no villi or decidua are seen in the aspirate
- ▶ **Anatomical anomaly:** In a bicornuate or septate uterus, the cannula may enter the side of the uterus that does not contain the pregnancy
- ▶ **Wipe the cervix** with a clean swab to confirm there is no significant bleeding.
- ▶ **Perform concurrent procedures**, such as IUD or implant insertion, female sterilization or repair of a cervical tear.
- ▶ **Remove all instruments and gauze** from the vagina and help client into a more comfortable position/location for recovery.
- ▶ **Start post-procedure steps**, such as instrument processing, removing gloves and washing hands, and helping woman to recovery area for post-procedure care.

2.6.3 Post-procedure care

- ▶ Monitor vital signs and bleeding to confirm recovery from the procedure and medications, and to detect and manage post-procedure complications.
- ▶ Provide post-procedure counselling and referral for other reproductive health needs, where relevant.
- ▶ Provide information about what to expect and do after going home.
- ▶ See section 2.12 for details about follow-up care.

2.7 Surgical abortion at or after 13 weeks' gestation

Surgical abortion is done using dilation and evacuation (D&E) after 13 weeks. D&E involves cervical preparation ahead of the procedure with medications and/or osmotic dilators (see Table 3) and removal of the pregnancy with suction (via manual or electric aspiration) and/or additional instruments such as forceps. Provision of D&E requires additional training and expertise. Detailed information and guidance is provided in Annex 1.

2.8 Medical abortion up to 12 weeks' gestation

Medical abortion – or medication abortion – refers to inducing abortion with medicines and is a safe and effective method. WHO recommends using a combination of mifepristone and misoprostol or misoprostol alone for inducing a medical abortion (Box 1). Both drugs are included in the WHO Model List of Essential Medicines.

Medical abortion up to 12 weeks' gestation can be provided on an outpatient basis by a wide range of providers including auxiliary nurses and lay health workers. In addition, a woman can self-manage her abortion using medical abortion, with a range of support options available to her if needed and desired, up to 12 weeks' gestation (see Section 2.14 for more details).

Box 1: Medical management of abortion (WHO)



POCKET GUIDE:

Medical management of abortion



Summary chart of recommendations on medical management of abortion

RECOMMENDATIONS	COMBINATION REGIMEN (RECOMMENDED ^a)		MISOPROSTOL-ONLY (ALTERNATE)
	MIFEPRISTONE	1-2 DAYS MISOPROSTOL	MISOPROSTOL
1A. INCOMPLETE ABORTION < 13 WEEKS	None	Use misoprostol-only regimen	600 µg PO ^b or 400 µg SL ^b
1B. INCOMPLETE ABORTION ≥ 13 WEEKS	None	Use misoprostol-only regimen	400 µg B, PV or SL every 3 hours ^b
2. INTRAUTERINE FETAL DEMISE ≥ 14–28 WEEKS	200 mg PO once	400 µg PV or SL every 4–6 hours ^b	400 µg SL (preferred) or PV every 4–6 hours ^b
3A. INDUCED ABORTION < 12 WEEKS	200 mg PO once	800 µg B, PV or SL ^b	800 µg B, PV or SL ^b
3B. INDUCED ABORTION ≥ 12 WEEKS	200 mg PO once	400 µg B, PV or SL every 3 hours ^b	400 µg B, PV or SL every 3 hours ^b
TIMING OF POST-ABORTION CONTRACEPTION			
IMMEDIATE INITIATION			
4A. HORMONAL CONTRACEPTION	Immediately after the first pill of the medical abortion		
4B. IUD	With assessment of successful abortion		

B: buccal; **PO:** oral; **PV:** vaginal; **SL:** sublingual

^a Combination regimen is recommended because it is more effective.

^b Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. The *Medical management of abortion* guideline does not include a recommendation for a maximum number of doses of misoprostol. Health-care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision. Uterine rupture is a rare complication; clinical judgement and health system preparedness for emergency management of uterine rupture must be considered with advanced gestational age.

Accessible at <https://apps.who.int/iris/bitstream/handle/10665/329412/WHO-RHR-18.40-eng.pdf?sequence=1&isAllowed=y>

2.8.1 Pain management

- ▶ Offer pain medication to all women undergoing medical abortion.
- ▶ Advise NSAIDs, either prophylactically (taken with misoprostol) or when cramping starts.
- ▶ Do not recommend paracetamol unless client has allergy or contraindication to NSAIDs.
- ▶ Offer non-pharmacologic pain management measures, such as a supportive environment and applying a heating pad or hot water bottle to the lower abdomen.

Antibiotics

- ▶ Do not routinely give antibiotics to women undergoing medical abortion.
- ▶ Give antibiotics only to those with signs or symptoms of sexually transmitted infection, but the treatment should not delay medical abortion.

2.8.2 Medical abortion regimens up to 12 weeks

1) Using a combination of mifepristone and misoprostol

For pregnancies up to 12 weeks' gestation:

- ▶ **Step 1:** One 200mg mifepristone pill should be taken orally (swallowed with water)
- ▶ **Step 2:** Wait 1-2 days. During this time, the woman can continue with routine activities.
- ▶ **Step 3:** Four misoprostol pills (200mcg each) should be taken either buccally (between the cheek and gum), sublingually (under the tongue) or vaginally. If taken buccally or sublingually, she should keep the pills in place for 30 minutes as they dissolve, avoiding eating or speaking. After 30 minutes, she can swallow everything that is left of the pills. After the misoprostol is given, a painkiller such as ibuprofen should be taken, as the cramping will begin soon.
- ▶ **Step 4:** If bleeding does not begin within 24 hours, or if it is unclear whether the abortion has worked, the woman can be given 4 more pills of misoprostol, to be taken in the same way as the initial dose (e.g. buccally, sublingually or vaginally). It is common for women to require two doses of misoprostol for pregnancies between 10–12 weeks' gestation.

2) Using misoprostol only

For pregnancies up to 12 weeks' gestation:

- ▶ **Step 1:** Four pills (200mcg each) of misoprostol should be taken buccally, sublingually or vaginally. If taken buccally or sublingually, she should keep the pills in place for 30 minutes as they dissolve, avoiding eating or speaking. After 30 minutes, she can swallow everything that is left of the pills. After the misoprostol is given, a painkiller such as ibuprofen should be taken, as the cramping will begin soon. Whichever way a woman chooses to use misoprostol (e.g. buccally, sublingually or vaginally), it should be used the same way for any additional doses.
- ▶ **Step 2:** Wait 3 hours.
- ▶ **Step 3:** The woman should take another 4 misoprostol pills (200mcg each) in the same way as the first dose (either under the tongue, between cheek and gum or in the vagina) following the same instructions as above.
- ▶ **Step 4:** Wait 3 hours.
- ▶ **Step 5:** If bleeding has not begun or if it is unclear if the abortion has worked, the woman can be given another 4 misoprostol pills (200mcg) to take in the same way as the first dose (either under the tongue, between cheek and gum or in the vagina) following the same instructions as above.
- ▶ While some women may require additional doses of misoprostol to complete an abortion, if bleeding does not begin within 24 hours of the third dose of misoprostol, or if it is unclear if the abortion worked, the woman should be advised to contact you or another healthcare provider.

- ▶ Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. WHO guidelines do not provide a maximum number of doses of misoprostol. Health-care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant individuals with prior uterine incision.

For details about follow-up care, see Section 2.12.

2.9 Medical abortion at or after 12 weeks' gestation

2.9.1 Pain management

Higher gestational age, more misoprostol doses and longer induction-to-abortion intervals are associated with more pain. Pain rarely starts after taking mifepristone, but cramping pain starts after using misoprostol and the pain peaks at expulsion.

- ▶ Start nonsteroidal anti-inflammatory drugs (NSAIDs) with misoprostol.
- ▶ Offer narcotic analgesics and anxiolytics in addition to NSAIDs.
- ▶ Offer non-pharmacologic measures such as information about expected pain and bleeding, a supportive environment, and a heating pad or hot water bottle to the lower abdomen.
- ▶ Offer regional anaesthesia or client-controlled anaesthesia, if available.



Medical abortion with uterine scar: If gestation > 22 weeks with 1 previous uterine scar or gestation between 13–22 weeks with more than 1 uterine scar, decrease the misoprostol dose to 200mcg with or without lengthening dosing interval, to reduce risk of uterine rupture.

2.9.2 Medical abortion regimens at or above 12 weeks

1) Using a combination of mifepristone and misoprostol

Provide mifepristone 200mg orally, followed 1–2 days later by misoprostol 400mcg buccally, sublingually or vaginally, repeated every three hours until fetal and placental expulsion (see Section 2.8.2 for details on administering the pills). The placenta generally expels shortly (within 1 hour of the fetus); however, sometimes it takes longer. If the woman is stable and willing to wait, allow at least four hours after fetal expulsion for the placenta to be expelled before intervening to remove it. Removal of the placenta may be attempted manually or with forceps if the placenta is visible at the cervix or by using vacuum aspiration, similar to postpartum retained placenta.

The combined regimen is safe and effective, with fetal expulsion rates over 90% at 24 hours, an induction-to-abortion time of 6–10 hours, and major complications rate < 1%.

2) Using misoprostol only

Give misoprostol 400mcg sublingually, buccally or vaginally every three hours until fetal and placental expulsion (see Section 2.8.2 for details on administering the pills). The placenta generally expels shortly (within 1 hour) of the fetus; however, sometimes it takes longer. If the woman is stable and willing to wait, allow at least four hours after fetal expulsion for the placenta to be expelled before intervening to remove it. Removal of the placenta may be attempted manually or with forceps if the placenta is visible at the cervix or by using vacuum aspiration, similar to postpartum retained placenta.

If mifepristone is not available, misoprostol-only medical abortion is also safe and effective, with fetal expulsion rates of 72-91% at 24 hours, average induction-to-abortion time of around 10-15 hours and major complication rates of < 1%.

For post-procedure care and follow-up, follow guidance outlined above in section 2.8.3.

2.10 Medical abortion for treatment of missed abortion or IUFD

2.10.1 Missed abortion

Misoprostol 600mcg sublingually or 800mcg vaginally (if no vaginal bleeding) should be given every 3 hours until expulsion (generally 1-3 doses). If available, give mifepristone 200mg orally 1-2 days before the misoprostol.

2.10.2 IUFD

Medical management is done with mifepristone plus misoprostol (recommended) or misoprostol alone (alternative). The dosing until 28 weeks is mifepristone 200mg orally followed 1-2 days later by 400mcg misoprostol sublingually (preferred) or vaginally, every 4-6 hours until expulsion of fetus and placenta. In the absence of mifepristone, only misoprostol is given in the same dosage and frequency through the same routes.

2.11 Medical abortion product quality

The quality of medicines influences the medical abortion process and its overall success. Substandard mifepristone and/or misoprostol products without the right active ingredients in the right dosages, or without correct manufacture, transport or storage under specified conditions, can affect the outcomes of a medical abortion and lead to unsuccessful treatment of incomplete abortion. Below is a list of recommendations to follow when procuring and storing medical abortion commodities, to ensure you are providing quality abortion pills.

- ▶ Consult the Medical Abortion Commodities Database (www.medab.org) to check availability of quality products in your country.
- ▶ If no quality-assured products are available to procure but you are able to source non-quality assured products, you should check the packaging and storage conditions. Misoprostol is extremely prone to degradation if it is exposed to moisture. Check for the following:
 - ▶ The pills are packaged in a double aluminium blister (the front and back should be aluminium, and not plastic).
 - ▶ The packages and blisters are intact and include product inserts in the box.
 - ▶ Check expiry date and ensure enough shelf life remains for your required stock levels.
 - ▶ If possible, check storage conditions of the supplier to ensure the products have been stored below 30°C.
- ▶ Track medical abortion success rates to check product quality, especially of misoprostol.
- ▶ Talk to other providers to see which local brands are the most effective.
- ▶ If there is decrease in medical abortion success rates compared to rates expected, stop using the current lot and start a new lot. Contact the vendor or manufacturer to see if there were any recalls of the affected lot.
- ▶ Store misoprostol and combipacks in a cool, dry place (up to 25°C and 60% humidity) and reconfirm that the package is not damaged before using.
- ▶ Store mifepristone below 30°C.

2.12 Follow-up care

2.12.1 Routine follow-up care

Routine follow-up after surgical or medical abortion using mifepristone and misoprostol is not necessary unless there are complications (see section 2.12.2 below). However, if the woman specifically desires a follow-up, this should be offered. For women using a misoprostol-only regimen, follow-up is recommended to confirm that the abortion was successful. Follow-up can be provided either remotely through digital channels such as phone or web chat or in-person through a clinic visit or visit to the woman's home and may be scheduled 1-2 weeks after abortion.

During the follow-up appointment:

- ▶ Ask how she is feeling, about the bleeding pattern and if pregnancy symptoms have resolved.
- ▶ If necessary and possible, do a physical examination.
- ▶ If there is any doubt regarding continuing pregnancy based on the client's symptoms or physical examination, perform or refer for an ultrasound.
- ▶ Confirm that earlier problems have resolved and treat/refer for new problems.
- ▶ Review laboratory tests results, if they were requested.
- ▶ Provide a contraceptive method, if desired and not already provided.
- ▶ Refer for other medical, gynaecological, counselling or social support services as indicated.

2.12.2 Managing complications

Women should be advised at the time of their surgical or medical abortion to return to the facility immediately for any of the following:

- ▶ Fever and/or chills
- ▶ Vomiting
- ▶ Fainting and/or dizziness
- ▶ Severe and/or prolonged pain
- ▶ Prolonged (>2 weeks) and/or heavy bleeding (more than normal menstrual bleeding)
- ▶ Foul smelling vaginal discharge
- ▶ Delay in menstrual periods (more than eight weeks)

Women may present with signs of complications following medical or surgical abortions; unsafe abortion; or spontaneous abortion.



Remember that provision of post-abortion care is always legal.

Assessment

- ▶ Do a rapid initial assessment for shock due to haemorrhage or sepsis as this needs immediate stabilization and possibly an urgent uterine evacuation.
- ▶ If she remains unstable or her clinical condition worsens or there is obvious bowel injury, refer her urgently to a higher facility.
- ▶ If she is stable establish her eligibility and preference for a uterine evacuation method, if indicated. If she is in pain or emotional distress, counsel her when she is able to understand enough to give voluntary, informed consent.
- ▶ In a legally restricted environment, women with self-induced clandestine abortions will be fearful of being reported to authorities. Reassure them that their information is confidential and cannot be released without their voluntary authorization, unless legally required.

Incomplete abortion

Incomplete abortion can be a complication following surgical or medical abortion (provided in a facility or self-managed) or following unsafe methods of abortion. Signs of incomplete abortion include heavy vaginal bleeding or haemorrhage, pain, and can include signs of infection such as fever and foul-smelling vaginal discharge.

Surgical and medical treatment depend on uterine size corresponding to weeks of gestation.

- a. MVA is done up to 13 weeks uterine size and D&E after 13 weeks
- b. Provide medical treatment as follows:

☞ *Less than 13 weeks uterine size:*

- i) **Incomplete abortion:** Single dose of misoprostol 600mcg orally or 400mcg sublingually or 400mcg vaginally (if no vaginal bleeding)
- ii) **Missed abortion:** Misoprostol 600mcg sublingually or 800mcg vaginally (if no vaginal bleeding) should be given every 3 hours until expulsion (generally 1–3 doses)
If available, give mifepristone 200mg orally 1–2 days before the misoprostol.

☞ *13 weeks or larger uterine size:*

- i) **Incomplete abortion:** Misoprostol 400mcg buccally, sublingually or vaginally (if no vaginal bleeding) should be given every 3 hours until expulsion.
- c. Some women can be successfully managed without any intervention (e.g. expectant management) if they are clinically stable (no signs or symptoms of haemorrhage or infection) and their pain is well managed. Expectant management allows the abortion process to follow a natural course with close monitoring to confirm that all uterine contents are fully expelled.
 - d. Women with signs of infection need antibiotic treatment in addition to uterine evacuation.

Haemorrhage

Heavy bleeding is due to uterine atony, retained products of conception, cervical or vaginal lacerations, placenta praevia or accreta, uterine injury or coagulopathy.

Management

- ▶ Treat cervical lacerations using direct pressure (gauze on ring forceps), topical clotting agents (silver nitrate or ferric subsulfate solution) or absorbable sutures.
- ▶ Uterine atony requires a rapid, sequential response in the following order: uterine massage – uterotonics – re-aspiration – uterine tamponade – surgical measures. Uterotonics may be repeated if bleeding does not improve after the first dose.

Uterotonics	Dosage
Methylergonovine	0.2mg intramuscularly or intracervically; can be repeated every 2–4 hours. Avoid in hypertension
Misoprostol	800mcg sublingually or rectally
Oxytocin	10–40 units per 500–1000mL fluid IV or 10 units IM
Intrauterine tamponade	Sterile gauze or 30–75mL Foley catheter balloon, condom catheter or obstetric balloon placed in uterus

- ▶ If tamponade (Foley balloon or obstetric balloon, gauze or inflated condom catheter) is used to stop bleeding, leave it in place for a few hours with the patient under observation. Discharge her if she is stable after the balloon or gauze is removed.
- ▶ Haemorrhage which does not respond to treatment for uterine atony in the absence of retained blood or products and no visible injuries, can be due to uterine perforation, coagulopathy or abnormally adherent placenta (accreta). Urgently refer the woman after IV line placement, supplemental oxygen and fluid resuscitation as blood products and surgical measures (such as hysterectomy, uterine compression sutures, uterine artery ligation or embolization) may be needed. Create and use clear protocols for resuscitation and transfer to higher level of care.

Uterine Perforation

Suspect uterine perforation if sudden loss of resistance during cervical dilation or vacuum aspiration, and instrument passes well beyond expected length of the uterus.

