



TEACH

Training in Early Abortion for
Comprehensive Healthcare



TEACH ABORTION TRAINING CURRICULUM

7th Edition: 2022

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Bixby Center
for Global
Reproductive
Health

UCSF

University of California
San Francisco

This Curriculum is dedicated to the courageous and compassionate providers, learners, and staff who are steadfast in their commitment to finding ways to care for people, no matter what.



Why the Papaya?

The [papaya simulation lab](#) was originally innovated by the TEACH Program's first Director, and is now used globally by new providers learning the skill of uterine aspiration.



TEACH

Abortion Training Curriculum

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User Testimonials

The TEACH workbook provides a roadmap to how to provide safe, effective, and competent abortion care. It was essential in preparing me to participate in hands-on care in a safe manner and expedited my learning curve. —3rd Year Resident

This curriculum has been with me since medical school. I've gone through it many times now, and it has helped me be more comfortable with the things I've seen as well as the things I haven't yet seen. - 3rd Year Resident

The TEACH Curriculum and training gave me the skills, passion, and inspiration to pursue reproductive health as part of my life-long career. —Trainer

Was just reflecting on this experience, at this moment in history, and that I'm really grateful to have been included in this process. This Curriculum is incredible and I'm excited to use it for the rest of my career as an educator and provider. —Fellow; 7th Edition Co-Author

7th Edition Prologue

We stand in a maelstrom of forces informing the 7th Edition TEACH Curriculum at this time in history: a full-scale assault on abortion legality as *Roe v. Wade* is gutted, social movements for equity long overdue, and global pandemic lessons lived and learned.

In spite of a two decade global trend toward liberalized abortion laws, the U.S. is experiencing a starkly different reality. Nearly 50 years of federal constitutional abortion protections have come to an end, triggering states to ban and criminalize abortion. The Curriculum Working Group has made myriad changes to meet this moment, as the community rapidly rearranges to continue caring for patients, no matter what, in the face of this blow. The evidence is clear that people denied an abortion face worse financial, health and family outcomes for years to come. For those living in states in the South and Midwest, “post-Roe” restrictions were long a reality, with many states including no exceptions for rape, incest, or to save a pregnant person’s life. People will travel farther, spend more, face criminal penalties or forced births. Not surprisingly, these laws most impact those with fewer resources, people of color, people with disabilities, undocumented people, and gender diverse people - further reinforcing systemic oppression.

We approach Self-Managed Abortion (SMA) in more depth in this Edition, and through a person-centered lens, as a valid and necessary option that some, but not all individuals come to by choice. We focus specifically on self-managed medication abortion (SMMA) due to its safety, efficacy, and our knowledge of it in the medical community. Acknowledging the long history of community and indigenous providers of SMA, we expect knowledge on all SMA forms will grow. As abortion care evolves to fit this social and political landscape, we hope to train providers to support patients with all safe abortion management options, uplifting and centering the complex circumstances of patients’ lives.

TEACH, like many organizations, also reflected on its own personal and structural biases and committed to taking steps to dismantle racist power structures during this period. Guided by reproductive justice advocates, TEACH developed an antiracist strategic realignment footprint for moving forward to diversify, better mentor those we train, and better reflect the communities of providers and patients we serve. This commitment guides this and future Editions.

The pandemic also provided many lessons since the last Edition – pivoting practice models to require less in-person contact via telemedicine and remote follow-up. We have added significant material to help providers streamline and eliminate unnecessary steps in diagnosis, care and follow-up.

Lastly, we want to mark the collective nature and evolution of this Curriculum. Starting from an internally developed workbook for our own trainees, it has grown to an online open-access textbook downloaded for use in all 50 U.S. states and over 100 countries. We are pleased it has been instrumental for many trainees in learning to provide services to underserved rural, urban, and global communities. We could not be more thrilled to have two new Co-Editors at the helm who will be taking the Curriculum into the future. Through its development over 2 decades and 7 Editions, the work of so many people - 6 Co-Editors, 50 Co-Authors (Faculty, Fellowship and Program Directors, Fellows, Training Specialists, and Residents), and well over 100 Advisory Members - can still be traced in these pages. With each version, the Curriculum has become more representative and inclusive of our mission and larger community, and for this we are grateful and proud.

