SOCIAL MARKETING FOR A BETTER LIFE

MEDICATION ABORTION GUIDE

Rutgers | For sexual and reproductive health and rights

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INTRODUCTION

Medication Abortion (MA) using a combination of Mifepristone and Misoprostol or Misoprostol only is a safe, effective, and acceptable option for terminating early pregnancies (FMOH 2014, WHO 2018). Millions of women throughout the world have chosen MA (also referred to as the abortion pill) and find it to be a highly acceptable option. Many women describe MA as a method that feels more natural. Women who do not have access to safe abortion are too often forced to resort to unskilled providers who work in unhygienic conditions, in many cases causing death and disability.

Article 551 of the Penal Code of the Federal Democratic Republic of Ethiopia (2005) allows termination of pregnancy **in cases of rape, incest or fetal impairment. In addition, a woman can legally terminate a pregnancy if her life or her child's life is in danger, or if continuing the pregnancy or giving birth endangers her life. A woman may also terminate a pregnancy if she is unable to bring up the child, owing to her status as a minor or to a physical or mental infirmity.**

Prior to 2005, the contribution of unsafe abortion to maternal mortality had been 32%. Changing the law to improve access to safe abortion services, introduction of safe and effective methods like MA and extensive training on Comprehensive Abortion Care (CAC) has led to drastic drop in abortion related morbidity and mortality. The contribution of unsafe abortion to maternal mortality has been currently estimated to be 6-9%. Changing the abortion law has also contributed to most first trimester abortion to be carried out in safe condition. There has been also increased uptake of MA over surgical methods. These factors prompted the need to train diverse category of eligible health professionals on MA and safe abortion in general. Therefore, this guide will serve as a quick reference tool for all categories of health professional working on MA.

SAFE ABORTION METHODS

Uterine evacuation may be accomplished by medication, vacuum aspiration or sharp curettage. However, WHO guidelines state sharp curettage, otherwise known as Dilation and Curettage (D&C), should be used only when vacuum aspiration or MA are not available and that all possible efforts have to be made to replace D&C with vacuum aspiration and MA (WHO 2012). Also, a statement by the International Federation of Gynecology and Obstetrics (FIGO) supported the use of vacuum aspiration or medications over D&C for uterine evacuation (FIGO 2011).

With vacuum aspiration, the contents of the uterus are evacuated through a plastic or metal cannula using suction provided by a handheld, portable aspirator (manual vacuum aspiration) or by an electric pump (electric vacuum aspiration). Vacuum aspiration is an important alternative to and occasional back-up for MA.

Medication Abortion (MA), a globally endorsed method, involves the use of a drug or combination of drugs to evacuate the uterus. WHO stated in 2003 and reiterated in 2012 and 2018, that "medical methods of abortion have been proven to be safe and effective". In 2005 WHO added mifepristone with misoprostol and misoprostol only to its Model List of Essential Medicines. Mifepristone with misoprostol was also included in the Interagency List of Essential Medicines for Reproductive Health, compiled by several of the UN agencies and other international NGOs, specifically for medication abortion within 9 weeks gestation (WHO 2006).

Different Features of Safe Abortion Methods for First Trimester

	VACUUM ASPIRATION (VA)	MA – MIFEPRISTONE & MISOPROSTOL
What is it?	A procedure that uses electric or manual suction instruments to evacuate the uterus.	Drugs that are taken to cause the uterus to expel the pregnancy.
How does it work?	The pregnancy is removed from the uterus through a tube inserted into an electric pump or handheld aspirator.	Mifepristone makes the pregnancy detach from the side of the uterus. Misoprostol causes contractions that expel the pregnancy
When can it be used?	Up to 12 completed weeks	Often until 9 weeks of gestational age but can be used in 2nd trimester as well
How effective is it?	97%-99.5%	95%-98%
What are the side effects?	Bleeding, cramping, uterine/cervical injury, infection, acute hematometra	Bleeding (might be longer and excess compared to VA and menstruation), cramping, nausea, vomiting, diarrhea, fever/ chills or dizziness.
What are possible complications?	Rare complications include injury to the uterus or cervix, excessive bleeding, infection and blood collecting in the uterus. Failed manual vacuum aspiration (MVA) occurs in less than 1% of women, especially when performed by a skilled Provider	Rare complications include excessive bleeding and infection. Failed MA occurs in 2-5% of women and ongoing pregnancy occurs in less than 1% of women.
How is it typically used?	The pregnancy is removed with suction through a tube inserted into a handheld aspirator or an electric pump. Procedure time is 2-10 minutes. Completion of the procedure is immediately confirmed, requiring only one facility visit.	Mifepristone is taken orally on day one. 24 – 48 hours later, misoprostol is inserted in the vagina or taken orally, buccally or sublingually. The abortion usually occurs within 4-6 hours but can take up to several days.
What if the abortion fails?	The procedure is repeated.	Use surgical methods to complete the abortion (by the end of two weeks follow up period).