Clients with suspected perforation should be monitored, even if asymptomatic.

- ▶ If she is stable, inform her about the complication and educate her about the warning signs for which she should seek emergency care after going home. Make a follow-up appointment before she leaves the clinic.
- ▶ If she is unstable or her clinical status worsens or there is obvious bowel injury, refer to a higher facility immediately.

2.13 Post-abortion contraception

Acceptance of contraception must NEVER be a precondition for providing an abortion.

Women can ovulate within 2 weeks, even as early as 8 days' post-abortion. Therefore, pre- and post-abortion counselling should include a discussion about contraception, with clients supported to choose the method most appropriate for their needs. If the woman's choice is not available, refer her for the preferred method and provide an interim method if she is willing.

- ▶ After **surgical abortion** (MVA or D&E), all methods of hormonal and non-hormonal contraception, including IUD insertion, can be started immediately. IUD insertion or female sterilization may need to be delayed in the setting of abortion complications such as haemorrhage, genital injuries or infection.
- ▶ After **medical abortion**, hormonal contraception (pills, patches, rings, injectables and implants) can be started with the first pill/dose. IUD placement and female sterilization can be provided after confirming that the abortion is complete.

Contraception after treatment of incomplete abortion follows the same protocols.

- ▶ If there are no complications, all methods can be provided as long as the woman understands the methods, is medically eligible and gives an informed consent.
- ▶ If there is infection, all methods of contraception can be offered except the IUD and female sterilization, which should be provided after the infection has resolved.

- ▶ Genital injuries may delay the use of certain contraceptive methods, including female sterilization, IUD, spermicides, and barrier methods except the male condom.
- ▶ Excessive blood loss may delay female sterilization and IUD placement depending on the severity of bleeding, and if lab tests or clinical signs indicate significant anaemia.
- ▶ Emergency contraception pills can be provided as a back-up method to prevent future contraceptive failure leading to unwanted pregnancy.

2.14 Abortion self-care or self-managed abortion

With the increasing access to highly sensitive pregnancy tests and availability of simple, safe, highly effective abortion pills (misoprostol alone or mifepristone and misoprostol combined), more women and girls have the option of safely and effectively ending a pregnancy with or without the involvement of a health provider.

IPPF understands abortion self-care as the right of women and girls to lead, in part or entirely, their abortion process, with or without support from health providers.



Abortion self-care usually includes the self-administration of medical abortion but could also mean being in charge of other aspects of the abortion process, such as the post-abortion care or the decision of engaging (or not) other stakeholders throughout the process (i.e. healthcare providers; peers; pharmacists).

The World Health Organization recommends that individuals in the first trimester (up to 12 weeks gestation) can self-administer mifepristone and misoprostol medication without the direct supervision of a health provider, as well as self-assess the success of the abortion process using low sensitivity pregnancy tests and checklists.³

Evidence indicates that the safest environment for self-managed abortion is one where:

- ▶ Women and girls' health literacy is supported. That is, their capacity to obtain and understand health information, ask critical questions about their choices, and actively participate in their care.
- ▶ Medical care is accessible when chosen and needed, with referral mechanisms in place for women to access in-clinic care, including in case of complications or for complementary services.
- ▶ Women and girls have access to quality medical abortion pills, either misoprostol alone or a combipack of mifepristone and misoprostol.
- ▶ Women and girls have the conditions to implement the abortion with the desired level of privacy.

In legally or socially restrictive settings, for those living in humanitarian settings, or during health epidemics/pandemics when in-person care is limited, abortion self-care may not always be the preferred option, but the only available option. In addition, abortion self-care is often a wanted alternative for women because it is affordable and can be done in the privacy, comfort and convenience of one's own home. Also, it can give women a sense of control and the ability to have earlier intervention in the pregnancy.

³ World Health Organization (WHO) (2019) *WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights*. Geneva: WHO.

2.14.1 Components of support for abortion self-care

Abortion self-care places women and girls firmly at the centre of the abortion process, as the key decision makers in control of their bodies. Medication abortion is a process comprised of several steps or tasks. A woman may choose to self-manage all of these steps, or may prefer or need support to manage some steps in the abortion process. Healthcare workers should recognise self-managed abortion as a valid approach and be ready to play a supportive and enabling role, by acting on three components of support for abortion self-care:

1. **Delivery of accurate and accessible information** on abortion and, particularly, on medical abortion including on what to expect, dosage, side effects, and signs of complications. Information can be provided through various strategies including hotlines, peer provision, websites, or referral to other reliable sources of information and support.
2. **Access to quality medical abortion pills.** Women who choose to self-manage abortion can be supported to access quality medical abortion pills, for example by providing digital prescriptions, partnership with pharmacists, and sending pills by post or dispensed by community health workers.
3. **Providing supportive care during the self-care process.** Healthcare workers should ensure readiness to meet the needs of a woman at any point in her abortion process. This includes, for example, providing on-demand abortion counselling when requested; establishing virtual mechanisms of support which women can use throughout the process, such as use of SMS or hotlines; and setting up referral networks in case of doubts or for treatment of complications, for post-abortion care, or other relevant services, as needed.

Member Associations should review existing programmes and pathways to care and consider how they can be adapted to integrate the above three components of support for abortion self-care. For example, a strong network of community health workers could be leveraged to create an accompaniment network for abortion self-care. An existing hotline model or telemedicine service could be adapted to include information and support for women undertaking abortion self-care.

When implementing support for abortion self-care, assess your legal framework to understand how the regulatory framework supports or restricts abortion self-care initiatives. Any restrictions should be understood in order to create risk mitigation strategies while, at the same time, supporting women and girls in their abortion process.

2.14.2 Harm reduction approach

In highly legally restrictive settings, an effective approach to supporting women in abortion-self care is through the implementation of a harm reduction model. In this approach, providers offer evidence and rights-based information and care before and after an abortion, to the extent allowed by the law, and women and girls self-manage the procedure itself.

The model is split into three stages:

1. Pre-abortion counselling and consultation is provided, including pregnancy options counselling and information on the safest methods of abortion available (i.e. the use of misoprostol).
2. Women self-manage their abortion outside of the clinic setting.
3. Post-abortion care is provided, offered via telephone/remote methods or in-person follow-up consultation.

Studies have shown that services provided under this model contribute to a reduction in maternal mortality, are feasible and acceptable, and provide an opportunity to reduce unsafe abortion.

2.15 Safe abortion care outside clinic settings

As well as the provision of abortion care in clinic settings, quality abortion care can be provided through out-of-clinic care models, including, for example, through digital health interventions, home provision of medical abortion, or supported self-care. In a growing number of countries, guidance no longer restricts the provision of abortion care to registered facilities, enabling health workers, clinics, and organisations to innovate and use new models of care to increase reach and access to a wider number of women, in particular those who may have difficulty accessing in-clinic care due to geographical location or other challenges. Adapting existing service delivery models and introducing new pathways to care allows for a more person-centred approach to abortion care, enabling women to end a pregnancy through a pathway which is most suited to her personal situations and preferences.

Out-of-clinic abortion care may not be possible or appropriate for all services or cases, and in-clinic care for the provision of surgical abortion and treatment of incomplete abortion or complication management should remain an accessible and widely available service. However, in addition to in-clinic abortion care, Member Associations should review existing national guidelines and policies and identify opportunities to expand abortion care through out-of-clinic models, in particular for the provision of information and counselling, and in the provision of medical abortion care. The information provided in this guidance document can be adapted and applied to the design and implementation of out-of-clinic models of care.

2.16 Integrated package of SRH services

IPPF recommends offering a full and integrated package of sexual and reproductive health services that includes the following:

- ▶ Counselling
- ▶ Contraception
- ▶ Safe abortion care
- ▶ Sexually transmitted infections/reproductive tract infections
- ▶ HIV
- ▶ Gynaecology
- ▶ Obstetrics
- ▶ Sexual and gender-based violence

The exact SRH package will be determined and defined by the particular SRH needs of the community, with particular attention to the most vulnerable and marginalized, including young people. Service delivery points must organize service delivery so as to maximize integration of complementary services. Not only does this improve the overall quality of care provided to clients, but it is also more cost-effective than providing the individual services. The combination in the package must be acceptable to the client and feasible for the provider.

- ▶ Service providers should identify opportunities to integrate services, for example screening for gender-based violence during abortion counselling. A checklist should be prepared for providing integrated counselling and services.
- ▶ Integrated services should be offered at one site and preferably during one visit.
- ▶ Different packages can be offered at different levels; depending on treatment or investigations needed, the client can be referred to higher “tier” levels.

2.17 Safeguarding

All MAs are expected to have safeguarding policies in place that reflect standards and commitments set out in *IPPF's Safeguarding (Children & Vulnerable Adults) Policy, Code of Conduct, Respect At Work Policy and Raising A Concern Policy*⁴, as well as the relevant local statutory provisions relating to safeguarding children and vulnerable adults.

All IPPF staff, volunteers, clients and members of the public have access to *IPPF SafeReport*⁵, which is IPPF's confidential incident reporting service. This service is publicly available to report concerns and complaints about all types of exploitation and abuse, bullying and harassment, fraud and malpractice. MAs should display information about SafeReport in their offices and service delivery points.

4 <https://www.ippf.org/resource/policy-handbook>

5 <https://www.ippf.org/ippfsafereport>

3 Infection prevention and control

3.1 Introduction

This chapter includes detailed guidance on the following critical components of infection prevention and control:

- ▶ Hand hygiene
- ▶ Steps of instrument processing
- ▶ Storage of sterilized items
- ▶ Processing and replacement of MVA kits
- ▶ Surface disinfection
- ▶ Handling and disposal of biological waste
- ▶ Equipment maintenance
- ▶ Infection prevention measures specific to epidemics and pandemics, such as Ebola and COVID-19
- ▶ Infection prevention in mobile and community outreach sites
- ▶ Disposal of expired medicines

Importance of infection prevention and control

- ▶ Clinical activities expose healthcare staff and clients to the risk of infection.
- ▶ Some clients and staff, for example those with diabetes, may be more susceptible to infection.
- ▶ Clients, staff and visitors with infection can transmit it to others.
- ▶ The community around a healthcare site is also at risk of infection.

Spread of infection

1. **Contact transmission – direct or indirect – is the most common mode of spread.**

Direct transmission involves spread of microorganisms directly from the infected person to a non-infected person, for example HIV or hepatitis C.

Indirect transmission occurs through a vehicle (an object or person's hand) which transfers the microorganisms from an infected person to a non-infected person, for example Ebola or COVID-19.

2. **Droplet transmission** involves spread of microorganisms through small droplets released when an infected person coughs, sneezes or talks. Close proximity (less than one metre distance between people) increases risk, for example influenza or COVID-19.
3. **Airborne transmission** occurs when microorganisms are carried by air currents over long distances and remain in the air for a long time, for example tuberculosis or COVID-19.
4. **Vector borne transmission** occurs when a vector (an invertebrate animal) carries the microorganism to humans, for example mosquitoes transmitting malaria or yellow fever.

Preventing the spread of infection

Simple and inexpensive practices integrated into routine operations of healthcare sites can prevent the spread of infection. These include:

- ▶ Following standard precautions with every client
- ▶ Following isolation protocols for people with contact, droplet, or airborne infections
- ▶ Vaccinating healthcare workers according to guidelines, for example against hepatitis B

3.2 Standard precautions

These practices, if routinely followed, minimize the risk of infection for both clients and staff, and are explained in more detail in the sections below:

1. Washing hands (hand hygiene)
2. Wearing personal protective equipment (PPE), such as gloves, face shields and gowns
3. Following appropriate respiratory hygiene/cough etiquette
4. Preventing injuries with sharp instruments
5. Correctly processing and maintaining instruments and equipment
6. Maintaining environmental cleanliness
7. Following correct waste-disposal practices

3.2.1 Hand hygiene

Handrub

A 60%–80% alcohol-based handrub is the “gold standard” for hand hygiene in healthcare settings. Alcohol handrub quickly inactivates harmful microorganisms and is preferred over handwashing when hands are not visibly dirty, because it is quicker and simpler. Annex 2 shows how to use alcohol hand rub for hand hygiene.



Alcohol hand rub can be prepared by adding 2 mL of glycerine, propylene glycol, or sorbitol to 100 mL of 60%–80% alcohol.

You should use alcohol hand rub:

- ▶ Immediately after arriving at the clinic and before leaving the clinic
- ▶ Before and after examining each client
- ▶ After touching anything that may be contaminated, such as blood, used swabs and tissue
- ▶ Before putting on gloves for procedures and after removing them
- ▶ Before handling an invasive device such as a laparoscope, or doing an invasive procedure such as tubal ligation

Hand washing

Annex 3 shows how to wash hands correctly for hand hygiene. Hand washing with soap and running water is indicated:

- ▶ when hands are visibly dirty with blood, mucus, etc.
- ▶ after using the toilet or latrine
- ▶ when alcohol hand rub is not available



Some ‘Dos’ of Handwashing:

- ▶ Use running water, not standing water. If running water is not available, use a bucket with tap, or a bucket and mug to pour water on hands.
- ▶ Use small pieces of soap on a rack to allow drainage and avoid wastage.
- ▶ Use a fresh clean towel to dry hands or air-dry hands after washing.

3.2.2 Using Personal Protective Equipment (PPE)

Table 1 lists the use of different types of gloves for healthcare activities.

Table 1: Glove types for healthcare activities

Gloves	Healthcare activity
Sterile gloves	Likely to have contact with tissue or blood under skin; this includes all surgical procedures Must not be reused
Clean gloves	Likely to have contact with body fluids; this includes during vaginal examinations or when handling potentially infectious material such as tissue specimens Must not be reused
Utility gloves	Used during instrument processing, housekeeping activities, and waste disposal Can be reused
No gloves	No likelihood of contact with blood, body fluids or contaminated environment; this includes taking blood pressure, temperature or pulse

Gloves protect both clients and staff by acting as a barrier to infectious microorganisms, but they must be put on and removed correctly to reduce the risk of infection (Annex 4).

The WHO recommends **double gloving** (wearing two pairs of sterile gloves) in countries with high prevalence of hepatitis B, hepatitis C and HIV for 1) surgical procedures expected to last more than 30 minutes and 2) likelihood of contact with large amounts of blood or body fluids (e.g. vaginal deliveries)



3.2.3 Respiratory hygiene/cough etiquette

These are precautions that must be taken by clients, visitors and healthcare staff to prevent the spread of droplet infections, such as influenza or COVID-19.

- ▶ Cover your nose and mouth with a mask.
- ▶ Use a tissue or crook of elbow to cover nose and mouth during coughing or sneezing.
- ▶ Discard used tissues and masks in 'no-touch' bins for non-sharps infectious waste.
- ▶ Clean hands with alcohol hand rub or wash hands with soap and water frequently; and immediately after coming in contact with respiratory secretions (such as after sneezing) or potentially contaminated objects (such as door handles and counter-tops).
- ▶ Give clients with signs and symptoms of a respiratory illness (including cough and sneezing) a surgical mask to wear while they wait in common areas, and take them quickly into the examination room so that they are moved away from other clients.
- ▶ Place cough etiquette posters all around the health facility (Annex 5).
- ▶ Keep plenty of tissues, masks, waste bins and alcohol handrub in waiting and common areas.

3.2.4 Preventing injuries from sharps

Sharps like needles and surgical blades contaminated with blood containing pathogens like hepatitis B, are the leading cause of infection among healthcare staff.

Correct handling and disposal of sharps

- ▶ Always use a **hands-free technique** to pass sharps; for example, the surgeon and assistant do not touch the sharp item at the same time. The assistant keeps sharps in a “safe zone” or designated part of the sterile area, and the provider picks up sharps from the safe zone, uses them and puts them back in the safe zone.
- ▶ Do not remove needles from syringes before disposal.
- ▶ Never recap, bend, cut or break needles.
- ▶ Dispose of sharps in a puncture-resistant container, such as a metal box, thick cardboard box or an empty plastic jug, as shown below.



- ▶ Place sharps containers where sharps are generated/used (such as in injection rooms and procedure rooms), and put the sharps in them immediately after use.
- ▶ Always wear utility gloves when washing reusable sharps such as scissors and trocars and when handling and disposing sharps containers.

3.2.5 Instrument processing

Correct instrument processing reduces the risk of infection during procedures. The three steps of processing instruments are: 1) cleaning; 2) sterilization or high-level disinfection (HLD) as an alternative; and 3) storage or use. For detailed information on instrument processing, refer to the WHO's *Decontamination and Reprocessing of Medical Devices for Health-care Facilities*.⁶ (Note: for specific guidance on the processing, disposal and replacement of MVA kits, please refer to section 3.3 below).

Step 1: Cleaning

Cleaning removes organic material, dirt and foreign matter that can make sterilization or high-level disinfection less effective. Cleaning also reduces the number of microorganisms on instruments.

Cleaning should be carried out as soon as possible after use. Where necessary, instruments and equipment can be placed in a bucket of detergent water until ready for removal to the processing area. Make sure any detergent-based products are mixed to the correct dilution. Keeping the instruments moist will prevent soil from drying on devices and make them easier to clean. However, soaking of instruments for a prolonged period should be avoided.

Make sure all contaminated items are placed in an enclosed, leak-proof, puncture-proof container before moving them to the cleaning area.

Do not use saline as a soaking solution because it will damage some medical devices.



All soiled instruments should be opened and kept moist. You can do this by covering with a moist towel with water until you are ready to clean the instruments. Do not transport in containers with water because this is a splash hazard.

Soaking of instruments in disinfectant prior to cleaning

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 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 workers and result in inappropriate handling and accidental damage
- ▶ May contribute to the development of antimicrobial resistance to disinfectants

Source: WHO (2016) *Decontamination and Reprocessing of Medical Devices for Health-care Facilities*. Available at: <https://apps.who.int/iris/handle/10665/250232>.