This Curriculum provides many ways to support reproductive autonomy. We hope users will better counsel, destigmatize, date, refer, manage, provide, advocate, and/or train future providers and leaders. But no matter the scope, we hope every user walks away with the knowledge and skills to support people in achieving equitable access to sexual and reproductive health care. As our community bands together to find creative means to care for our patients and each other, we hope this Curriculum serves as a resource in those efforts, and as a source of inspiration and motivation. As Roe falls, we will rise.

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Ibis Reproductive Health



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Early Pregnancy Ultrasound Skills Evaluation

New Trainer Skills Evaluation

1. ABORTION IN PERSPECTIVE

Updated June 2022 by Monica Agarwal, MD, Sheila Attaie, DO, Anna Sliwowska, MD

Welcome to your early pregnancy options and abortion training. Especially in light of the U.S. activist Court's gutting nearly 50 years of federal reproductive protections, we are committed to training, supporting, and mobilizing all primary care clinicians to help ensure equitable access to sexual and reproductive health care, including abortion, to all our patients.

Primary care providers globally serve an important role in the provision of reproductive health services as they practice in diverse, rural, and underserved areas ([Graham 2005](#)), receive procedural training, and care for patients throughout their reproductive years. This text is primarily U.S.- focused, with expanded global reporting for a growing global audience.

This curriculum can help you be a better primary care provider for patients of reproductive age. There are many skills to gain including pregnancy dating, options counseling, timely referrals, miscarriage management, and abortion care. It is beneficial to read Chapters 1 and 2 before beginning your training to help explore your personal values about pregnancy outcomes, how they may differ from your patients' values, and think about professional judgments you may be called upon to make.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

- Explore your personal values and feelings about pregnancy options
- Clarify your individual training goals and strategies to achieve these with faculty
- Describe constraints on reproductive care and access globally
- Be familiar with data on abortion safety and factors that promote/limit safety
- Understand the influence of abortion-related stigma on patients and providers
- Understand professional ethics within a justice-based & public health framework.

VIDEOS

- [Overview of abortion in the international context](#) (IERH)
- [Advancing Equity & Justice in Sexual and Reproductive Healthcare](#) (Structures & Self Series; IERH)
- [Global Perspectives](#): video interviews with U.S. and international experts:
- [RHEDI/SisterSong-Reproductive Justice 101 Webinar](#)

RESOURCES

- [Pregnancy Options](#) (NAF)
- [State and Global Policy Updates](#) (Guttmacher Institute):
 - [States Laws and Policies](#)
 - [International Laws and Policies](#)
- [Sistersong Reproductive Justice Resources](#)
- [When Abortion is Not Available](#) (IERH)

SUMMARY POINTS

SKILLS

- It is valuable to identify and understand the life experiences that have affected your opinions in order to promote a non-judgmental climate for patient care.
- Patient-centered counseling uses a non-directive approach with active listening, open-ended questions, and accurate information about pregnancy options.

SAFETY

- Abortion is safe, and removing legal restrictions is associated with significant reductions in maternal morbidity and mortality globally. In fact, the only factors decreasing abortion safety are those decreasing access (NASEM 2018, Upadhyay 2015, White 2015).
- Nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions (98%) occur in developing countries (Singh 2018, Sedgh 2016).
- Patients who receive an abortion are not at risk for mental health problems, and are at no higher risk of post-traumatic stress disorder (PTSD) than patients denied an abortion (Horath 2017, Biggs 2016)
- People have been trying to end unwanted pregnancies on their own throughout history. The advent of abortion pills has changed the framework and self-managed medication abortion is proven to be safe and effective (Conti 2019).