INFORMATION, COUNSELING & INFORMED CONSENT

1. Pregnancy options

Usually, a woman seeking an abortion has carefully considered her options and decision prior to seeking care; therefore, pregnancy options counseling should not be such a concern or serve as a barrier to receiving abortion care. If a woman has questions about her pregnancy options, providers can discuss them with her.

Pregnancy options include:

- Continue the pregnancy to term and raise or give the child for adoption, or
- Terminate the pregnancy

By providing any information needed and supporting a woman's decision, providers can help women feel confident and comfortable that they are making the decision about their pregnancy that is best for themselves as well as other important people in their lives.

2. Informed consent

Informed consent is a process in which a woman gathers the information she needs to make a voluntary choice to undergo an abortion procedure. To ensure that women are giving informed consent for the abortion, providers should discuss and confirm that women have understood:

- The benefits and risks of and alternatives to abortion,
- Consequences of not receiving abortion care once the chosen method started,
- Details of the planned procedure, once the method has been determined,
- Expected symptoms,
- The side effects of the drugs – nausea, vomiting, diarrhea, fever, headache, dizziness and/or chills,
- Potential harmful effect on the fetus, if pregnancy continues once after administration of the mifepristone pill. Mifepristone is teratogenic if pregnancy continues after use,
- Readiness for vacuum aspiration (VA) in case of MA failure or excessive bleeding

Providers need to explain this information in simple language and ensure that women have understood it. Privacy and confidentiality (ethical obligation not to disclose

information) are critical to the informed consent. Also, providers should ensure that women have given consent voluntarily and are not being pressured or coerced by anyone else to consent to the abortion.

3. Procedure options
Once a woman has clearly made a decision to terminate her pregnancy, providers should discuss the abortion procedure options, both MA and VA, and appropriate for that woman's clinical condition. They should discuss the possible benefits, risks and what to expect with each procedure.

The provider can help the woman explore her options and choose which procedure is best for her by reviewing the necessary information. As long as the different methods are clinically appropriate, providers should refrain from inserting their own method preferences into the discussion and support a woman's decision.

CLINICAL ASSESSMENT

Clinical assessment prior to medication abortion (MA) includes gestational dating and assessment of the woman's general health and any contraindications or precautions to the abortion method chosen. As with any procedure, the woman needs to know what to expect; this is especially true with MA because in many cases, the abortion may take place outside the clinic once after the woman takes the misoprostol pills.

Gestational dating
Determining the gestational age is a critical factor in selecting the most appropriate abortion method. Bimanual pelvic examination, abdominal examination and recognition of symptoms of pregnancy are usually adequate. Laboratory or ultrasound testing may also be used, if needed.

Clinicians who prescribe medications for MA should have strong skills in pelvic examination and be competent in diagnosing and dating early pregnancy. Three commonly used approaches to pregnancy dating are:

- Determining the date of the last menstrual period (LMP) as well as about her menstrual history, including the regularity of her cycles;
- Performing a pelvic exam to assess uterine size (softening of the cervical isthmus and softening and enlargement of the uterus);

- Using ultrasound can help to exclude an ectopic pregnancy from 6 weeks of gestation.

Underestimating gestational age is not likely to be clinically important, because several studies suggest that MA efficacy and safety decrease only gradually as gestational age increases (WHO 2012).

1. Last menstrual period

The LMP refers to the first day of a woman's last menstrual period. A woman may have a difficult time remembering this date. LMP estimations may be difficult for other reasons, including:

- Some women experience bleeding during early pregnancy which they can mistake for a menstrual period.
- A young woman may experience irregular menstrual cycles or may never have experienced a menstrual period before she becomes pregnant.
- Breastfeeding women may become pregnant without having regular menstrual periods (without noticing they are pregnant).

Use of LMP to estimate gestational age may be more accurate for women who rely heavily on fertility awareness methods. However, a woman's LMP should not be the only factor in determining the length of a pregnancy.

2. Pelvic examination

Prior to performing a pelvic exam, the clinician should ask the woman to empty her bladder and let her know what to expect. This is especially important if this is the woman's first pelvic exam.