Cleaning Tips

- ▶ Always put on utility gloves, a mask and protective eyewear.
- ▶ Disassemble all instruments with multiple parts.
- ▶ A mild alkaline detergent is preferred for manual cleaning. Mild alkaline detergents (pH range, 8.0 – 10.8) are more efficient cleaning agents for surgical instruments than neutral pH

⁶ <https://apps.who.int/iris/handle/10665/250232>

detergents or surfactant-based detergents.

- ▶ Hold items under water while scrubbing to avoid splashing.
- ▶ Remove gross soil using tools, such as brushes and single-use cloths. Use soft (nylon) bristle brushes so that the surface of the instrument is not damaged.
- ▶ Scrub all grooves, teeth, and joints to remove blood, tissue and other foreign matter.
- ▶ Clean devices that have lumens (inner spaces in tubes) with an appropriate brush, then manually or mechanically flush with a detergent solution and rinse with potable water.
- ▶ Rinse under running water to remove all detergent as it interferes with sterilization or high-level disinfection. If there is no running water, clean instruments in a bucket of detergent solution first and then rinse them in another bucket of clean water.
- ▶ Allow cleaned items to air-dry or dry them with a clean towel. Water on instruments dilutes chemicals used for sterilization and high-level disinfection, making these processes ineffective.



Only use appropriate detergents for cleaning instruments cleaning. Detergents used for home cleaning or laundry are not suitable for cleaning medical devices or instruments.

After the items have been cleaned and are dry, inspect them for cleanliness and function:

- ▶ Inspect each set separately
- ▶ Inspect all joints, serrations and crevices for cleanliness
- ▶ Check hinges on devices for ease of movement
- ▶ Assemble multi-part instruments to ensure all parts are complete and working

Any damaged, incomplete or malfunctioning devices should be reported immediately to the clinic manager or supervisor.

Step 2: Sterilization

Sterilization kills all microorganisms including bacterial endospores. It is the method of choice for processing needles and surgical instruments that come in contact with the blood stream and tissues under the skin.

Steam sterilization

The preferred method for sterilization of most medical and surgical devices is steam (or moist) sterilization (Box 1). Most medical and surgical devices are heat- and moisture-resistant and can be sterilized using steam.

Steam sterilization is the preferred method of sterilization for most medical and surgical devices.



To prepare all devices for sterilization, follow these steps:

- ▶ Items should be clean and dry.
- ▶ Jointed instruments should be in the open or unlocked position.
- ▶ Multi-part instruments should be disassembled, unless otherwise instructed by the manufacturer.
- ▶ If an item has a concave surface that might retain water, place it so that water or condensate cannot collect.
- ▶ Arrange heavy items so that they do not damage lighter ones.
- ▶ Sharp items should have their tips protected but without being too tight.

Linens (gowns, surgical drapes) should be sterilized by steam sterilization.

Box 1: Steam sterilization – step by step

Steam sterilization (using moist heat under pressure in an autoclave)



- ▶ Clean and dry all instruments and items to be sterilized.
- ▶ Open jointed items and disassemble those with sliding or multiple parts.
- ▶ Wrap items correctly in two layers of paper, newsprint, muslin or cotton. Wrapped items remain sterile as long as they are intact and dry. Annex 6 demonstrates how to wrap items correctly before heat sterilization.
- ▶ Ensure holes are open and items are not tightly packed inside the instrument's drum.
- ▶ Arrange packs, drums and unwrapped items loosely so that steam can reach all surfaces.
- ▶ Sterilize wrapped items for 30 minutes and unwrapped items for 20 minutes at 121°C (250°F) and 106 kPa (15 lb/in²) pressure.
- ▶ Open lid or door when pressure gauge reads "0" and allow steam to escape.
- ▶ Leave packs and other items in the autoclave until they are completely dry (up to 30 minutes). Damp items draw microorganisms and are considered contaminated.
- ▶ Remove packs, drums and unwrapped items from the autoclave with sterile pickups.
- ▶ Store or use the sterile packs, drums and unwrapped items after they have cooled to room temperature.

Dry-heat sterilization (electric oven)

Dry-heat sterilization is **not recommended** as a best practice for sterilizing medical devices. This method should only be used to sterilize devices that will be damaged by moisture, pressure and/or vacuum.

- ▶ Wrap items in foil or double-layered cotton or muslin (Annex 6). Wrapping items before heat

sterilization reduces the risk of contamination of sterile items.

- ▶ Use an electric oven for dry-heat sterilization. Unlike autoclaving, dry-heat sterilization raises temperature of all parts of the contents of the oven to the desired temperature; so, there is no need to open, unlock or disassemble instruments before putting them in the oven, and items can be placed in the oven in closed containers. Dry heat dulls sharp instruments, so temperature should not be more than 160°C for 2 hours.
- ▶ Remove and store or use the sterile items after they have cooled to room temperature.

Chemical sterilization

Chemical sterilization with glutaraldehyde is **not recommended** for sterilizing medical devices. Its efficacy is uncertain and difficult to control, and re-contamination is likely during rinsing or drying. Wherever possible, disinfection by heat is preferable to chemical methods. However, this method can be used for heat-sensitive items or if there is no access to steam sterilization equipment.

- ▶ Soak cleaned and **thoroughly dried** items in a chemical solution (such as Cidex containing glutaraldehyde) and then rinse with sterile water after a specific period of time.
- ▶ Follow the manufacturer's instructions on preparing the solution, storage temperature, time needed for high-level disinfection, and replacing the solution, but replace the solution if it becomes cloudy.
- ▶ Open hinged items, and disassemble those with sliding or multiple parts.
- ▶ Immerse items and instruments completely so that the solution touches all surfaces.
- ▶ Leave to soak for recommended amount of time; generally, in a glutaraldehyde solution, items should be left to soak for at least 10 hours.
- ▶ Rinse items with **sterile** water before use to remove all traces of the toxic chemical.
- ▶ Never use boiled water for rinsing as it is not sterile and will contaminate the items.
- ▶ Decontaminated items cannot be stored and must be used immediately.



Glutaraldehyde is an irritant. Store the chemical in containers with tight fitting lids and keep in a well-ventilated area. Limit the amount of time staff are exposed to the solution and ensure they wear utility gloves and goggles when using the solution (for example when they rinse instruments soaked in glutaraldehyde).

High-level disinfection

Where sterilization is not available or feasible and instruments do not come in contact with the bloodstream or tissues under the skin, high-level disinfection can be used. Three options for high-level disinfection include:

- ▶ Boil instruments in water for 20 minutes
- ▶ Soak instruments in a 0.5% chlorine solution for 20 minutes
- ▶ Soak instruments in a 2% glutaraldehyde solution (Cidex or equivalent) according to manufacturer recommendations (usually 20-90 minutes)

More information on high-level disinfection is included in Section 3.5.3.

Step 3: Storage and use

- ▶ Keep sterile packs in closed cabinets that are not frequently opened, under conditions of moderate temperature and low humidity. They will remain sterile as long as the packs are intact and dry.
- ▶ Keep unwrapped sterile items in a covered, dry, sterile container and use immediately or within a week.
- ▶ Items decontaminated with glutaraldehyde must be used immediately and cannot be stored.

Step 4: Routine maintenance of equipment

- ▶ Before using the autoclave, always check gaskets, gauges, pressure and safety valves.
- ▶ If steam comes out of the safety valve, inspect and clean the pressure valve.
- ▶ If steam comes out from under the lid (or around the door), clean or replace the gasket.
- ▶ Regularly clean the autoclave chamber and cover according to manufacturer instructions.
- ▶ Keep the electric oven clean and check its temperature gauge every few weeks by putting a thermometer in the oven and comparing the thermometer reading with gauge reading.
- ▶ In addition to the checks carried out after each clean, the clinic supervisor/manager and other clinic staff should check all instruments and equipment every two weeks to ensure quality and performance. Any instrument that does not meet the standards should be replaced immediately. Instruments should be inspected for signs of corrosion and stains especially in the joints. If stains are seen, take immediate action to remove these. If this fails, and in cases of corrosion, immediate replacement is advised. Instruments with joints, such as forceps, should be checked to ensure that they open and close easily and if clasps and locks are fully functional. If in doubt, immediate replacement is advised.

3.2.6 Environmental cleanliness and surface disinfection

It is important to maintain general cleanliness of the entire clinic, with the type of cleaning solution and frequency of disinfection dependant on the area and associated risk of infection. Table 2 gives an example of a cleaning schedule at a healthcare site.

Table 2: Cleaning schedule for client-care areas

At the beginning of each day	<ul style="list-style-type: none"> · Clean all horizontal surfaces – procedure and examination tables, trolley tops, counters, office furniture – with a damp cloth. · Clean floors with a damp mop to remove dust and lint that accumulate overnight.
Between clients	<ul style="list-style-type: none"> · Clean horizontal surfaces – procedure and examination tables, trolley tops, counters and other potentially contaminated surfaces with a cloth dampened with disinfectant cleaning solution. Or, spray the solution on the surfaces with a spray bottle and wipe off with a damp cloth. · Clean spills of blood or body fluids with a 0.5% chlorine solution immediately. · Clean visibly soiled areas with a mop or cloth dampened with a disinfectant cleaning solution. · Put waste in leak-proof container; empty when three-quarters full.
At the end of each clinic session or day	<ul style="list-style-type: none"> · Clean and wipe down all surfaces – procedure and examination tables, trolley tops, counters and other potentially contaminated surfaces – with a cloth dampened with disinfectant cleaning solution. Or, spray the solution on the surfaces with a spray bottle and wipe down with a damp cloth. · Wipe down from top to bottom, paying attention to procedure table sides, base, and legs and cleaning them thoroughly. · Rinse sinks with clean water after cleaning with disinfectant cleaning solution. · Clean floors with a mop soaked in a disinfectant cleaning solution. · Check sharps-disposal containers; remove and replace them if they are three-quarters full. · Remove medical waste and hazardous chemical waste. Burn or bury waste as soon as possible to limit exposure. · Wash waste containers with disinfectant cleaning solution and rinse with water.
Once a week	<ul style="list-style-type: none"> · Clean ceilings with a mop dampened with a disinfectant cleaning solution.

Types of cleaning solutions

1. Plain detergent and water should be used to clean low-risk areas.
 2. Disinfectant (0.5% chlorine solution) should be used to clean blood and body fluid spills.
 3. Disinfectant cleaning solution containing disinfectant, detergent and water should be used to clean contaminated areas (procedure rooms, latrines, processing rooms, etc.)
- Cleaning by scrubbing with a disinfectant cleaning solution is the most efficient and cost-effective way of cleaning potentially contaminated areas in a facility. The solution should be prepared by making a 0.5% chlorine solution, adding detergent to it gradually and mixing it with the chlorine solution until the solution becomes mildly foamy.

Risk classification of healthcare facility areas:

1. **Low-risk areas** (waiting rooms, administrative areas)
Risk of contamination is minimal. Clean them once a week with detergent and water.
2. **Toilets, latrines, and sluice rooms**
These areas are heavily contaminated. Clean daily (more often if client traffic is high) with disinfectant cleaning solution.
3. **Client-care areas** (procedure rooms, labs, instrument processing rooms) are likely to be contaminated. Clean with disinfectant cleaning solution after every procedure.



Remember that cleaning equipment also needs cleaning. Used mops and buckets must be decontaminated with 0.5% chlorine solution, cleaned with detergent water, rinsed in clean water and then dried before they are reused.

Fumigation with formalin does not decrease risk of infection. It must be discouraged because the chemical is toxic and irritating to the eyes and mucous membrane.

3.2.7 Handling and disposal of waste

Four kinds of waste are produced in health facilities:

1. **Sharps waste** – Hypodermic and suture needles, scalpel blades and glass items.
2. **Non-sharps infectious waste** – blood and other body fluids; materials containing fresh/dried blood or body fluids such as sponges and gloves; and human tissue
3. **Non-sharps, non-infectious, non-hazardous waste (general waste)** – paper, food, trash
4. **Hazardous waste** – poisonous materials such as disinfectants and expired drugs

The four steps of good waste management are:

1. **Sorting** – Separating waste by type, where it is generated
2. **Handling** – Collecting and transporting waste within the facility
3. **Interim storage** – Storing waste within the facility until it is disposed of
4. **Final disposal** – Disposing sharps, infectious waste and hazardous waste

Tips for handling and disposal of biological waste

- ▶ Use multi-coloured plastic bins with labels for different types of biological waste.
- ▶ Remove waste before containers are full, and at least once a day.
- ▶ Dispose of sharps containers when they are three-quarters full.
- ▶ Wear protective clothing (surgical mask, utility gloves, rubber/plastic apron, boots).
- ▶ Store waste in the facility in labelled, covered, leak-proof containers in a closed area that is not accessible to clients, visitors, insects, animals or non-housekeeping staff.
- ▶ If possible, final disposal of non-sharps infectious waste should take place immediately.
- ▶ Do not store waste within facility for more than two days (24 hours in summer).

Tips for disposing of liquid medical waste

- ▶ Wear heavy utility gloves and shoes and avoid splashing
- ▶ Liquid biological waste (e.g. tissue from MVA) can be poured into a sink, drain, flushable toilet or buried with solid medical waste. The drain should not empty into open gutters.

Final Disposal

1. Non-sharps non-infectious waste – dispose of at community waste-disposal point
2. Solid non-sharps infectious waste – burn or bury on-site or off-site
 - a. **Burning on site** is the preferred method of disposal of infectious waste as high temperatures destroy microorganisms and reduce volume of waste. An industrial incinerator is recommended.
 - b. **Burying on site** is the next best option, but you need space big enough for all infectious waste (sharps and non-sharps) generated on-site to be disposed of. Annex 7 shows how to build and use a burial pit.
 - c. **Off Site Disposal** is done when neither burning nor on-site burial is possible. The waste must be transported safely to an incinerator or a designated burial site.
3. **Sharps waste** – bury the sharps container in the burial pit for non-sharps infectious waste. Sharps are not destroyed by burning, except in large industrial incinerators.
4. **Hazardous waste** – The best way to dispose of hazardous unused or expired medicines (prescription and over the counter) is to drop them off at a drug take back site. If you cannot go there or none exists, see Annex 8 for further instructions.

3.3 Processing, disposal and replacement of MVA Kits

During manual vacuum aspiration (MVA), the cylinder of the aspirator fills with the client's blood. Therefore, contaminants from one client can potentially infect the next client if the MVA aspirator and cannulas are not processed in between clients.

3.3.1 Processing Ipas MVA Plus® and Ipas Single-Valve Aspirators

Step 1: Point-of-use preparation

After the MVA procedure, do not let the device dry. Pre-soak, rinse or spray the device with water or enzymatic spray. Do not use chlorine or saline.

Step 2: Cleaning

Disassemble the aspirator and adaptor (if used) and clean with warm water and detergent using a soft brush.

Step 3: Sterilization or high-level disinfection (HLD)

All aspirators and adaptors must be sterilized or high-level disinfected after each use (Table 3).

Table 3 lists the options for sterilization or high-level disinfection. These options are presented in decreasing order of effectiveness.

Table 3: Sterilization and high-level disinfection (HLD) options

STERILIZATION OPTIONS
Steam autoclave instruments at 121°C (250°F) with a pressure of 106kPa (15lbs/in ²) for 30 minutes
2% glutaraldehyde (Cidex or equivalent) – soak according to manufacturer recommendations – usually for 10 hours
Sporox II solution – soak for 6 hours
HLD OPTIONS
Boil instruments in water for 20 minutes
0.5% chlorine solution – soak for 20 minutes
2% glutaraldehyde (Cidex or equivalent) – soak according to manufacturer recommendations – usually for 20-90 minutes
Sporox II solution – soak for 30 minutes

- ▶ If chemical agents are used for processing, aspirator parts and adaptors (if used) should be thoroughly rinsed in clean drinking water after sterilization or HLD.
- ▶ The aspirators and adapters should be dried, the O-ring lubricated and the device reassembled and stored in a clean dry place until next use. The aspirator does not need to remain high-level disinfected or sterilized for the next use.
- ▶ Instruments processed by wet methods such as cannulas should be reprocessed daily.
- ▶ Ipas Single Valve Aspirators should not be boiled or autoclaved.
- ▶ Proper instrument processing allows effective reuse of MVA equipment for at least 25 cycles.

A wall chart with step-by-step, easy to use guidance on correct cleaning, sterilization or high-level disinfection of the Ipas MVA Plus Aspirator and the Ipas Easy Grip Cannula can be downloaded from <https://www.ipas.org/resource/processing-the-ipas-mva-plus-aspirator-and-ipas-easygrip-cannulae/>.

3.3.2 Disposal of MVA equipment

- ▶ Contaminated aspirators cannulas should be disposed of as non-sharps infectious waste.

3.3.3 Replacement of MVA equipment

Replace aspirators if:

- ▶ Cylinder cracks or becomes brittle
- ▶ Valve parts become cracked, bent or broken
- ▶ Buttons have broken
- ▶ Plunger arms no longer lock or mineral deposits inhibit plunger movement
- ▶ Aspirator no longer holds a vacuum

Replace cannulas if:

- ▶ They become brittle, cracked, twisted or bent, particularly around the aperture
- ▶ Tissue cannot be removed from the cannula during the cleaning process

3.4 Infection prevention during outbreaks of communicable disease

During outbreaks of respiratory communicable diseases including during epidemics and pandemics, the goal is to maintain essential services by containing and preventing transmission in healthcare facilities and keeping clients and staff healthy and safe.