ROLE

- Abortion is common. One in four U.S. pregnancy capable people will have an abortion. One in 4 pregnancies end in abortion globally (Jones 2017).
- Given how common unintended pregnancy, abortion, and early pregnancy loss are, most primary health care providers will treat patients experiencing these issues.
- Restrictive laws seek to discourage abortion, however individuals seek abortion even in settings where it is restricted (Bearak 2020).
- Reproductive health access and training are limited by hospital mergers, religious restrictions at training sites, stigma, and lack of transparency for patients and trainees (Thorne 2019, Uttley 2013).
- First trimester abortion is provided by physicians and advanced practice clinicians, with similar safety, effectiveness, and patient acceptability in locations where abortion care is not restricted to physicians (NASEM 2018, Sjöström 2017).
- If you do not provide abortion services directly, it is important to know how to refer patients and handle follow-up issues within the context of your practice setting.

REPRODUCTIVE HEALTH THROUGH A JUSTICE LENS

As we move beyond Roe, we must center the experiences of people who are — and have been — most impacted by systemic inequities and injustices. There is a long history of coercive reproductive practices in the US and globally. Many gynecological techniques were developed using enslaved and immigrant women without proper consent or anesthesia. Abuses continue today with forced sterilization as recently as 2020, incentivized use of long-acting reversible contraceptives and resistance to remove them, and threats to parenthood (including differential referrals to child protective services). These abuses have been disproportionately imposed upon Black, Indigenous, and People of Color, low income people, those with disabilities, immigrants, LGBTQIA+ and incarcerated individuals (NPWF 2020, Owens 2017). This history continues to shape the perception of family planning services by marginalized individuals and communities (Thorburn 2005).

In response to this discriminatory history, Black communities have organized and developed frameworks to fight for their reproductive autonomy (Silliman 2004). The Reproductive Justice framework was named and conceptualized by 12 Black women in 1994, and it is defined by the SisterSong Reproductive Justice Collective as the:

- Right to maintain personal bodily autonomy
- Right to have children
- Right to not have children
- Right to parent the children we have in safe and sustainable communities

It is one of three distinct frameworks that together provide a complementary solution for addressing reproductive oppression: [1] Reproductive Health, [2] Reproductive Rights, and [3] Reproductive Justice. A Reproductive Health framework emphasizes access to the very necessary reproductive health services that people need. A Reproductive Rights framework is based on universal legal protections, and sees these protections as rights. A Reproductive Justice framework explains that reproductive oppression is a result of the intersections of multiple factors and is inherently connected to the struggle for social justice and human rights. It recognizes that people may have limited options regarding their pregnancy outcomes based on their race, gender, class, sexual orientation, and age. Reproductive experience occurs within a social, structural, political, environmental, and economic context that includes things like insurance, employment, food, safe water and air, and education. Supporting reproductive justice and bodily autonomy requires that we examine, understand, and improve the structural and social context in which people experience reproduction and parenting (Ross 2017, ACRJ 2022, Chrisler 2012).

Where reproductive health and rights are limited by a “pro-choice” framework, the reproductive justice framework draws on concepts of social justice, intersectionality, and other scholarly and intellectual work throughout Black history (NBWRJ 2022, BMMA 2020). Moreover, in contrast to the reproductive rights movement which was known to center the voices of cis-gender white, heterosexual women on the legal right to abortion (Nichols 2020), the reproductive justice movement is an expansive, transformational, and grassroots movement led by Black, Indigenous and People of Color to improve institutional policies and create systems changes that improve the reproductive lives of marginalized communities (NBWRJ 2022).

Given the historical devaluation of the childbearing of marginalized populations (Brandt 2018, Brown 2014), we must remain focused on providing care that is respectful of, and responsive to individual patient preferences and values (Gomez 2014) to ensure that patient preferences guide our clinical decisions (Institute of Medicine 2001). Our curriculum is informed by this history and this lens.

DEFINING PREGNANCY DESIRES AND OUTCOME INDICATORS

Although researchers have been measuring unintended pregnancy for decades, the concept of pregnancy intention is complex, and unintended pregnancies are not created equally. The conventional approach of categorizing recalled pregnancy desires does not capture the complexities of patients' desires, their experiences prior to pregnancy or the context in which a pregnancy occurs (Gomez 2019, Borrero 2015). Ambivalence, partner influence, and cultural perspectives all inform how patients feel about pregnancy intention (Aiken 2016).