To assess the uterus and adnexa, the clinician places two fingers into the vagina and then palpates the abdomen with the other hand. The size of the uterus is then compared with the history of amenorrhea.

After 6 weeks gestation, the uterus increases in size by approximately 1 centimeter per week and takes on a roundish shape. Signs of pregnancy which are detectable during a bimanual pelvic examination as early as 6–8 weeks of gestation include softening of the cervical isthmus and softening and enlargement of the uterus.

Situations that make it difficult to accurately assess uterine size include fibroids, retroverted position of the uterus, obesity, full bladder or the woman contracting (not relaxing) her abdominal muscles. If there is uncertainty about the gestational age, or if there is a discrepancy between uterine size and gestational age as determined by LMP, it may be helpful to use an ultrasound, if available, or to ask another clinician to check the uterine size by bimanual exam.

3. Ultrasound

Ultrasound is not required for early abortion provision. Ultrasound can be used when there is difficulty assessing gestational age based on history and exam (WHO 2012), to assess abortion completion and to diagnose other conditions requiring treatment, such as ectopic pregnancy. Routine ultrasound may increase the cost of the procedure and the likelihood of unnecessary intervention; it may also prevent some providers from offering MA due to a lack of equipment (Gynuity 2007). MA can be offered even if ultrasound services are not available.

MA WITH MIFEPRISTONE & MISOPROSTOL

A. THE DRUGS

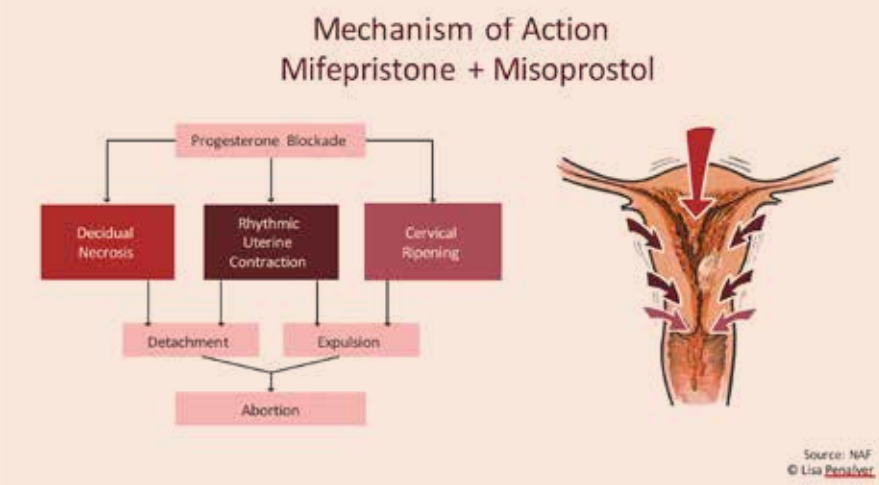
The combination of Mifepristone plus Misoprostol is more effective (95-98%) in achieving complete abortion than Misoprostol used alone (83-87%). In the first trimester, the combination of Mifepristone and Misoprostol results in successful abortion with no need for aspiration evacuation in over 95% of cases.

- Mifepristone, a synthetic steroid anti-progestin, blocks progesterone activity in the uterus, alters the uterine lining and causes it to shed leading to detachment of the pregnancy from the uterine wall. Mifepristone increases uterine sensitivity to prostaglandins (like misoprostol) and softens the cervix.
- Misoprostol, a synthetic prostaglandin E1 analogue, stimulates cervical ripening (softening) and uterine contractions, causing uterine evacuation.

Misoprostol can also be used for cervical preparation before vacuum aspiration and other intrauterine procedures, labor induction and treatment of postpartum hemorrhage. Although it is stable at room temperature, the potency of misoprostol can degrade over time depending on its packaging or if it is exposed to high heat or humidity (Hall 2011). In 2009, misoprostol was added to the WHO list of essential medications for treatment of incomplete abortion and miscarriage and in 2011 for prevention of postpartum hemorrhage.

DKT-Ethiopia has obtained EFDA's license for importing and distributing Safe-T Kit: mifepristone-misoprostol combination pack (combi-pack) for medication abortion in its Social Marketing program in Ethiopia.

Mifepristone is an anti-progestogen. It works by blocking the effects of progesterone. Mifepristone alters the uterine lining and causes it to shed leading to detachment of the



pregnancy from the uterine wall. Mifepristone also causes softening and dilatation of the cervix making it easier to open, and an increase in the sensitivity of the myometrium to the contractile effects of prostaglandins promoting contraction of the uterus when exposed to Misoprostol.