Priorities

1. Rapid identification of suspected cases of infection
 - a. Screening/triage at initial encounter and rapid source control
 - b. Prohibiting entry of staff, clients and/or visitors with suspected (or confirmed) infection
2. Immediate isolation and referral for testing
 - a. Separating clients with suspected or confirmed infection
 - b. Referring all suspected clients for testing
3. Adherence to infection prevention and control practices at all times
 - a. Following all standard precautions, especially frequent hand hygiene
 - b. Using personal protective equipment (PPE), especially appropriate masking
 - c. Following transmission-based precautions specific to the virus/disease, for example physical distancing of at least one metre

The following measures should be adopted during outbreaks of respiratory communicable diseases. In the case of outbreaks of non-respiratory communicable diseases, follow any WHO or local public health guidelines for healthcare facilities.

- ▶ Post visual alerts in local language at registration and all over the healthcare facility.
- ▶ Instruct client and accompanying persons to inform healthcare staff at registration about any respiratory symptoms they may have.
- ▶ Instruct clients and visitors to practice respiratory hygiene and wear a surgical mask if they have respiratory symptoms.
- ▶ Direct symptomatic clients to a separate waiting area or request them to sit at least one metre away from other people in common waiting areas.
- ▶ Use disposable or dedicated patient care equipment if possible (including stethoscopes, blood pressure cuffs). If, however, equipment needs to be reused by other clients, clean and disinfect it with ethyl alcohol (at least 70%) between uses.
- ▶ Keep rooms well ventilated, and clean and disinfect bathrooms at least twice daily.
- ▶ Restrict the number of accompanying persons coming with clients.
- ▶ Ensure healthcare workers have adequate numbers of appropriate PPE.
- ▶ Train healthcare workers on putting on and removing PPE.
- ▶ Ensure principles of PPE use, such as:
 - ▶ Changing PPE immediately if soiled/contaminated or damaged
 - ▶ Not adjusting or touching PPE during client care
 - ▶ Not touching face while wearing PPE
 - ▶ Removing PPE carefully to avoid self-contamination
- ▶ Ensure all healthcare staff:
 - ▶ wear a medical mask (surgical/medical mask or N-95 respirator)
 - ▶ wear eye protection (goggles) or facial protection (face shield)
 - ▶ wear a clean, non-sterile, long-sleeve gown and gloves

3.5 Infection prevention in mobile or community outreach sites

All standard precautions must be followed. The following challenges may be faced at mobile and outreach community sites while following standard precautions.

3.5.1 Waste disposal

Open burning causes the scattering of waste and pollution and therefore it is not recommended. If there is no other option, burn the waste in a small, designated area and remain there until the waste has completely burnt.

The drum incinerator is an option for small amounts of infectious waste. Select a site that will not let smoke and odours from the burning enter into the clinic. Ensure sufficient air inlets on the side and bottom of the drum for efficient burning. Place the drum on hard earth or a concrete base so that the grass does not catch fire.

If the waste is wet, add some kerosene before starting the fire so that the fire is hot enough to burn all the waste. Dispose of the remaining ash as general waste.

3.5.2 Autoclaving

Autoclaving may pose a challenge if there is no electricity. Pressure cooker types of autoclaves can be used for steam sterilization in the absence of electricity as follows:

- ▶ Put water in the autoclave up to the ridge located on the inner wall.
- ▶ Place items in the autoclave loosely, so that steam can circulate around them.
- ▶ Fasten the cover securely and place the autoclave on high heat.
- ▶ Once steam is released from the pressure valve, begin timing the sterilization cycle. In this type of autoclave, 20 minutes is used for both wrapped and unwrapped items.
- ▶ After 20 minutes, remove the autoclave from the heat source, open pressure valve to release the steam, and allow the autoclave to cool for 15–30 minutes before opening.

3.5.3 Sterilization

High level disinfection (HLD) kills most microorganisms, but it does not kill all bacterial endospores, unlike sterilization, which kills all microorganisms. Where sterilization is not available or feasible and instruments do not come in contact with the bloodstream or tissues under the skin, HLD is an acceptable alternative to sterilization. Thorough cleaning beforehand is needed for HLD to be effective.

There are two methods of HLD – HLD by boiling and chemical HLD.

HLD by boiling

Boiling can be done anywhere with access to clean water and a heat source. The steps are as follows:

Step 1: Open hinged instruments and disassemble those with sliding or multiple parts.

Step 2: Immerse instruments and parts in a pot of water that is heated to boiling.

Step 3: Leave to boil for 20 minutes.

→ Do not add or remove anything once boiling begins.

Step 4: Remove items carefully after 20 minutes. Do not leave items in the water after boiling stops, because they will become contaminated once the water cools down.

Step 5: Use HLD items immediately, or keep them covered in a dry, HLD container and use within a week.

Chemical HLD

HLD using a liquid disinfectant is used for heat-sensitive items or when a heat source is not available. A 2% glutaraldehyde or 0.5% chlorine solution is used for chemical HLD. The steps are as follows:

Step 1: Items must be clean and completely dry.

Step 2: Open all hinges and disassemble items with sliding or multiple parts.

Step 3: Submerge all items in the disinfectant for 20 minutes using a timer.

→ Do not add or remove anything once timing begins.

Step 4: Rinse items thoroughly with boiled water after 20 minutes.

4 Clinic logistics and commodity management

A good logistics system manages the delivery, quality and storage of essential clinic supplies. Without these supplies, no service can be provided.

This chapter is split into two sections:

The first section (4.1) is intended for staff responsible for maintaining the store and supplies within a clinic.

The second section (4.2) is for clinic managers and supervisors who monitor supplies, and request and purchase new stock.

4.1 Responsibility of staff maintaining supplies

4.1.1 Proper storage

All products and supplies must be available and accessible and stored in good condition. Facilities using a small amount of supplies can store them in a cupboard instead of a storeroom, but the same principles will still apply.

- ▶ Store all supplies in a covered, dry, well-lit and well-ventilated area, away from direct sunlight.
- ▶ Cartons and supplies must be at least 4 inches (10 cm) above the floor, 1 foot (30 cm) away from the walls and stacked no more than 8 feet (2.4 m) high.
- ▶ Arrange cartons such that identification labels, expiry dates and manufacturing dates are clearly visible.
- ▶ Store all supplies for first-to-expire or first-in-first-out distribution.
- ▶ Store drugs and contraceptives away from insecticides, chemicals, files, office supplies and other materials.
- ▶ Dispose of damaged or expired supplies and medicines immediately, according to local and donor regulations.
- ▶ Ensure security from theft, damage and fire. Fire safety equipment must be functional and accessible.
- ▶ Clean and disinfect the storage area regularly.

First-to-expire, first-out policy ensures drugs do not expire by using the oldest stock first.



- ▶ When cartons arrive, mark each carton clearly with the expiry date.
- ▶ Stack cartons by date with older supplies on top of or in front of the new supplies so that they can be reached first.
- ▶ Issue the oldest supplies first, making sure that they are not very near or past their expiry date.

4.1.2 Checking new supplies

When the supplies arrive, follow these steps:

Step 1: Look for their expiry date. If the box only has the date of manufacture, calculate expiry date by adding shelf life to the manufacturing date (Table 1, section 4.1.4).

Step 2: Write the expiry date on the box in large letters and numbers.

Step 3: Make sure there is enough time before the expiry date to allow for storage time at the clinic and with the client before they are used. If the expiry date is too close, return the product to the supplier.

Step 4: Check cartons for damage before you open them. If there is any damage, examine the contents carefully. Make a note on the stock card and the requisition and issue voucher that these items arrived damaged.

Step 5: Check some of the contents (drugs, supplies) to confirm they are in good condition (see section below 'Checking for quality').

4.1.3 Checking for quality

Quality should be checked at several points:

- ▶ When supplies arrive, examine both the outer box and the inner boxes for signs of damage.
- ▶ Check supplies before dispensing them. If the supplies arrived in good condition, there is no need to check them if they are dispensed within six months, unless there is an unusual situation, such as floods.
- ▶ If the supplies remain in storage for more than six months or if the storage conditions are not optimal (e.g. high heat or humidity), they should be checked before they are dispensed.

Conduct a thorough quality check using the following steps:

Step 1: When supplies arrive or when conducting a routine inspection, take a random sample (box of supplies) from one or two cartons, and from different parts of the same carton.

Step 2: From each of these boxes, select one or two individual units (such as IUDs or pill packets).

Step 3: Inspect their quality and record the findings.

Step 4: When the inspection is complete, return each individual unit to the box from where it was taken.

Step 5: Return all boxes to the carton.

Step 6: Date and initial the carton with a note that it has been inspected.

Box 1 outlines signs to look out for that indicate the quality may be compromised. If supplies arrive with any damage, do not accept or use them. If signs of damage are identified at any other stage, dispose of the items immediately and do not use them.

Box 1: Warning signs indicating concerns about quality of medicines and supplies**Tablets and capsules (including contraceptives and medical abortion)**

- ▶ The package is broken or puffy (moisture leak).
- ▶ The foil laminate has cracks.
- ▶ Tablets or capsules are missing, discolored, soft, wet, damp or crumble easily.

Packets of surgical gloves, cotton wool and gauze

- ▶ Seal of packet is broken.
- ▶ Packet is open, discoloured, damp, puffy (moisture leak) or stained.
- ▶ Gloves are discoloured, stained or moist after opening.

Equipment

- ▶ Seals are damaged on the packages.
- ▶ Instruments are rusted, discoloured, non-functioning or faulty (e.g. electrical apparatus).

Condoms

- ▶ Packet is brittle, yellowed or otherwise damaged.
- ▶ Seal is broken.

IUDs

- ▶ The sterile packaging is broken or perforated.
- ▶ Contents are missing from the package.

Note: The effectiveness of copper-bearing IUDs is not affected if the copper darkens or tarnishes.

Injectables

- ▶ Solid material remains on the bottom of the vial even after vigorous shaking.
- ▶ Cap is missing.

Implants

- ▶ Sterile packaging is broken.
- ▶ One or more capsules is missing, discolored, broken or bent.

Spermicidal jelly

- ▶ The tube is wrinkled or leaking.
- ▶ Applicator cannot be screwed easily to the top of the tube.

Diaphragms

- ▶ The package seal is damaged.
- ▶ The diaphragm looks dirty or shows holes or cracks when held against light (the service provider needs to check for this).

4.1.4 Shelf-life and storage conditions for contraceptives

Contraceptives remain effective for a number of years if stored under proper conditions, as described in Table 1, unless otherwise directed on product packaging. This is known as their shelf-life.

Table 1: Storage requirements and shelf life of contraceptives

Type of contraceptive	Required storage conditions	Shelf-life
Pills	Store away from direct sunlight in a cool, dry location	5 years
Condoms	Below 40°C – no long exposure to high humidity, direct sunlight or ozone, and do not store near chemicals	3–5 years
IUDs	15–30°C – protect from direct sunlight and excessive moisture	7 years
Injectables	15–30°C – store away from direct sunlight, and store vials upright	4–5 years (4 years for USAID donated, 5 years for others)
Implants	Below 30°C – store in dry location	5 years
Spermicides	15–30°C – no extreme fluctuations in temperature and humidity	3–5 years (5 years for USAID donated)

4.2 Responsibility of supervisors and clinic managers

4.2.1 Monitor supply management

Each clinic should have a minimum of three months' stock on hand at any given time during the year. The supervisor/clinic manager should do the following:

- ▶ monitor the waste disposal system within the clinic, including disposal of medicines and supplies
- ▶ prevent both over-stocking (which leads to wastage) and shortage or stock-out of supplies
- ▶ periodically oversee the tasks carried out by staff member(s) in charge of the store
- ▶ conduct routine checks of supplies and stock
- ▶ ensure adequate stock of essential items by using the following steps:
 - ▶ collecting monthly data on number and type of drugs and contraceptives dispensed to clients
 - ▶ collecting data on the status of stock in hand
 - ▶ using this information to calculate monthly requirement of drugs and supplies; quarterly for contraceptives



Calculating months of supply on hand:

Stock on hand ÷ Average monthly consumption = **Months of supply on hand**

Table 2 shows that pills, condoms, paracetamol tablets and surgical cotton rolls all need to be ordered urgently, as stock levels are below three months of supply (using the above formula).

Table 2: Example supply calculation

Product	Stock in hand	Average monthly	Months of supply consumption
Pills	560 cycles	250	2.2
Condoms	25,000	15,000	1.6
Paracetamol tablets	1,000	450	2.2
Amoxicillin capsules 500mg	4,000	750	5.3
Surgical gloves	200	35	5.7
Surgical cotton rolls	45 rolls	21	2.1

Average monthly consumption is equal to one month's supply. It is usually calculated as the monthly average of the quantity of the product that has been dispensed to users during the past three months. The information on the quantities dispensed is taken from the daily activity register or summary reports of dispensed-to-user data.

Calculating average monthly consumption – three-month average:

Total dispensed three months ago + two months ago + last month ÷ 3 = **Average monthly consumption**



4.2.2 Common logistics problems, probable causes and solutions

Table 3 outlines common problems, causes and solutions related to supply management in clinics.

Table 3: Supply management: common problems, causes and solutions

Problem	Probable causes	Possible solutions
Under-supply	Poor forecasting	Improve data used for forecasting
	Inaccurate or incomplete counts of supplies	Review record-keeping and inventories
	Seasonal increase in product use (drugs and contraceptives)	Adjust order amounts or issues for seasonal variation
Over-supply	Poor forecasting	Improve data used for forecasting
	Inaccurate or incomplete counts of supplies	Review record-keeping and inventories
	Seasonal decline in product use (drugs and contraceptives)	Adjust order amounts or issues for seasonal variation
	Decline in use due to client preference	Train staff to deal with side-effects and rumours
	Same product is available from other sources	Improve coordination with other programmes; investigate why clients use other sources
Damaged stock	Improper handling	Give feedback to storekeeper; increase supervision to improve handling procedures
	Improper storage	Review storage procedure and sites; increase supervision of the store; repair or renovate storage facilities; reduce exposure of supplies to light, water/moisture, chemicals and pests
Expired stock	Over-supply	See possible solutions for over-supply
	Failure to use oldest supplies first	Use first-to-expire, first-out procedures
	Accepting supplies at or near expiry date	Implement a policy ensuring that supplies must have a minimum shelf life remaining when they are received
	Not used because of deterioration of packaging	Improve storage procedures; use damaged items for training; implement policy not to receive damaged supplies
Stock records do not match physical inventory	Incorrectly recorded receipts and issues or incorrect calculations	Pay greater attention when recording entries and calculations; simplify records; conduct refresher training for staff responsible
	Late or delayed entries	Encourage prompt entries and checking of all transactions
	Use of incorrect accounting units	Implement policy that all staff use the same units (cycles of pills, not cartons)
	Failure to conduct physical inventories frequently	Ensure that inventories are conducted regularly
	Same product stored in different locations	Consolidate same products in one location
	Theft, pilferage	Improve security

Adapted from Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (2000) *Pocket Guide to Managing Contraceptive Supplies*.

4.2.3 Supply guidance for medical abortion

The Ipas Medical Abortion Supply Guidance Tool is a simple tool to help quickly and easily calculate a facility's average monthly consumption of misoprostol (and mifepristone, depending on your setting) and recommended minimum and maximum inventory levels. It can be used in clinics that use misoprostol for treatment of incomplete abortion (TIA) as well by clinics where both TIA and induced abortion are available. Please see <https://www.ipas.org/resource/ma-en/>.

For guidance on ensuring supply of medical abortion during events that cause disruption to supply chains, refer to Annex 9. This guidance was developed during the COVID-19 pandemic and can be referred to during any potential disruption.

4.2.4 Quality of misoprostol

As discussed in Chapter 2, misoprostol is extremely vulnerable to degradation if exposed to moisture. Therefore, it is essential to ensure you procure products that have been packaged appropriately and that you store them in suitable conditions (under 25°C and in dry conditions). Refer to the Chapter 2 section titled 'Medical abortion product quality' for more details.

To check whether there are quality medical abortion products in your country, refer to www.MedAb.org.

4.2.5 MVA supply guidance

The Ipas MVA calculator is an easy-to-use online tool for health facility supply managers and distributors who need to calculate the number of manual vacuum aspirators (MVA) to keep in stock in health facilities. It is available at: <https://www.ipas.org/resource/mva-calculator/>.

Procuring MVA kits

1. In 2017, DKT International became the worldwide distributor for Ipas MVA technology. DKT now markets and distributes the Ipas MVA in over 100 countries. You can place an order with DKT WomanCare by sending an inquiry to: orders@dktwomancare.org.
2. You can also find a local distributor of Ipas MVA equipment at: <https://dktwomancare.org/how-to-buy>.
3. In humanitarian settings, Ipas MVA equipment is available in the Inter-Agency RH Kits (Kit 8) through the UNFPA Procurement Services Branch Marmorvej 51 2100 Copenhagen, Denmark. You can write to procurement@unfpa.org and visit the site at www.unfpaprocurement.org/humanitarian-supplies.

Please see <https://www.ipas.org/resource/postcard-creating-a-sustainable-supply-of-manual-vacuum-aspiration-instruments-in-humanitarian-settings/>.

5 Utilizing data for service delivery and programme management

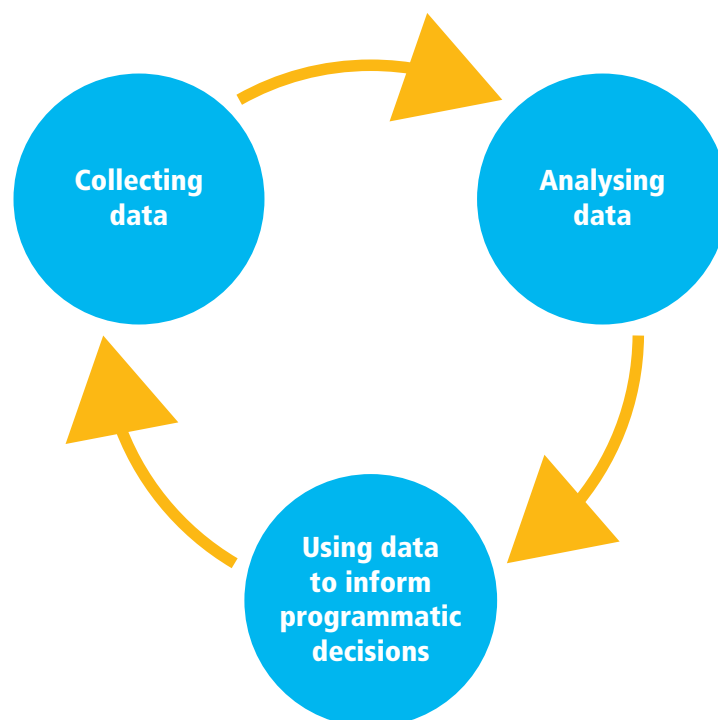
5.1 Introduction

Systematic collection, analysis and utilization of client-based and service data are essential to ensure strong programmes and quality, client-centred care. Strong health systems are central to achieving better health outcomes, and strong information systems are the backbone of effective health systems. Following that principle, since 2007 IPPF has been implementing client-focused clinic management information systems (CMIS) in Member Associations. Many Member Associations' clinics are now using manual or electronic CMIS to effectively capture, manage and utilize clients' demographic and medical data as well as financial and inventory information in clinical settings. In addition, service providing Member Associations report their service data to IPPF annually through DHIS2, and this includes all abortion-related services.⁷

The information collected through CMIS and other clinic data management systems can be utilized to make informed programme decisions and improve service delivery and quality of care, while maintaining clients' privacy and confidentiality. Data should not be collected for reporting purposes only. It should be analysed by service providers and managers to identify and celebrate achievements; find and address gaps; and inform advocacy work and management and planning decisions. Data collection and analysis is vital for assessing quality of care and overall clinic performance.

Data should be reviewed monthly, quarterly and annually by clinic and head office staff. Analysis should be done at the MA level, as well as at the clinic/service delivery point level, with trends over time reviewed and discussed.

Collecting and using data



⁷ Refer to IPPF's Institutional Data Guidelines for more information on the annual service statistics reporting process.

Staff training on how to collect and use data must be a core component of capacity-building activities of all clinics and Member Associations.



5.2 Analysing and using data

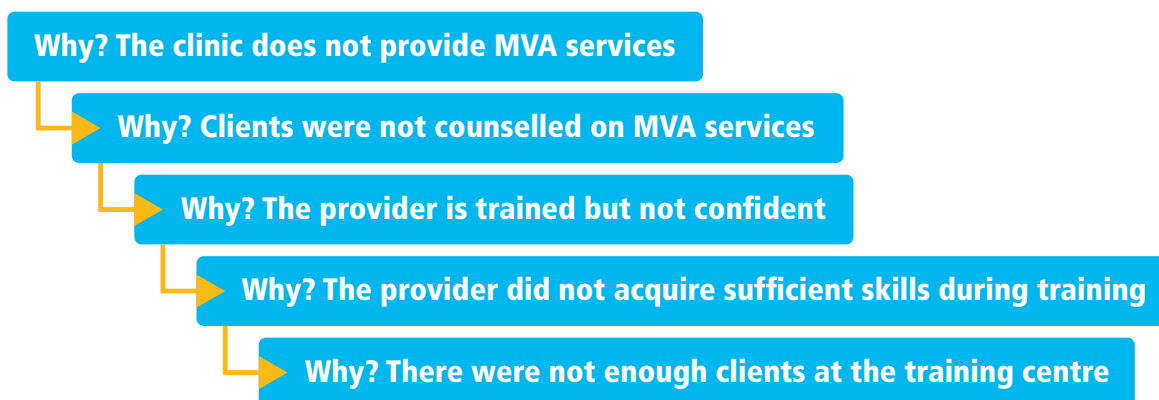
Data should be collected systematically by clinic staff and analysed at least monthly. Findings of the analysis should be discussed with all staff to identify trends and issues, and to understand how performance could be improved.

A common question to ask when reviewing data is:

Why has there been a significant change in the number of clients served/services provided?

To understand the root cause of a significant increase or decrease in number of services, you can use the “5 Whys” technique, and then come up with practical solutions to address the issue. In the first example below, a clinic team investigates a decrease in the number of MVA clients and services, and then develops a simple action to address this issue. In the second example, the head office team investigates an increase in the number of abortion clients and services, arrives at a cause after asking ‘Why’ three times, and makes a plan to improve performance.

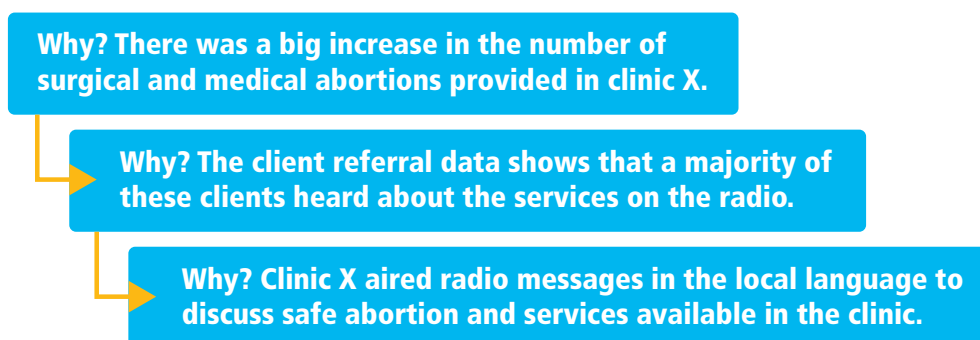
EXAMPLE 1 – Issue: Data shows low numbers of MVA clients and services.



Finding: Using the 5 Whys technique, the team can identify the reason for the low number of MVA clients and services.

Programming decision: Ensure good client load at the training centre to enable sufficient skills building of trainee providers.

EXAMPLE 2 – Issue: MA data shows a significant increase in number of abortion services provided.



Finding: Using an adapted 5 Whys technique, the team finds that the radio messages in the local language were effective in raising awareness about safe abortion services available in the clinic.

Programming decision: The MA team decides to 1) ask the Clinic X team to share its experience with the other clinics, and 2) invest in radio programmes in local language/s in the other clinic sites.

In addition to investigating reasons behind increases or decreases in the number of abortion services, other abortion-related service data can be reviewed and analysed, with subsequent action taken to improve performance. Below are some examples of analyses that can provide insight into abortion service delivery and help teams identify any areas to improve.

- ▶ Total SRH services compared to trend for total abortion-related services; trends over time should also be reviewed
- ▶ Number of clients provided with pre-abortion counselling services compared to number of clients provided with induced abortion services
- ▶ Trends in services related to treatment for incomplete abortion
- ▶ Medical abortion compared to surgical abortion; trends over time should also be reviewed
- ▶ Post-abortion counselling services compared to the number of surgical + medical abortion services
- ▶ Follow-up services compared to the number of surgical + medical abortion services
- ▶ Number of clients provided with post-abortion contraception compared to the number of clients provided with surgical abortion + medical abortion + treatment of incomplete abortion

5.3 Using data to monitor quality of care

Collecting and analysing data is also useful to monitor the quality of care of service delivery. The collection and review of client-based data enables clinic staff to understand the type of services provided and level of care received by each client, to ensure comprehensive, quality care is provided. For example, client data can be reviewed to analyse the proportion of clients provided with post-abortion counselling, to ensure all clients are provided with adequate information and support following their abortion.

The systematic collection and review of data on abortion complications is an essential aspect of clinical governance and is important to understand reasons behind complications, and to make decisions about what changes to make to improve quality of abortion service provision. In addition to using the 5 Whys technique, you can also investigate reasons behind certain trends using a series of questions and going through a process of elimination. In Example 3 below, the MA team reviews complication data, looking at what proportion of all surgical abortions and medical abortions ended in a complication.

In addition, data from client exit interviews and clinic suggestion boxes should be reviewed to understand how clients feel about your services and how you can improve quality of care at your service delivery points.

EXAMPLE 3: MA data shows that Clinic x had a 3% complication rate for medical abortion (6 clients out of a total of 201).

Question 1: What was the complication in each case?

Answer: All six clients had retention of ovular products.

Assumption: There could have been a quality issue with the pills.

Question 2: Were the medical abortion pills from the same batch as the other clinics (which reported no complications)?

Answer: Yes, they were all from the same batch.

Assumption: This is not likely due to a quality issue.

Question 3: Which service provider/s provided the medical abortion?

Answer: Of the clinic's three service providers, all six clients with complications were served by one particular midwife.

Assumption: This midwife may need refresher training.

Next step: The clinic manager spoke to the midwife and learned that she has been telling clients to swallow the misoprostol, rather than take it sublingually or vaginally.

Action: This midwife received refresher training on medical abortion regimen and received supportive supervision.

For more information, please see:

Utilizing Data: A guide to collect, review, analyse, report and use data. Available here: <https://www.ippf.org/resource/utilizing-data-guide-collect-review-analyse-report-and-use-data>

Utilizing CMIS: A guide to install and use clinic management information systems in static clinics. Available: From your IPPF colleagues.

Video: Clinic Management Information Systems. Available at: <https://www.youtube.com/watch?v=ByARJ1CtaiU>



6 Monitoring clinics and quality of care

Ensuring clients' rights and the highest possible standards of care in a sexual and reproductive health clinic requires rigorous and systematic monitoring which can only be achieved successfully if all staff members feel responsibility for it. All assessments should include observations of clinic set-up, infection prevention and control, service delivery and commodities and supplies. This type of detailed monitoring is a valuable way to celebrate achievements and address challenges.

Monitoring is mainly an internal process carried out by those implementing the project, but clinic assessments should ideally involve all stakeholders. Assessments should begin and conclude with joint discussions and agreement between assessors and clinic staff on:

- ▶ the objectives and process
- ▶ the expected output (findings and recommendations)
- ▶ the action plan based on recommendations

6.1 Types of assessment

- ▶ **Initial** – New clinics are assessed initially using agreed quality standards that are reflected in the Comprehensive Clinic Monitoring Checklist (Annex 10). Baseline observations are documented and areas needing improvement are discussed and agreed with staff members, who develop a time-bound action plan based on these recommendations to meet required standards where gaps exist.
- ▶ **Periodic** – Once clinics are set up and functioning, they are assessed regularly (every six to 12 months) using the Periodic Clinic Audit Tool (Annex 11), which is a shorter version of the full monitoring checklist and more suitable for use during periodic assessments, or other similar quality of care assessment tool. An automated clinic audit tool for abortion care is also available on the DHIS2 platform and can be used instead of the excel-based templates to conduct your clinic monitoring and assessments. Please contact your Regional Office for more information. Progress made on the action plan is assessed and further assistance needs (if any) are identified.
- ▶ **Random** – In addition to the mandatory initial assessment and regular quality reviews, technical assistance and monitoring visits using the same checklist/tool as used for periodic assessments can be conducted at any time for quality and performance improvement.

6.2 Preparing for the assessment

The clinic selected should be asked not to make any special arrangements to ensure minimal disruption, and to allow observation of how the clinic functions on a normal day.

6.3 Conducting the assessment

While it is beneficial to have medical personnel assess the quality of clinic services, the minimum quality standards in this manual are designed to be easily monitored by trained non-medical staff. Box 1 gives an example of how an MVA procedure can be assessed by medical or non-medical personnel. The following steps should be followed.

- ▶ Introduce the monitoring checklist and exercise to all clinic staff, explaining that its purpose is to identify their achievements and innovation, while identifying areas that need support.
- ▶ Reassure them that this is a supportive and participatory activity, rather than punitive.

- ▶ Try to observe as many different types of services as possible. Talk to as many staff as possible; be aware that some of them may prefer to talk to you in private.
- ▶ When observing a counselling session, ask permission from the client and sit in a position that does not distract the counsellor (i.e. sit behind, rather than in front).
- ▶ When observing procedures including MVA, ask the client for permission to be present by explaining who you are and why you are there.
- ▶ If possible, talk to clients to find out their opinion of the clinic and what areas they believe need improvement.
- ▶ The assessment is also an opportunity to provide hands-on technical support if you can, especially if there are urgent changes that need to be made (e.g. correct sharps disposal). This should be done during the assessment to prevent further risk or harm, but with minimal disturbance to clients and services.
- ▶ When translations are required, do not disrupt the service by asking the translator to take notes or translate each step; you can ask the translator to provide a summary later. Simply observe the steps in the checklist and body language of both client and provider.
- ▶ Take photographs of good practice and of areas needing improvement. Avoid photographing people, but if this cannot be avoided, make sure to get consent from the client and the provider in the photo.

Box 1: Observation of a manual vacuum aspiration procedure

Manual vacuum aspiration (MVA) is a simple procedure provided by the majority of Member Association clinics. The quality of this service can be assessed by trained staff (medical or non-medical) using a structured checklist. Any omissions and areas of concern should be documented and followed up by an experienced clinician if necessary.



A service provider with 'good' attitudes is easily identified by non-technical persons, and this is as important for a high quality service as good knowledge and skills. It is possible to assess the quality of a service by observing the service provider, who must:

- ▶ be pleasant, reassuring and gentle with the client
- ▶ make the client feel comfortable
- ▶ explain the procedure before starting, including what to expect
- ▶ reassure the client throughout the procedure
- ▶ not rush through the procedure (an MVA normally takes 10–15 minutes)
- ▶ encourage good team dynamics
- ▶ be courteous to both staff and clients

When assessing quality of services at a clinic, ask yourself if you would use the same clinic for yourself, a friend or family member. If your answer is NO, there is something wrong with the quality.



6.4 Concluding the assessment

- ▶ At the end of the assessment, discuss your findings and recommendations with clinic staff and agree on the actions to be taken for improvement, keeping in mind budgetary implications.
- ▶ Keep a copy of the completed checklist at the clinic to help staff develop an action plan based on your findings and to follow up on the observations.
- ▶ A formal report that includes the findings of the monitoring assessment and recommendations from the assessment should be sent to the clinic within two weeks.
- ▶ The report should be followed by a formal action plan from the management detailing steps planned for improvements, which are followed up.

6.5 Clinic monitoring checklist and guidelines

The clinic monitoring checklists (Annexes 10 and 11) have been developed:

- ▶ to support Member Association clinics provide high quality abortion and contraceptive services
- ▶ to measure a clinic's performance in providing comprehensive abortion and contraceptive care
- ▶ for use by clinic managers regularly to assess quality of services in their clinics and make changes
- ▶ for use by clinic and project staff, as well as other stakeholders, as a tool and guidance to assess overall quality of abortion care in a clinic

The checklist helps to evaluate progress and achievement in **four key areas**:

1. quality of care provided by clinic management
2. skills of providers
3. financial management
4. clinic performance in terms of client load

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Chapter 2

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Annexes

Chapter 2: Providing services and support

Annex 1: Surgical abortion using dilation and evacuation (D&E), including IUFD

Pain management

Pain should be managed using a combination of paracervical block, nonsteroidal anti-inflammatory drugs (NSAIDs) and narcotic analgesics, with or without anxiolytics. Intravenous sedation can be offered where available. Helpful non-pharmacological measures include educating the client about what to expect during the procedure; conducting the procedure in a clean and private place with supportive staff; providing verbal support; using a gentle technique; and applying a heating pad or hot water bottle to the lower abdomen in the recovery room.

Preparation

- ▶ Perform standard preparation steps as noted for MVA (see Section 2.6.2).
- ▶ Remove osmotic dilators (if used) digitally or with ring forceps after placement of the speculum, and ensure that they are all accounted for.
- ▶ Administer paracervical block.
- ▶ If additional cervical dilation is required, utilize the same methods for progressive manual dilation as described for MVA. Larger cannulas or tapered dilators may be necessary for adequate dilation for D&E procedures.

Uterine evacuation

- ▶ Perform amniotomy (rupture the membranes) and allow time for the fluid to drain into a suitable container that has been placed specifically to capture fluid, or evacuate with suction aspiration or size 14 mm manual vacuum aspiration (MVA) cannula or 14–16 mm electric vacuum aspiration (EVA) cannula
- ▶ For gestations over 16 weeks, the largest available cannula should be used. Rotate the cannula as for first trimester MVA to aspirate the amniotic fluid
- ▶ When no further fluid can be aspirated, remove the cannula. This process usually takes 1–2 minutes.
- ▶ Pass closed (Sopher or Bierer) ovum forceps through the cervical canal, and open the forceps to grasp conceptus tissue, then rotate 90° and try to pull out.
- ▶ Release the tissue without contaminating the forceps and re-insert the forceps to repeat the previous step until evacuation is complete.
- ▶ Remove the placenta using the same technique.
- ▶ Inspect the extracted tissue progressively as it is removed.

Important notes

- ▶ If strong resistance is felt, release the tissue and repeat the grasp.
- ▶ Always use gentle clinical technique and, where possible, complete evacuation from the lowest section of the uterus by bringing the tissue down from the upper part of the uterus with suction.
- ▶ Avoid probing too deeply in the uterus, especially with the instruments in the horizontal position.
- ▶ Move the forceps in and out in a consistent axis in uterine cavity while evacuating.
- ▶ Remember that the uterus will be becoming progressively smaller as progress is made.
- ▶ Be careful not to cause trauma when removing bony parts.

- ▶ To make sure evacuation is complete, use a number 10 or 12 cannula with MVA syringe and evacuate any remaining tissue with suction aspiration.