Misoprostol is a prostaglandin analogue. It causes strong myometrial contractions leading to expulsion of tissue. It also causes cervical ripening with softening and dilation of the cervix to allow the uterine contents to pass.

B. ELIGIBILITY & ADMINSTRATION OF MA

Indication:

- Termination of first-trimester intrauterine pregnancy in most clinical facilities (up to 9wks of GA)
- Termination of second trimester pregnancy in Hospital settings

Contraindications for MA:

- Confirmed or suspected Ectopic Pregnancy (pregnancy outside the uterus) or undiagnosed adnexal mass. MA, if used unknowingly since ectopic pregnancy is difficult to detect at early gestation, will not harm the woman but it will also not terminate the pregnancy. A woman with an ectopic pregnancy needs medical care to safely induce an abortion with other method but not MA.
    - Index of Suspicion for Ectopic Pregnancy are:
        - History (amenorrhea or missed period, lower abdominal pain, vaginal bleeding or spotting)
        - Physical examination (abdominal/adnexal mass or tenderness of lower abdominal/adnexal)
    - Undiagnosed ectopic pregnancy can lead to maternal death. Always refer suspected ectopic pregnancies to a hospital with a surgical operative facility with emergency back-ups
- Presence of an IUD. If the woman has an IUD (intrauterine contraceptive device), it is advisable to first evaluate for potential presence of an ectopic pregnancy; if none, then remove the IUD before administering MA.
- Allergy/hypersensitivity to mifepristone, misoprostol or prostaglandins. The only way to know if a woman is allergic to the drug(s) is if she has used these before and had an allergic reaction. It is impossible to know before using the pills if she will be allergic or not.
- Coagulopathy or concurrent therapy with anticoagulants such as Heparin and Warfarin.

- Chronic systemic use of corticosteroids. If the woman has been using long term steroids such as Prednisone or Dexamethasone it is not recommended to use Mifepristone. However, she can have an abortion with Misoprostol only.

If a woman has one or more of these specific conditions, under no circumstance should she be offered MA. Consequently, MVA should be considered or she should be referred for alternative care.

Precautions for MA

- Severe uncontrolled Asthma.
- Severe/unstable health problems including but not limited to hemorrhagic disorders, heart disease and severe anemia.

If a woman has these specific conditions, MA has higher risks than normal. Thus, referral to a higher-level facility is advisable.

- If the woman is breast feeding, there is no enough evidence-based data on effects of the MA drugs on infants. However, it is recommended to discard breast milk for a few days after misoprostol has been administered to a breast-feeding woman.

Eligibility for use of MA

- Non-ectopic pregnancy
- Absence of contraindications
- Willingness to undergo vacuum aspiration in case of MA failure
- Free of psycho-social factors:
    - o able to clearly understand the basic information provided
    - o able to make a self-assured and final decision in short time
        - the pregnancy will keep progressing as she takes more time for decision
        - it is not possible to change mind once mifepristone pill is administered due to risk of fetal malformation
- able to return to the facility for follow-up visit (has no issue of distance or other barrier)

MA is safe for women who have had a vaginal delivery or C-section before as well as for women who have had a surgical, aspiration or medication abortion before. MA is

also safe for women that have undergone genital mutilation, and it is a good option for women for whom surgical abortion could pose a problem like women with uterine malformation.

ADMINISTRATION OF MA: MIFEPRISTONE & MISOPROSTOL REGIMENS

For pregnancies Up to 12 weeks
The recommended MA dose is 200 mg mifepristone administered orally, followed 24 to 48 hours later by 800 µg misoprostol administered vaginally, sublingually or buccally.

For pregnancies of gestational age of 12 weeks or more
The recommended MA dose is 200 mg mifepristone administered orally, followed 24 to 48 hours later by repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours.

The dose of misoprostol should be reduced for pregnancies beyond 24 weeks owing to the greater sensitivity of the uterus to prostaglandins. Misoprostol is a very powerful stimulator of uterine contractions in late pregnancy and can cause uterine rupture if used in high doses.

Routes for taking the drugs

Mifepristone
Mifepristone is taken orally (swallowing the pill) on day one of the abortion.

Misoprostol
There are a range of options in Misoprostol route, dosage and timing.

- Oral: pills are swallowed;
- Buccal: two pills are placed between each cheek and gums and swallowed after 30 minutes;
- Sublingual: pills are placed under the tongue and swallowed after 30 minutes;
- Vaginal: pills are placed in the vaginal fornices (deepest portions of the vagina) and the woman should lie down for 30 minutes.

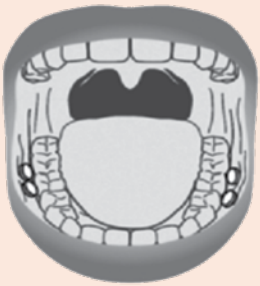
Buccal use of Misoprostol

- Place two pills between each cheek and gums (four in total).
- After 30 minutes, swallow any remaining pill fragments.

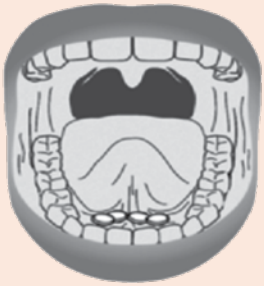
Sublingual use of misoprostol

- Place four pills under the tongue.
- After 30 minutes, swallow any remaining pill fragments

It is very important that the pills remain in between her cheek and gums (buccal) or under the woman's tongue (sublingual) for 30 minutes. In these 30 minutes the pills will be absorbing into her system. After 30 minutes she may drink water to wash down and swallow any remaining pill fragment.



Buccal



Sublingual

If the woman vomits during the 30 minutes that the Misoprostol pills are in between her cheek and gums or under her tongue, it is likely the pills will not work. In this case, it is necessary to immediately repeat. If she vomits after the pills have been in between her cheek and gums or under her tongue for 30 minutes, there is no need to repeat as the pills have already absorbed into her system.

Vaginal use of misoprostol

- The woman empties her bladder and lies down.
- If a provider is inserting pills, the provider washes hands and puts on clean exam gloves. All the misoprostol pills are inserted.

- The pills need to be inserted as far into the vagina as possible; they do not need to be in any special place in the vagina.
- Often the pills will not dissolve but the medication is still absorbed.
- Fragments of the pills may remain visible for many hours.
- After lying down for 30 minutes, if pills fall out when a woman stands up or goes to the bathroom, the pills do not need to be reinserted; the active medicine has been absorbed by that time.

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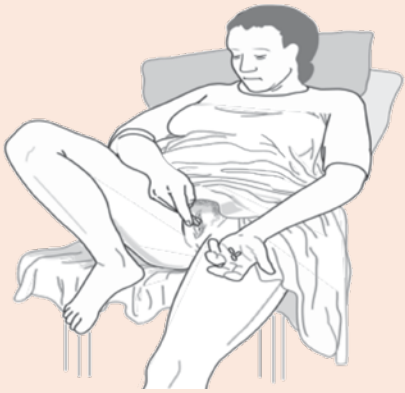


HOW TO USE MIFEPRISTONE & MISOPROSTOL PILLS

Step 1: Mifepristone pill swallowed with water

Give the woman the Mifepristone pill to swallow with water on day one of the abortion. If the woman throws up in the first hour (60 minutes) after swallowing, it is likely that the pill will not work, and it is necessary to repeat the dose.

Step 2: Wait 24-48 hours after Mifepristone is swallowed
After administering Mifepristone, advise the woman to come back 24-48 hours later to take Misoprostol.

Step 3: Give non-steroidal anti-inflammatory drug 1 hour before giving Misoprostol
This step is not required, but it is highly recommended. Pain medications will reduce the intensity of the cramps and help the woman manage the possible side effects of Misoprostol such as headache, fever and chills.

Step 4:
Administer the 4 Misoprostol pills orally, buccally, sublingually or vaginally.

Step 5: Wait for 3 hours to see if there is a need for additional dose of Misoprostol
If 3 hours have passed since using the first 4 pills of Misoprostol and the woman has not had any bleeding or the bleeding has been lighter than her normal period, the best thing to do is use 2 more misoprostol pills the same way you have been using them before.

There is no need to use additional misoprostol pills if she started bleeding.
Repeat doses of misoprostol can be considered when needed to achieve success of the abortion process. Health-care providers should use caution and clinical judgement to decide the maximum number of doses of misoprostol in pregnant women 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.

An abortion with pills can take around 2 weeks to complete itself, so it is normal to have remaining tissue in the uterus during this time.

If abortion does not occur during the time of observation in the facility, the woman should be advised to come back to the facility 2 weeks later to confirm that the abortion is completed. If by this time the abortion has failed, use surgical methods to complete the process.

Note:

- Mifepristone should always be administered orally.
- The minimum recommended interval between use of mifepristone and misoprostol is 24 hours. In the case of late pregnancies, 48 hours interval is ideal between use of mifepristone and misoprostol.
- There is a range of options in the route, dosage and timing for giving misoprostol.
- Evidence suggests that vaginal route is the most effective for use of misoprostol after seven completed weeks since LNMP.