Post procedure

- ▶ Check fetal tissue for:
 - ▶ head (calvarium)
 - ▶ two upper limbs
 - ▶ two lower limbs
 - ▶ thorax/spine
 - ▶ placenta
- ▶ Dispose of fetal parts in accordance with the arrangements for the specific centre.
- ▶ If all fetal parts are not accounted for, repeat evacuation and evaluate client for possible retained products of conception.
- ▶ If ultrasonography is available with suitably trained providers, fetal parts can be located if there is doubt whether they have been removed.
- ▶ In a very small number of cases where fetal parts cannot be removed due to fundal location, uterotonics can be given, the client reassessed after 30 minutes - 3 hours, and the uterus re-evacuated:
 - ▶ 400 mcg misoprostol buccally or
 - ▶ high-dose oxytocin (200 units in 500 ml normal saline) or Ringer's lactate solution, at 50 ml/hour (approx. 16 drops/minute)

If there is a suspicion of uterine perforation (if the cannula or forceps advance beyond the expected limits of the uterus based on bimanual examination or ultrasound, or if fat or bowel is removed from the uterus), the procedure should be abandoned and arrangements for further care either onsite or at a suitable referral facility should be arranged immediately (see section 2.12.2).

For additional post-procedure care, follow guidance outlined in sections 2.6.3.

Chapter 3: Infection prevention and control

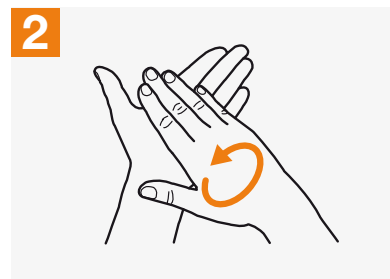
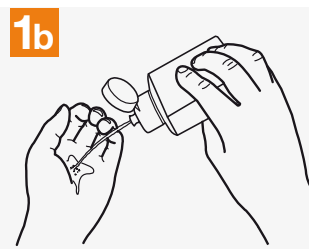
Annex 2 – How to hand rub

Hand Hygiene Technique with Alcohol-Based Formulation

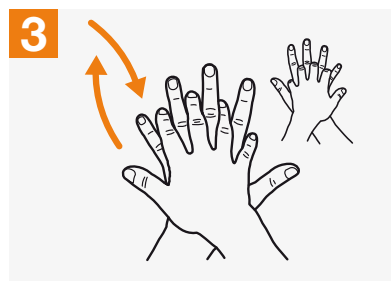
 Duration of the entire procedure: 20-30 seconds



1a Apply a palmful of the product in a cupped hand, covering all surfaces;



2 Rub hands palm to palm;



3 Right palm over left dorsum with interlaced fingers and vice versa;



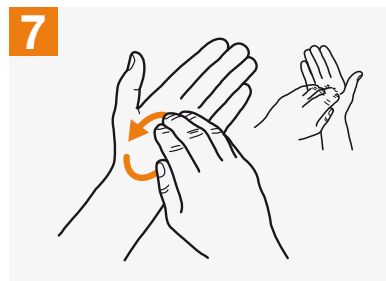
4 Palm to palm with fingers interlaced;



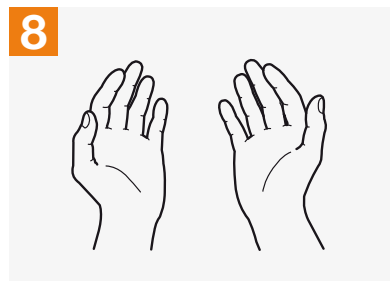
5 Backs of fingers to opposing palms with fingers interlocked;



6 Rotational rubbing of left thumb clasped in right palm and vice versa;



7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



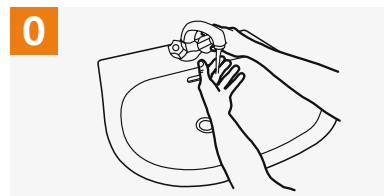
8 Once dry, your hands are safe.

Source: WHO (2009) WHO Guidelines on Hand Hygiene in Health Care, p. 155. Available at: <https://www.who.int/publications/item/9789241597906>.

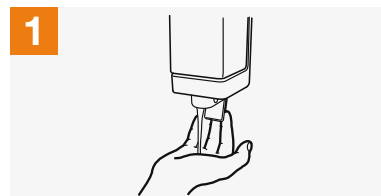
Annex 3: How to handwash

Hand Hygiene Technique with Soap and Water

 Duration of the entire procedure: 40-60 seconds



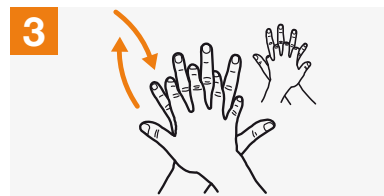
0 Wet hands with water;



1 Apply enough soap to cover all hand surfaces;



2 Rub hands palm to palm;



3 Right palm over left dorsum with interlaced fingers and vice versa;



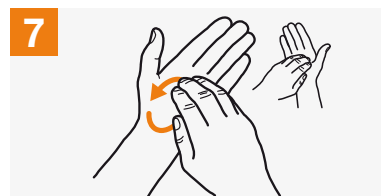
4 Palm to palm with fingers interlaced;



5 Backs of fingers to opposing palms with fingers interlocked;



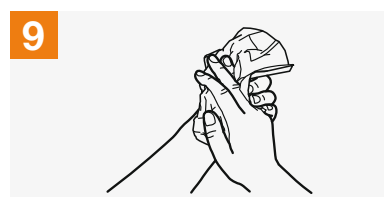
6 Rotational rubbing of left thumb clasped in right palm and vice versa;



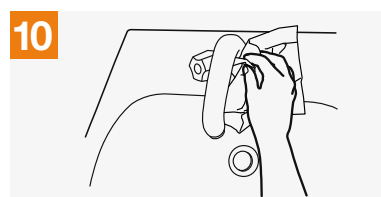
7 Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;



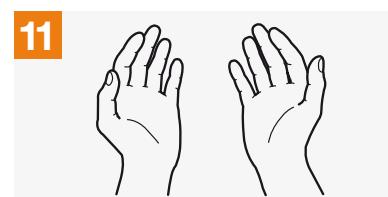
8 Rinse hands with water;



9 Dry hands thoroughly with a single use towel;



10 Use towel to turn off faucet;



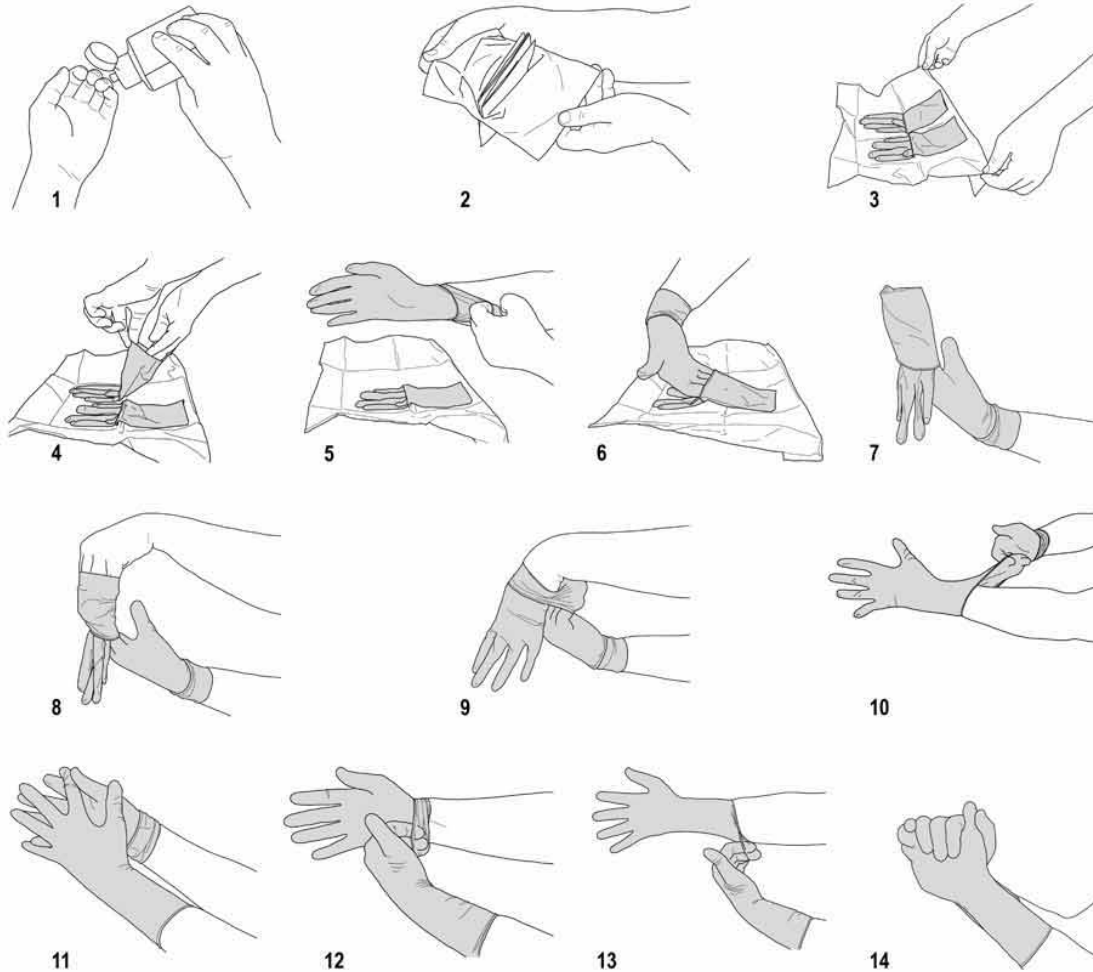
11 Your hands are now safe.

Source: WHO (2009) WHO Guidelines on Hand Hygiene in Health Care, p. 156. Available at: <https://www.who.int/publications/item/9789241597906>.

Annex 4 – Putting on and taking off sterile gloves

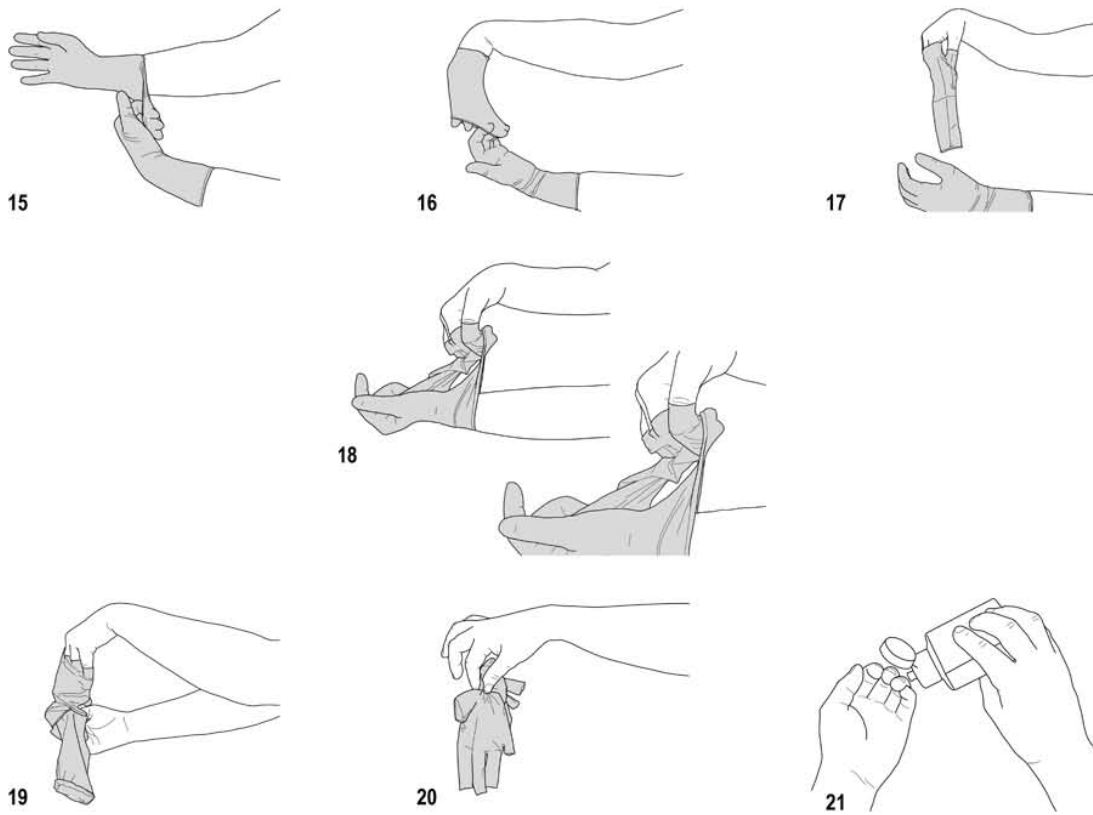
The purpose of this technique is to ensure maximum asepsis for the patient and to protect the health-care worker from the patient's body fluid(s). To achieve this goal, the skin of the health-care worker remains exclusively in contact with the inner surface of the glove and has no contact with the outer surface. Any error in the performance of this technique leads to a lack of asepsis requiring a change of gloves.

I. HOW TO DON STERILE GLOVES



1. Perform hand hygiene before an "aseptic procedure" by handrubbing or hand washing.
2. Check the package for integrity. Open the first non-sterile packaging by peeling it completely off the heat seal to expose the second sterile wrapper, but without touching it.
3. Place the second sterile package on a clean, dry surface without touching the surface. Open the package and fold it towards the bottom so as to unfold the paper and keep it open.
4. Using the thumb and index finger of one hand, carefully grasp the folded cuff edge of the glove.
5. Slip the other hand into the glove in a single movement, keeping the folded cuff at the wrist level.
- 6-7. Pick up the second glove by sliding the fingers of the gloved hand underneath the cuff of the glove.
- 8-10. In a single movement, slip the second glove on to the ungloved hand while avoiding any contact/resting of the gloved hand on surfaces other than the glove to be donned (contact/resting constitutes a lack of asepsis and requires a change of glove).
11. If necessary, after donning both gloves, adjust the fingers and interdigital spaces until the gloves fit comfortably.
- 12-13. Unfold the cuff of the first gloved hand by gently slipping the fingers of the other hand inside the fold, making sure to avoid any contact with a surface other than the outer surface of the glove (lack of asepsis requiring a change of gloves).
14. The hands are gloved and must touch exclusively sterile devices or the previously-disinfected patient's body area.

II. HOW TO REMOVE STERILE GLOVES



- 15-17. Remove the first glove by peeling it back with the fingers of the opposite hand. Remove the glove by rolling it inside out to the second finger joints (do not remove completely).
18. Remove the other glove by turning its outer edge on the fingers of the partially ungloved hand.
19. Remove the glove by turning it inside out entirely to ensure that the skin of the health-care worker is always and exclusively in contact with the inner surface of the glove.
20. Discard gloves.
21. Perform hand hygiene after glove removal according to the recommended indication.

NB: Donning surgical sterile gloves at the time of a surgical intervention follows the same sequences except that:

- it is preceded by a surgical hand preparation;
- donning gloves is performed after putting on the sterile surgical gown;
- the opening of the first packaging (non-sterile) is done by an assistant;
- the second packaging (sterile) is placed on a sterile surface other than that used for the intervention;
- gloves should cover the wrists of the sterile gown.

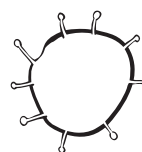
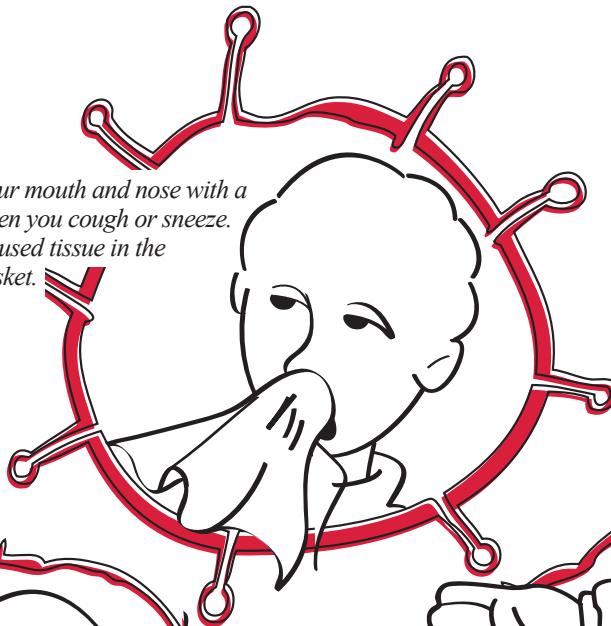
Source: WHO (2009) WHO Guidelines on Hand Hygiene in Health Care, pp. 142-143. Available at: <https://www.who.int/publications/item/9789241597906>.

Annex 5 – Cough etiquette

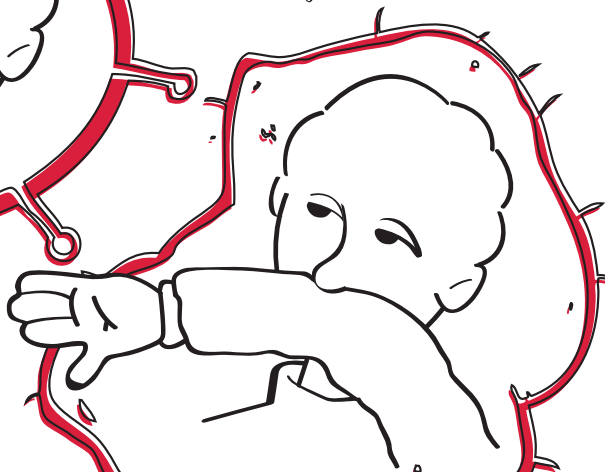
Cover Cough

— Stop the spread of germs that can make you and others sick! —

Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.



If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.



You may be asked to put on a facemask to protect others.



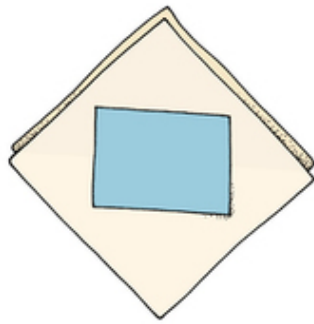
Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.