Provide additional services

- Provide iron tablets for anaemia, if needed.
- Provide any necessary non-narcotic analgesics for pain control. The pain medication is much more effective when taken before start of feeling pain as oppose to taking it when the pain starts to feel.
- Provide emotional support, if needed.
- Refer her to other services as determined by an assessment of her needs; for instance, counselling and testing for Sexually Transmitted Infections (STIs) including HIV, abuse support services, psychological or social services, or other specialist health or medical services.
- Ensure to provide access to a clean, functioning and nearby toilet facility after administration of the misoprostol pills.

C. THE ABORTION PROCESS

Thorough information on what the woman might expect helps her to be prepared. Reassurance and support during the abortion process, either by clinic staff or a person at home, can also be helpful.

When taking Mifepristone (for abortion with mifepristone and misoprostol), most women feel no change after taking the pills. This means that if the woman takes it but do not see any changes, it is perfectly normal. Approximately 8-25% of women will have some spotting or bleeding after mifepristone, prior to taking Misoprostol. Symptoms typically will appear after using Misoprostol.

Once a woman takes Misoprostol, the MA process may feel like an intense menstrual period or similar to a spontaneous miscarriage. Most women feel cramps, and all women should experience bleeding. It is impossible to know beforehand how much time after Misoprostol the woman will begin to feel symptoms, as they can take some minutes or several hours to appear. The most intense symptoms occur anytime during

the first 24-48 hours after using Misoprostol. The normal, expected effects - vaginal bleeding and cramping - should be distinguished from side effects of the medications or warning signs of true complications.

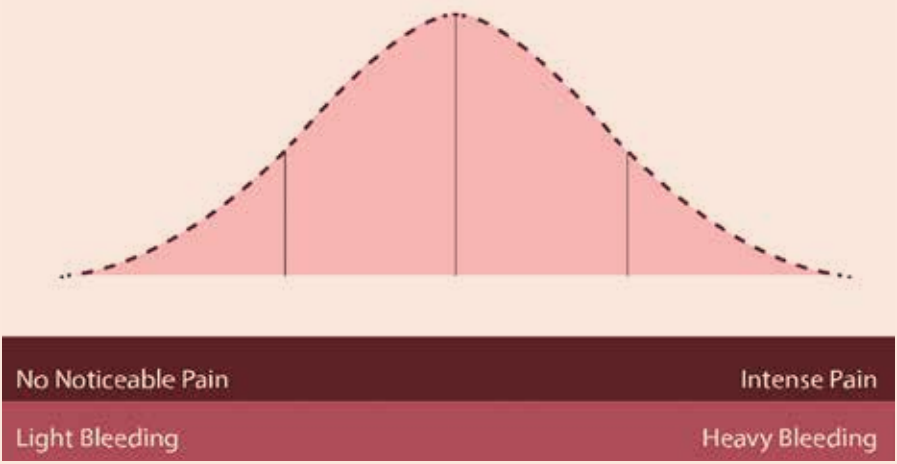
Vaginal bleeding, often accompanied by passage of clots, is usually heavier than a menstrual period but sometimes may be lighter. After the first heavy bleeding (expulsion of products of conception) the blood flow will decrease, but can continue, coming and going, for several days or even weeks after.

Despite the longer duration of bleeding, women who had MA did not have a clinically significant drop in hemoglobin when compared to women who had an aspiration. After MA with Mifepristone and Misoprostol, the average duration of bleeding is approximately 14 days. Approximately 20% of women undergoing MA continued to bleed or spot for 45 days, which may include start of the first post abortion menses. Remember that each abortion experience is different, and the symptoms can vary from woman to woman.

EXPECTED EFFECTS OF BLEEDING & CRAMPS

- Pain (abdominal cramps)
- Bleeding Heavier than normal menstruation and possibly with clots
- Average duration of vaginal bleeding: 14 days; bleeding can last up to 45 days in rare cases
- Total amount of blood loss related to gestational age
- Keep the woman well-informed of expected amount of bleeding

NORMAL DISTRIBUTION RANGE OF PAIN & BLEEDING EXPERIENCE



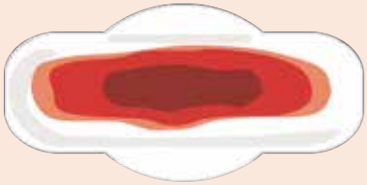
HOW MUCH BLEEDING IS TOO MUCH?

Heavy bleeding can be surprising, but it is normal. If the woman soaks less than 2 thick pads per hour, for two hours in a row, it is typically okay. If she is bleeding more than this amount, it is advisable to seek medical assistance to check for potential complications.

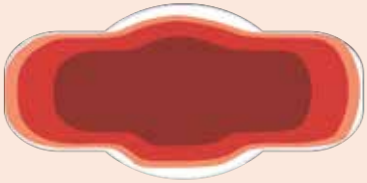
Scant amount
Blood only on tissue when wiped or
Less than one-inch stain on maxi pad
Within one hour.

Light amount
Less than four-inch stain on maxi pad
Within one hour.

Moderate amount
Less than six-inch stain on maxi pad
Within one hour.



Heavy amount
Saturated maxi pad within one hour.



WARNING SIGNS OF MA

If the woman has one of the following symptoms, it is considered as a warning sign that she might be experiencing a complication and she needs immediate medical attention:

- If her bleeding fills two pads or more (completely soaked front to back, side to side) in 1 hour or less and this last for 2 hours or more;
- If she shows symptoms of anaemia or hypovolemia
- Persistent fever of 38 degrees Celsius or higher, confirmed with a thermometer, that does not decrease after taking NSAIDs and beginning more than 8 hours after taking the Misoprostol pills
- Pain that does not get better after taking NSAIDs
- No bleeding within 24 hours of taking Misoprostol pills
- The color or smell of her blood is very different from her regular period or has an offensive smell
- Redness, itchiness or swollen hands, neck and face which are signs of allergic reaction to the medication/s. Antihistamines can be used in such cases, but if the woman finds it difficult to breathe then the allergic reaction is very serious, and she needs medical care immediately.

TREATMENT AND MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS OF MA

A description of common effects, complications, and suggestions for management of problems with MA are listed in the following table, adapted from Providing Medical Abortion in Low-resource Settings - An Introductory Guidebook, Second Edition; Gynuity Health Projects 2009.

EFFECTS	DESCRIPTION	MANAGEMENT
Pain	Reports of pain and perceived need for analgesia vary greatly from culture to culture, clinic to clinic, and person to person. For instance, in places where surgical terminations are performed with no anesthesia, medical abortion is often rated as almost painless. Most women report at least some pain, however, and roughly half perceive a need for analgesia. Pain rarely indicates the need for a surgical intervention and tends to improve rapidly once the expulsion takes place.	Hot water bottle or heating pad Sitting or lying comfortably Support of friends/family Soothing music, television, tea (where available) Non-steroidal anti-inflammatory drugs (NSAIDs) such as diclofenac or ibuprofen
Bleeding	All women who experience a successful medical abortion will experience vaginal bleeding. Bleeding is likely to be more abundant and prolonged than normal menstruation but typically does not adversely affect hemoglobin levels. The total amount of blood loss is related to gestational age.	Set reasonable expectations about bleeding during pre-abortion counseling Give clear instructions about how to decide if bleeding is excessive and where to go for additional care

EFFECTS	DESCRIPTION	MANAGEMENT
Heavy or prolonged bleeding	Excessive or prolonged bleeding causing a clinically significant change in hemoglobin concentration is uncommon. Approximately 1% of women will require uterine evacuation for haemostatic control. The need for transfusion is even rarer (0.1% to 0.2%). There are no reports in the medical literature of hysterectomy for homeostasis after medical abortion. While it is important to explain to the woman that most medical abortions take place without incident, it is equally important to encourage the woman to call her provider if she experiences excessively heavy bleeding. Establishing a sanitary pad count (or local equivalent) will help make bleeding measurement concrete	If there is evidence of hemodynamic compromise, intravenous fluids should be administered. If bleeding is particularly profuse or prolonged, surgical intervention may be required. Transfusion should be provided only if clearly medically required.
Fever/chills	Misoprostol can sometimes cause temperature elevations. These temperature elevations do not usually last more than two hours or so. Although uterine/pelvic infections are rare in medical abortion, a fever that persists over several days or that starts days after prostaglandin administration could signal an infection.	Provide anti-pyretics and reassurance If fever persists for more than four hours or develops more than a day after misoprostol administration, the woman should be instructed to contact the clinic