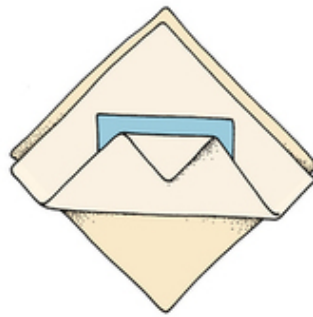
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Downloadable poster available at: https://www.cdc.gov/flu/pdf/protect/cdc_cough.pdf

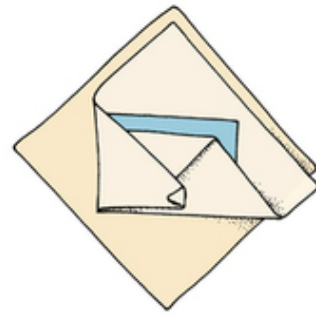
Annex 6 – Wrapping items for sterilization



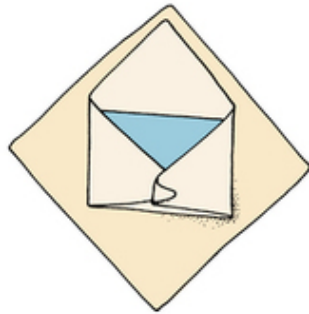
1. Place two wrappers on flat surface with one point toward you. Place item to be wrapped in center of wrapper with its length parallel to you.



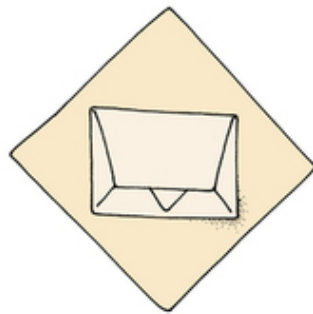
2. Fold corner nearest you over item until it is completely covered. Fold corner back toward you 2 to 3 inches.



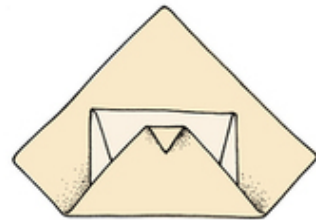
3. Fold left side of wrapper over and parallel to item. Fold end of corner back 2 to 3 inches.



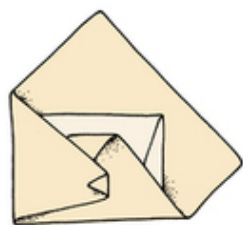
4. Repeat with right side. Lap center folds at least 1/2 inch.



5. Tuck in side edges of remaining corner to eliminate any direct opening to item. Bring top corner down to bottom edges and tuck in, leaving point for opening.



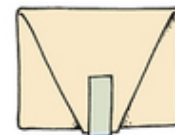
6. Repeat step 2.



7. Repeat step 3.



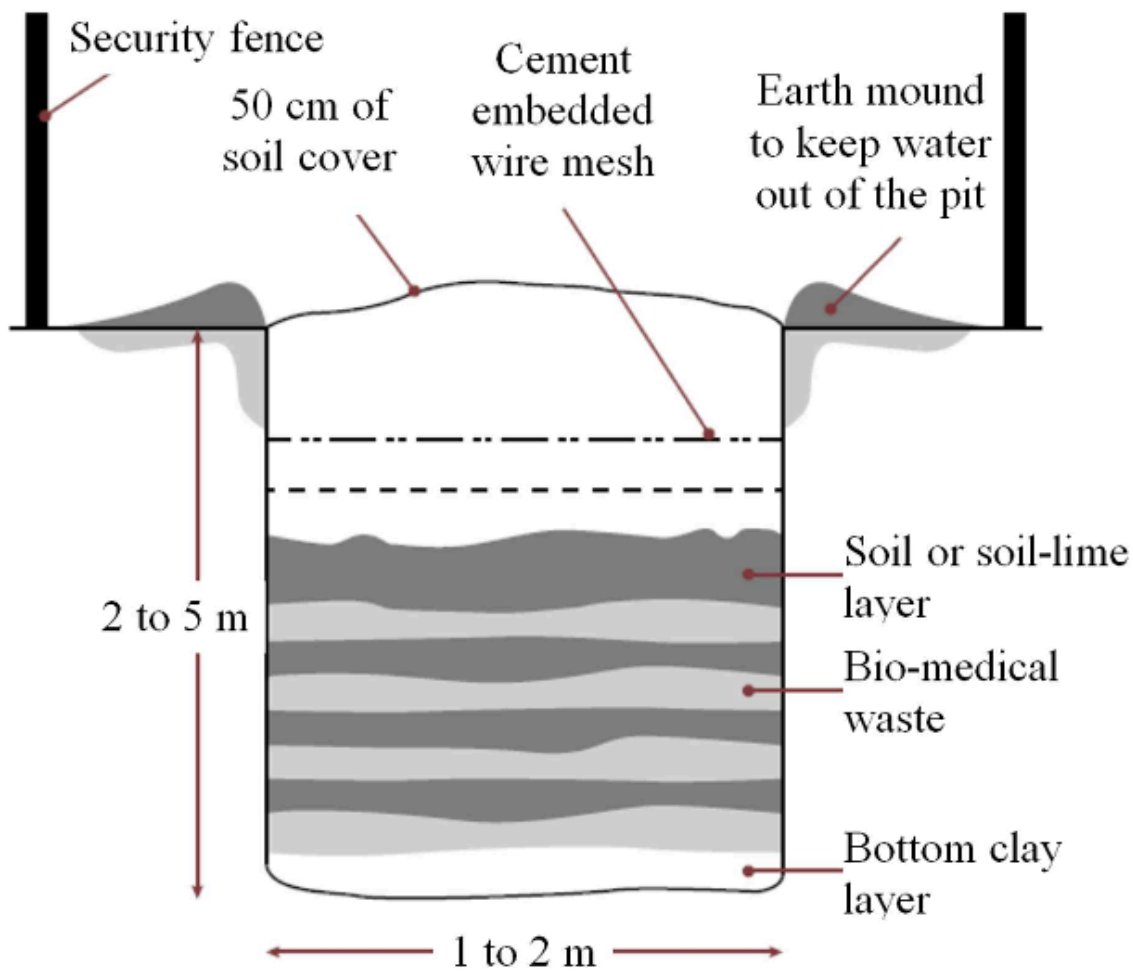
8. Repeat step 4.



9. Bring point of wrapper completely around package and seal with appropriate tape.

Source: <https://basicmedicalkey.com/sterilization/>

Annex 7 – Building and using a waste burial pit



Source: Ali, S and Ahmed, I (2016) *A Study of Hospital Waste Management Practices at Two Tertiary Care Teaching Hospitals : What Are the Alternate Options in Hospitals of Developing Countries.*

1. Choose a site visible from the facility to prevent accidents and scavenging.
2. The site must be at least 50 meters away from the water source, located downhill from wells, be free of standing water and not prone to flooding, to prevent contamination.
3. Dig a pit 1 to 2 meters wide and 2 to 5 meters deep. The bottom of the pit should be at least 2 meters above the water table.
4. Line the pit with plastic, clay, or concrete to prevent seepage.
5. Fence in the area to keep out animals, scavengers, and children.
6. Keep waste covered. Every time waste is added, cover with a 10cm to 30 cm layer of soil.
7. When waste reaches 30cm to 50 cm from the surface, fill pit with dirt and seal with concrete and dig a new pit.
8. If it is not possible to bury all the infectious waste, sharps should be given preference since they pose the biggest risk of injury and infections.

Annex 8 – Disposing of hazardous waste

I need to get rid of this medication.

Drug Disposal Options
Do you have medicine you want to get rid of?

Do you have a drug take-back option readily available?
Check the **DEA website**, as well as your local drugstore and police station for possible options.

NO

YES

Is it on the **FDA flush list**?

NO
Follow the **FDA instructions for disposing of medicine in the household trash.**

YES
Immediately flush your medicine in the toilet.
Scratch out all personal info on the bottle and recycle/throw it away.

Take your medicine to a drug take-back location.
Do this promptly for **FDA flush list** drugs!

www.fda.gov

Source: U.S. Food and Drug Administration, *Disposal of Unused Medicines: What You Should Know*. Available at: <https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know>.

Follow these simple steps to dispose of medicines in the household trash

MIX

Mix medicines (do not crush tablets or capsules) **with an unpalatable substance** such as dirt, cat litter, or used coffee grounds;



PLACE

Place the mixture **in a container** such as a sealed plastic bag;



THROW

Throw the container **in your household trash**;



SCRATCH OUT

Scratch out **all personal information** on the prescription label of your empty pill bottle or empty medicine packaging to make it unreadable, then dispose of the container.



Source: U.S. Food and Drug Administration, *Drug Disposal: Dispose 'Non-Flush' List Medicine in Trash*. Available at: <https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-dispose-non-flush-list-medicine-trash>.

Chapter 4 – Clinic logistics and commodity management

Annex 9 – Procurement of medical abortion commodities during COVID-19: Guidance for IPPF Member Associations

Purpose – This document provides interim guidance to Member Associations on procuring medical abortion commodities during the COVID-19 pandemic.

The COVID-19 pandemic has caused disruption to supply chains of essential commodities, including medical abortion (misoprostol, mifepristone, and combipacks of misoprostol and mifepristone). To avoid a shortage of essential SRH commodities, including medical abortion supplies, Member Associations need to:

- ▶ Increase coordination with in-country stakeholders to monitor national stock levels and to plan and forecast requirements
- ▶ Map the landscape of regional and local distributors, wholesale organisations and manufacturers to limit requirements of lengthy, restricted and expensive international supplies
- ▶ Continuously plan 9–12 months ahead, and escalate any foreseen shortages to IPPF
- ▶ Ensure effective and efficient clinic-level stock management

Member Associations are increasingly needing to procure medical abortion commodities locally, which may mean changing suppliers and/or brands. In order to provide safe and effective medical abortion care, it is essential to ensure quality medical abortion products are procured. The following guidelines should be followed when procuring misoprostol and/or combipacks[1] to ensure quality products are identified.

Check availability and order supplies	Check with usual supplier – Contact your usual supplier of quality assured medical abortion products to enquire about stock availability and place an order to ensure a minimum of a six-month buffer stock.
	Check locally – Contact your local UNFPA office to ask about availability of medical abortion supplies.
	Check locally – Contact the local office of an international social marketing organization, including PSI, Marie Stopes International (MSI) or DKT, to ask about availability of medical abortion supplies.
Ensure quality	Check if the product is listed on www.MedAb.org , which lists misoprostol and combipack products that have been internationally quality assured or independently assessed for evidence of quality.
	Check the list of manufacturers on www.MedAb.org of quality misoprostol and/or combipacks: <ul style="list-style-type: none"> • Manufacturers of quality misoprostol • Manufacturers of quality combipacks
	If no quality-assured products are available to procure but you are able to source non-quality assured products, you should check the packaging and storage conditions, due to increased likelihood of misoprostol degrading when exposed to heat or humidity. Check for the following: <ul style="list-style-type: none"> • The pills are packaged in a double aluminium blister (the front and back should be aluminium, and not plastic). • The packages and blisters are intact, and include product inserts in the box • Check expiry date and ensure enough shelf life remains for your required stock levels. • If possible, check storage conditions of the supplier to ensure the products have been stored below 30 Degrees Celsius.
Adjust service provision	If your Association usually procures combipacks and there are none available, you can procure mifepristone and misoprostol separately if that enables you to access quality pills. For misoprostol, follow the product quality guidelines listed above.
	If mifepristone is not available, you can procure misoprostol and provide quality misoprostol-only medical abortion,[2] ensuring counselling is adequately adjusted.

[1] Due to the potential for misoprostol to degrade if exposed to heat and/or humidity, the focus on quality set out in this document applies to misoprostol and combined packs of misoprostol and mifepristone (combipacks).

[2] Following dosing regimens as outlined by the WHO: <https://www.who.int/reproductivehealth/publications/medical-management-abortion/en/>.

Chapter 6 – Monitoring clinics and quality of care

Annex 10 – Comprehensive clinic monitoring checklist

The clinic monitoring checklist has eight sections:

- A. Organizational set-up
- B. Facilities
- C. Skills, attitude and empathy of service providers
- D. Recording and reporting
- E. Programme management
- F. Financial management
- G. Other activities
- H. Recommendations and action plan

Findings on assessment are documented as follows:

Y-Yes: Meets IPPF standards

N-No: Does not meet IPPF standards. Major changes will be needed in terms of funds, clinic staff time, extensions, building new rooms, etc.

NI-Needs improvement: Needs improvement to meet IPPF standards; No or minimum funds and/or disruption to clinic staff time and services needed, e.g. shifting from one room to another.

Details or comments on any indicator or improvements needed, should be provided in the corresponding comments section.

Name of service delivery point:								
Indicators	Assessment number:			Assessment number:				
	Date:			Date:				
	Name of observer:			Name of observer:				
A ORGANIZATIONAL SET-UP								
Indicators	Y	N	NI	Comments	Y	N	NI	Comments
Do you have a clear organizational policy on increasing access to safe abortion care?								
When recruiting staff, do you ensure they support and are comfortable with IPPF values (abortion, young people, HIV, etc.)?								
Do you have a policy for serving clients who are unable to pay? (Describe in comments)								
Do you have systems to support and protect abortion providers and community workers from opposition groups, local authorities and police?								
1 Administrative requirements								
	Y	N	NI	Comments	Y	N	NI	Comments
Does the clinic have a gestational limit for providing safe abortion services? Is this imposed by law or by the organization?								
Does the clinic have consent requirements? Are these imposed by law or by the organization?								
Are there any other conditions that a client needs to meet before obtaining an abortion? Are these imposed by law or by the organization? (Specify condition/s in comments section)								
2 Available services – Abortion								
	Y	N	NI	Comments	Y	N	NI	Comments
Manual vacuum aspiration								
Electric vacuum aspiration								
Medical abortion – Up to 12 weeks								
Medical abortion – After 12 weeks								
Surgical abortion – After 13 weeks								
Post-abortion contraception (if a method is not available, explain why in comments)								
Condoms								
Pills								
Injectables (indicate if self-injection is practiced or encouraged)								
Emergency contraception								
IUDs (insertion and removal)								
Implants (insertion and removal)								
Tubal ligation								
Vasectomy								
Other (Specify)								

3 Client load									
	Number of clients	Comments	Number of clients	Comments					
What is the average number of clients seen per day/month in the clinic?									
What is the average number of clients who seek abortion-related services per day/month?									
What is the average number of clients undergoing surgical and medical abortion?									
What strategies are used to increase client load and generate demand for services?									
B FACILITIES									
1 Clinic location and accessibility for clients									
	Y	N	NI	Comments	Y	N	NI	Comments	
Accessible by public transport (no more than a 20 minute walk from nearest public transport)									
Area safe for women to travel to on their own									
Well signposted – information on opening times and provided services clearly visible									
Security of clients and staff ensured									
Entrance clean, unobstructed, client friendly									
Good overall maintenance									
Opening times are convenient to clients									
Accessible by people with a disability									
Effective (one-way) client flow mechanism in place (see Chapter 1)									
Fees subsidized and/or free services available and offered									
2 Registration and waiting area									
	Y	N	NI	Comments	Y	N	NI	Comments	
Appointment system is available									
Walk-in services are available									
Clients requiring immediate attention (e.g. with incomplete abortion) are given priority									
Simple and accurate information, education and communication materials are available (leaflets, posters, etc.)									
Service list and fee system are clearly displayed									
Registration is done confidentially or if this is not possible, only basic client information is gathered									
Client records filed alphabetically for easy accessibility									
Client information stored securely									
Referral and follow-up client records filed separately									
Operational clinical management information system									

Waiting area clean and comfortable (adequate ventilation and seating)									
Water and clean toilets accessible									
Suggestion box in place and used									
3 Counselling Area									
	Y	N	NI	Comments	Y	N	NI	Comments	
Client's audio and visual privacy ensured									
Little or no disruption to the counselling session ensured									
Appropriate counselling aids are available									
Room well ventilated, clean and comfortable, enabling clients to relax and speak freely with the counsellor									
4 Consultation room/ physical examination area									
	Y	N	NI	Comments	Y	N	NI	Comments	
Client's audio and visual privacy ensured									
Appropriate equipment present (see Chapter 1)									
Infection prevention protocols followed									
Hand-washing facilities available									
5 Procedure room									
	Y	N	NI	Comments	Y	N	NI	Comments	
Ensures audio and visual privacy									
Restricted access to non-essential staff									
Sufficient space for procedure table, equipment trolley, and easy movement for 2–4 staff									
No clutter; not used as storage space or consultation area									
Well ventilated, well lit and clean									
Adequate water supply									
Emergency protocols and flow charts are available and handy									
Emergency equipment and supplies are available (check using list and note down any gaps)									
Waste disposal systems in place									
Complication management protocols displayed clearly for staff									
6 Recovery room									
	Y	N	NI	Comments	Y	N	NI	Comments	
Easy access from procedure room (same floor and nearby)									
Well ventilated, quiet and comfortable, with drinking water available									
Ensures client's privacy									
Easy access to a clean toilet									

Restricted access to outsiders									
Nurses easily contactable by client									
Changing facilities are available									
7 Instrument processing and storage area									
	Y	N	NI	Comments	Y	N	NI	Comments	
Separate room/area is available for processing instruments									
Area is organized according to guidelines (e.g. one-way flow of instruments)									
Clean water supply is available									
Written and updated infection prevention and control posters and guidelines are clearly displayed in the room									
8 Storage area									
	Y	N	NI	Comments	Y	N	NI	Comments	
Secure and locked room with all materials (no more than a week's supply should be in provider rooms)									
Adequate storage space and shelves									
Properly ventilated and well-lit									
Suitable room temperature ensured									
Supplies stored out of direct sunlight									
No signs of dampness									
Fire extinguisher available and maintained									
Regular cleaning and disinfection carried out									
Supplies clearly labelled									
Supplies arranged in first-to-expire, first-out order									
Stock register maintained and updated									
Three months' buffer stock of essential supplies available									
Effective restocking system in place									
No damaged or expired supplies									
No unused or broken equipment									
Designated person in charge of store upkeep, disbursement and stock control									
Stock control system monitored quarterly by clinic manager									
9 Equipment, drugs and supplies									
	Y	N	NI	Comments	Y	N	NI	Comments	
Equipment and supplies for manual vacuum aspiration (use list in Chapter 1, and record any gaps as comments)									
Equipment and supplies for D&E (use list in chapter 1, and record any gaps as comments)									
Contraceptives – does the clinic have all types of contraceptives that are listed as available services in Section A2?									
Medical abortion pills (mifepristone and/or misoprostol, record any gaps as comments)									

Emergency supplies and equipment (use list in Chapter 1, and record any gaps as comments)									
Equipment and supplies for infection prevention and control (see list of equipment and supplies needed in the instrument processing room in Chapter 1; plus personal protective equipment (PPE), hand gel, gloves, sharps disposal box; record any gaps as comments)									
Other supplies									
Sanitary towels									
Gowns for clients									
Sheets (cloth and plastic)									
Sterile disposable gloves									
Antiseptic solution									
Cotton wool									
Gauze									
C SKILLS, ATTITUDE AND EMPATHY OF SERVICE PROVIDERS									
	Y	N	NI	Comments	Y	N	NI	Comments	
The clinic is fully staffed									
All staff have received on-the-job training (basic and refresher)									
1 Receptionist									
	Y	N	NI	Comments	Y	N	NI	Comments	
Greets the client respectfully									
Locates client file or creates new file									
Registers client request and allocates appointment									
Explains what to expect during the visit									
Files client records according to clinical management information system (CMIS) requirements									
Updates client records									
Manages referral records									
Triages clients needing urgent attention									
Manages follow-up system for referrals									
Manages follow-up for abortion clients (confirms well-being two weeks after abortion procedure)									
Reviews comments from suggestion box ,and/or client satisfaction surveys									
2 Counsellor									
2.1 Pre-abortion counselling									
	Y	N	NI	Comments	Y	N	NI	Comments	
Greets the client respectfully									
Listens patiently to client's needs and concerns									
Uses language the client understands									
Is non-judgemental and supportive									
Assures confidentiality									

Gives client the opportunity to talk alone (without partner or attendant)									
Provides psycho-social support									
Provides pregnancy options counselling and confirms decision about the pregnancy									
Explains consent requirements, if any									
Knows what to do if the client is or appears to be a minor									
Explains the abortion services available (surgical and medical)									
Explains the procedure (pain relief, benefits, side effects, risks, recovery)									
Uses appropriate information, education and communication materials during session (model, charts)									
Allows client to choose the abortion method and pathway to care									
Where relevant, ensures client has a safe means of travelling home									
Offers other sexual and reproductive health services such as testing for sexually transmitted infections and cervical screening									
Is able to provide appropriate support for gender-based violence									
Gives appropriate information on contraception									
Enables client to choose her method of contraception, if wanted									
Encourages client to ask questions									
Answers questions and concerns raised by the client in a supportive and comprehensive manner									
Obtains informed consent from the client									
If relevant, discusses discounted fee system and assures client that she will be cared for regardless of her ability to pay									
If client is being referred, explains reason and the referral process									
Explains the care and support available during and following the abortion, including follow-up care									
Explains where to go after counselling									
Records all information in client's file									
2.2 Post-abortion counselling									
	Y	N	NI	Comments	Y	N	NI	Comments	
Reviews client's symptoms after the procedure (bleeding, cramping, pain)									
Allows client to rest and lets her leave once she feels ready and able to do so (recovery period is at least an hour)									
Provides information on warning signs and symptoms to look out for									

Provides information on how to use any medication, if given							
Provides information on personal care, including resuming sexual activity							
Provides information on post-abortion contraception							
Ensures client gets her choice of contraceptive method, if wanted							
Provides information on what to do in case of emergency or concerns							
Provides client with a follow-up appointment, if wanted							

3 Service provider

3.1 Before the procedure (medical or surgical)

	Y	N	NI	Comments	Y	N	NI	Comments
Greets client and explains procedure								
Conducts a general examination								
Gently undertakes a pelvic examination (speculum, bimanual), for surgical abortion and if necessary								
Determines the gestation of pregnancy								
Notes and manages any signs of violence and/or sexually transmitted infections								
Orders laboratory tests if necessary								
Agrees on a pain management plan with the client								
Explains what to expect next								

3.2 During Surgical procedure (manual vacuum aspiration, D&E)

	Y	N	NI	Comments	Y	N	NI	Comments
Reviews client history before procedure								
Follows infection prevention and personal protection guidelines								
Provides anti-pain medication								
Demonstrates good leadership skills among staff in the room								
Performs procedure gently and accurately								
Completes procedure in 10–15 minutes								
Observes client vital signs throughout procedure								
Examines products of conception at the end of the aspiration procedure (before client is moved to recovery)								
Performs any concurrent procedure requested (IUD insertion, tubal ligation)								
Disposes contaminated instruments in decontamination solution before removing gloves and washing hands								
Provides advice and reassurance to client during and after the procedure								

Ensures client is well before transferring to recovery room									
Completes client records after procedure									
Manages complications competently if they occur (has access to equipment and knows how to use it or make a referral)									
3.3 Medical abortion									
	Y	N	NI	Comments	Y	N	NI	Comments	
Explains medication to be used, and clearly explains mode of administration, dosage and timing									
Explains options for pathways to care if applicable, i.e. medical abortion at home with or without support of a provider, or in-clinic provision									
Explains possible side-effects (bleeding, cramps, nausea, vomiting, headache, dizziness, etc.)									
Listens to the client's needs and concerns									
Supports the client's decision									
Encourages the client to ask questions about the procedure									
Conducts clinical assessment for eligibility									
Ensures client understands signs of complications to look out for									
Provides information on what to do in case of emergency or concerns									
Provides information on support available during and following the abortion									
Provides pain medication									
Provides the abortion medication, and supports the client to take the first dose, if relevant/preferred									
Provides the second dose of medication to be taken at home, along with clear instructions on use, if relevant/preferred									
Provides sanitary towels									
Provides post-abortion contraception (if relevant)									
Gives appointment for second dose of medication or contraception (if relevant)									
Records all information in client's file									

3.4 Treatment of incomplete abortion, other complications and post-abortion follow-up								
	Y	N	NI	Comments	Y	N	NI	Comments
Provides counselling in a supportive and sensitive manner								
Assesses general condition of the client								
Conducts physical examination to rule out continuing pregnancy, infection and retained products of conception								
Provides prompt treatment or referral for complications								
Re-evacuates the uterus if necessary								
Provides antibiotics if necessary								
Follows up on previous tests (cervical cancer screening, sexually transmitted infections, etc.)								
Provides contraception, if requested								
Addresses any other concerns (physical and/or emotional)								
If the client returns for follow-up post-referral, asks her opinion of the referral service for evaluation								
If follow-up is to be provided by an outreach worker, ensures outreach worker has access to necessary information about the client								
4 Healthcare worker assisting								
	Y	N	NI	Comments	Y	N	NI	Comments
Supports and reassures the client								
Provides client with clean and appropriate clothing/ gown for procedure								
Prepares instruments and the room								
Supports the service provider								
Follows infection prevention and personal protection guidelines								

5 Clinic aide/cleaner									
	Y	N	NI	Comments	Y	N	NI	Comments	
A staff member is designated for the task									
Trained on infection prevention and control									
Follows infection prevention and personal protection guidelines									
Prepares chlorine solution daily									
Prepares chlorine solution properly									
Has buckets for chlorine solution									
Follows decontamination guidelines for used instruments									
Follows guidelines for cleaning decontaminated instruments									
Dries cleaned instruments before sterilization									
Stores sterilized instruments and supplies according to guidelines									
Regularly checks instruments for rust, stains (at least every two weeks)									
Replaces instruments not meeting the required standards immediately									
Cleans and disinfects procedure room between procedures									
Checks autoclave before each use									
Disposes of waste regularly and appropriately									
D RECORDING AND REPORTING									
	Y	N	NI	Comments	Y	N	NI	Comments	
Operational clinical management information system									
Staff assigned to CMIS									
Client information recorded and updated daily									
Referrals and follow-up records									
Clinic data compiled as monthly performance reports									
E PROGRAMME MANAGEMENT									
	Y	N	NI	Comments	Y	N	NI	Comments	
All staff adhere to IPPF's mission and core values									
Programme uses service and/or client data for management and decision making. (Give examples of programmatic changes following review of service statistics in the Comments column)									
Clinic service statistics reviewed at least once a month									
All relevant staff are involved in clinic service data review									
Refresher training programmes in place									

F FINANCIAL MANAGEMENT									
1 Accounting records, and receipts and handling cash									
	Y	N	NI	Comments	Y	N	NI	Comments	
Procedures and responsibilities clearly defined (i.e. cashier authorized to receive cash)									
Pre-numbered receipts bearing the name of the organization are issued for all cash receipts									
Unused receipt books are kept in a safe place and proper procedures are in place for issuing them									
All cash received is recorded immediately and banked regularly									
2 Recording payments									
	Y	N	NI	Comments	Y	N	NI	Comments	
All payments are supported by payment vouchers									
Vouchers are supported by adequate documentation and explanations									
Vouchers and supporting documents are correctly filed									
3 Bank accounts									
	Y	N	NI	Comments	Y	N	NI	Comments	
All cheques are jointly signed by two of three designated signatories									
Details of cheque payments are recorded on counterfoil/stub									
Bank reconciliation prepared regularly									
4 Cash books									
	Y	N	NI	Comments	Y	N	NI	Comments	
Cash books kept for all cash and bank transactions									
All entries made in ink									
Corrections, if made, are with ink and clearly visible (white correction fluid is never used)									
Cash book is written and up to date									
5 Petty cash records									
	Y	N	NI	Comments	Y	N	NI	Comments	
Petty cash counts are carried out regularly according to guidelines									
No unauthorized payments entered in the cash book									
Petty cash imprest (float) is established at a reasonable level									
Petty cash expenses are supported by adequate documentation									

G OTHER ACTIVITIES									
	Y	N	NI	Comments	Y	N	NI	Comments	
Non-clinic-based services are provided, e.g. mobile, outreach, home-based, support for self-care and/or digital health services are provided (Include details of services in comments)									
Non-clinic-based services are quality assured using relevant indicators from the monitoring checklist									
Robust referral system is in place (particularly for abortion-related complications)									
Effective reporting and recording systems exist for documenting services provided									
Regular training needs assessment is done									
Training programmes are planned according to need to ensure high quality information and services									
Effective remuneration or incentive schemes are in place									
Partnerships exist with local non-governmental organizations, local government, etc. (Explain value of the partnership/s under comments)									
Activities exist to increase access to safe abortion (such as studies, networks, awareness raising, advocacy, etc.)									

H Recommendations and action plan (including any training requests)			
Assessment number:		Assessment number:	

Scoring the clinic using the monitoring checklist

1. For every Y – Score 3 in corresponding box
 2. For every N – Score 1 in corresponding box
 3. For every NI – Score 2 in corresponding box
- ▶ The total number of indicators x 3 is the maximum possible score.
 - ▶ Divide total score received during the assessment by the maximum possible score to arrive at a percentage score.
 - ▶ A percentage score can also be arrived at for specific sections.
 - ▶ If an indicator is not applicable, explain why it is not so in the comments. Do not score the indicator and deduct 3 for each inapplicable indicator from the maximum possible score.

CASE STUDY: The following is Mr X’s assessment sheet of the storage area

8 Storage Area								
	Y	N	NI	Comments	Y	N	NI	Comments
Secure and locked room with all materials (no more than a week’s supply should be in provider rooms)	3							
Adequate storage space and shelves	3							
Properly ventilated and well-lit	3							
Suitable room temperature ensured			2					
Supplies stored out of direct sunlight		1						
No signs of dampness	3							
Fire extinguisher available and maintained		1						
Regular cleaning and disinfection done	3							
Supplies clearly labelled	3							
Supplies arranged in first-to-expire, first-out order	3							
Stock register maintained and updated	3							
Three months’ buffer stock of essential supplies available	3							
Effective restocking system in place	3							
No damaged or expired supplies		1						
No unused or broken equipment		1						
Designated person in charge of store upkeep, disbursement and stock control	3							
Stock control system monitored quarterly by clinic manager	3							
TOTAL – 17 Indicators	36	4	2	TOTAL SCORE				
(MAXIMUM POSSIBLE SCORE = 17X3 = 51)				36+4+2 = 42				

% Score of storage area = Actual Total Score/Maximum Possible Score = 42/51 = 82%, showing that overall the storage area complies with quality standards. However, there are some areas that need improvement. For example:

- ▶ Sunlight falls directly on the supplies through the windows leading to a high room temperature. Direct sunlight can also damage the supplies. This must be corrected using dark curtains on the windows and a cooling unit (if needed) to keep the supplies at the appropriate temperature.
- ▶ There is no fire extinguisher. This needs to be procured, tested for functionality and

- maintained – all documented in a register at regular intervals.
- ▶ Expired drugs and rusted equipment were stored in one corner of the storage area. These need to be disposed of appropriately as soon as possible (See Chapter 3).

The following format can be used for action planning. An example is shown below. The grey section is from the assessor. The last four columns are to be completed by the clinic manager.

No	Date	Finding	Recommendation	Planned Activity	Resources Needed	Who is Responsible	Timeline
1	12 Dec 2020	Information on all abortion methods available not provided during pre-abortion counselling	Counsellor must inform client about all abortion methods available with their benefits and risks, to help her to make an informed choice	Counsellors to undergo on-site refresher training on abortion related counselling	<ul style="list-style-type: none"> · Updated training materials · Training logistics · Trainers · Funds for training 	Clinic Manager Mr X	To be completed by end of February 2021

Annex 11 – Periodic Clinic Audit Tool

Name of clinic:				
Number of providers in clinic:				
Number of providers providing comprehensive abortion care:				
Date of visit:				
Name of observer:				
SECTION 1 – SERVICE PROVISION				
A. Clinic facilities and set-up				
Suggested things to consider are listed against each indicator in parenthesis () – please refer to the comprehensive monitoring checklist for full details.	Score			Comments
	1	2	3	
Clinic location, visibility and accessibility (accessible by public transport)				
Days open and opening times (convenient to most clients)				
Fees – subsidized/free services (no-refusal policy in place)				
Clinic fully staffed (no vacant positions)				
All staff trained and certified (skills recently refreshed)				
Registration (done confidentially, client-friendly)				
Waiting area (clean, comfortable, suggestion system in place)				
Counselling area (private, comfortable, counselling aids available)				
Consultation room (private, clean, appropriate equipment present)				
Procedure room (refer to guidelines for correct set-up)				
Recovery room (comfortable, private, access to toilets and water)				
Instrument processing area (one-way flow, appropriate equipment)				
Storage area (lockable, temperature controlled, dry, organised)				
Stock management (Stock register maintained, buffer stock in place)				
Availability of supplies (adequate stocks of medical abortion and contraceptives)				
Quality of supplies and equipment (well-maintained, no rust or wear)				
Waste disposal facilities (inline with local authority requirements)				
Overall total (add all scores and enter total in box)				51
B. Service providers				
Individual staff (skills, knowledge and attitude)				
	Score			Comments
	1	2	3	
Receptionist/Registrar(s)				
Counsellor(s)				
Doctor/Paramedic(s)				
Midwife/Midwives				
Nurse(s)				
Support staff/cleaner(s)				
Overall total (add all scores and enter total in box)				18
C. Infection prevention				
	Score			Comments
	1	2	3	
Infection prevention protocols, guidelines and practice				
Decontamination process				
Cleaning of instruments				
Sterilization process				
Storage of sterile instruments				
Disposal of waste products				
Overall total (add all scores and enter total in box)				18
Section 1 – Service provision – GRAND TOTAL (TOTAL SUM OF A + B + C)				87 0 0%

SECTION 2 – PROGRAMME MANAGEMENT SKILLS	Score			Comments	
	1	2	3		
Clear organizational policies in place and followed					
Staff adhere to IPPF mission and core values					
System to support and protect staff from threats and criminalization					
General maintenance					
Maintenance of equipment					
Monitoring supplies					
Staff management and support					
Liaising with local government					
Liaising with other partners					
Liaising with headquarters					
Promoting clinic activities					
Liaising with the community					
Overall total (add all scores and enter total in box)					36
B. Clinic management information system					
	Score			Comments	
	1	2	3		
Unique Identifying Number (ID) for each client with a unique client record					
All client records filed together and archiving done either alphabetically or using the unique IDs (or similar) but not by service					
Client records updated with relevant information after each visit					
Effective follow-up system is present (follow-up and referrals)					
Master register updated and maintained (manual system)					
The clinic is able to generate full reports from an electronic system (eCMIS)					
Data back-up and recovery plan exists (electronic CMIS)					
Inventory stock in the system is up-to-date (electronic CMIS)					
CMIS training plan established and relevant staff trained on the system					
All service providers interact with the system and input information (eCMIS)					
Overall total (add all scores and enter total in box)				30	
C. Performance management					
	Score			Comments	
	1	2	3		
Monthly review of clinic performance					
Performance reports shared among clinic staff					
Appropriate action taken					
Performance reports shared with headquarters					
Use of feedback from headquarters, and IPPF Secretariat					
Overall total (add all scores and enter total in box)				15	
D. Financial management					
	Score			Comments	
	1	2	3		
Accounting records					
Receipts and handling cash					
Recording payments					
Bank accounts					
Cash book(s)					
Overall total (add all scores and enter total in box)				15	
Section 2 – Programme management skills – GRAND TOTAL (total sum of A + B + C + D)				96	0%
Grand total of sections 1 + 2				183	0%

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.



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