EFFECTS	DESCRIPTION	MANAGEMENT
Nausea and vomiting	Nausea has been documented in approximately half of all women undergoing medical abortion and vomiting may occur in less than a third. These symptoms are usually related to pregnancy and administration of the medical abortifacients. They may appear or increase in intensity after mifepristone administration and usually decline hours after misoprostol intake.	Reassure women that nausea and vomiting are commonly associated with pregnancy and are also a possible side effect of the medication Provide women with anti-nausea or anti-emetic medication for severe symptoms if the drugs are available
Diarrhea	Misoprostol can sometimes cause temperature elevations. These temperature elevations do not usually last more than two hours or so. Although uterine/pelvic infections are rare in medical abortion, a fever that persists over several days or that starts days after prostaglandin administration could signal an infection.	Provide anti-pyretics and reassurance If fever persists for more than four hours or develops more than a day after misoprostol administration, the woman should be instructed to contact the clinic
Headache and faintness	These symptoms have been documented in less than a quarter of all women. They are usually self-limited, resolve spontaneously, and are best managed symptomatically	Provide reassurance and analgesia as needed

EFFECTS	DESCRIPTION	MANAGEMENT
Infection	Serious infection following medical abortion (defined as an infection requiring IV antibiotics and hospitalization) is rare. Overwhelmingly, infections reported following medical abortion are not serious and are treated with a single course of oral antibiotics in an outpatient setting	If infection is suspected (see fever) the woman should be evaluated. If there is evidence of endometritis and the abortion is incomplete, a surgical abortion should be performed, and antibiotics provided Any severe infection could require hospitalization and parenteral antibiotic Antibiotic administration (either prophylactically or with screen and treat protocols) is used in some settings. However, routine antibiotic use may not be feasible in all settings, for all women, and is not without its own risks of side effects and serious adverse events, such as serious and fatal allergic reactions. WHO does not recommend routine antibiotics for medical abortion procedures

D. FOLLOW-UP AND ASSESSMENT FOR COMPLETENESS OF ABORTION

A follow-up visit must be scheduled for 2 weeks after the woman takes MA. During the follow-up visit, inquire about the woman's experience with the abortion, assess completeness of the abortion, review any laboratory results with the woman, provide a contraceptive method, if she desires it.

Abortion with MA is considered to be very likely successful if the woman experienced expected symptoms of MA like:

- bleeding, cramping and passage of tissue or clots of blood
- absence of pregnancy symptoms that she experienced prior to MA. For example, if the woman had morning sickness and breast tenderness beforehand, has that resolved?
- absence of signs of infection

Abortion completeness can also be confirmed with:

- Pelvic examination (uterus: involute, firm, not tender and smaller in size compared to the examination documented prior to the MA; cervix: closed and not tender)
- If there is any doubt, an ultrasound can confirm whether the embryo is still in the uterus or not.

Remember: blood and urine tests will continue to be positive at least 4 weeks after MA even if the pregnancy was terminated. However, a positive test 4 weeks after abortion indicates an incomplete abortion.

WHEN WILL MENSTRUAL PERIOD RETURN AFTER MA?

During an abortion (with MA or surgical or procedure) the woman's menstrual cycle will restart as if she has had her menstrual period. She will ovulate again approximately 10 days afterwards. This means she can get pregnant again if she has unprotected sex. The next normal menses can come back in approximately 4 to 6 weeks after using MA pills.

E. POST ABORTION CONTRACEPTION

After MA, a woman may have vaginal intercourse when she feels comfortable doing so. Confirm to the woman that MA does not impact her fertility, and that MA does not impact her ability to experience sexual pleasure.

If the woman is trying to avoid pregnancy again, she should receive and begin her method of contraceptive choice as soon as possible. If the woman chose a long-term contraceptive, she should be advised to use short term methods such as condoms or spermicides, to avoid a pregnancy until her long-term contraceptive method becomes effective.

If the woman desires long-acting contraception or sterilization but it cannot be provided, an interim method should be given, and referral made to the appropriate facility.

All women who wish to delay conception should leave the facility with an effective method of contraception of their choice.

WHEN TO START CONTRACEPTION AFTER MA

Contraceptive method	Initiation timing
Oral contraceptive pills	Day 1 of the MA regimen
Injections	Day 1 of the MA regimen
Implants	Day 1 of the MA regimen
IUDs	As soon as reasonably sure the woman is no longer pregnant (during follow up visit)
Sterilization	As soon as reasonably sure woman is no longer pregnant (during follow up visit)

ESSENTIAL REFERENCES:

1. Manual for In service training on CAC, FMOH 2013
2. Technical and Procedural Guideline for Safe Abortion Services in Ethiopia, FMOH 2014
3. Safe Abortion: Technical and Policy Guidance for Health Systems, Second Edition; WHO 2012.
4. Clinical Practice handbook for safe abortion; WHO 2014
5. Medical management of abortion, WHO 2018
6. Medical Abortion Study Guide; Ipas 2009