Recent work to identify contraceptive needs in a person-centered way does not rely on a framework of pregnancy intention or reproduce oppressive narratives (Samari 2020). In initiating sexual and reproductive conversations, it is important to ask for consent and honor a patient's answer. Screening for self-identified service-needs, rather than pregnancy intention, is aligned with evidence for how people want to be asked about their reproductive needs (Manze 2020). How we focus our quality metrics will help us to stay focused on patients' needs.

PROFESSIONAL ETHICS IN REPRODUCTIVE HEALTH

Prevention is increasingly recognized as the most effective means of ensuring health by initiatives such as Healthy People 2020 and U.S. Affordable Care Act. A comprehensive approach addressing patients' pregnancy preferences is an essential component of prevention within a public health framework (Samari 2020, Taylor 2011). Primary care clinicians are uniquely positioned and have ethical responsibilities to provide reproductive health screening, pregnancy options counseling, contraceptive services, miscarriage management, and appropriate referral or provision of abortion services.

The provision of care may represent a greater ethical challenge to clinicians in countries that challenge the legal status of abortion or other services. Stigma can lead to different kinds of unethical behavior, including the refusal to provide abortion services to patients, alleging conscientious objection or religious directives, and discrimination against patients who may have complications of ectopic pregnancy or abortion, without tending to the obligation of preventing harm to patients for whose care they are responsible (Faundes 2016).

Medical institutions and training programs should also be transparent about their religious affiliations and the potential impact on health services at their institutions. Patients of reproductive age want information about a hospital's religious restrictions on care when deciding where to go for reproductive care (Freedman 2018). Trainees want and deserve the same information. Growth in the religious health care sector demands an increasing need for transparency so that patients and trainees can make informed decisions.

COVID-19 AND ABORTION CARE

Most aspects of healthcare have been impacted by the COVID pandemic, and abortion care is no exception. Some states introduced legislation restricting abortion access by declaring it "elective" or "not medically necessary" for example. Numerous national and international organizations strongly opposed responses that cancel or delay abortion procedures, and explicitly classified reproductive health care as an essential health service that must be accorded high priority in COVID responses (Bayefsky 2020, Todd-Gerr 2020). Many providers pivoted rapidly towards innovative practice models streamlining diagnostic tests and contact between the patient and the healthcare system, and using telemedicine, mailing medications, and remote follow-up (Raymond 2020).

EMERGING TERMINOLOGY

Abortion Modifiers:

- We use the term “medication abortion” instead of “medical abortion” to represent medication-based methods to terminate pregnancies, and avoid implying medical necessity ([Weitz 2004](#)).
- We use the term “telemedicine” medication abortion, vs. “telehealth,” which implies allied health fields in many global settings, rather than “no-touch” or “minimal contact”.
- We use the terms “in clinic” or “aspiration abortion” instead of “surgical abortion” or “dilation and curettage” to avoid suggesting abortion is a surgical procedure requiring incisions or sharp curettage ([ACOG 2022](#)). Access to specific procedures may vary.
- We use the term “self-managed abortion (SMA)” as an umbrella term to refer to any actions or activities undertaken to end a pregnancy outside of the formal healthcare system. This has historically included the use of herbs, botanicals, supplements, self-harm, or obtaining a clandestine procedural abortion, as well as medications. While many other terms may be used (self-sourced, self-induced, self-managed medication abortion), best practice is to specifically describe the type and method of abortion that was used to avoid misunderstanding.

Abortion Indications:

- We avoid “elective vs. therapeutic” abortion, which imply a moral rather than a medical judgment on which patients are entitled to abortion care ([Watson 2018](#)).

Pregnancy Loss:

- We use the terms “early pregnancy loss” and “miscarriage” interchangeably, avoiding the term “pregnancy failure” which can leave patients feeling responsible.

Person-Centered Care

- We use “person-centered” as well as “patient-centered care” to broaden the perspective, considering the whole life of the patient influenced by care ([Eklund 2019](#)).

Gender-Neutral Language:

- We use gender-neutral language to recognize that a wide spectrum of individuals need reproductive and abortion care (trans men, nonbinary persons, etc, as reproductive care is not restricted to cis women). We use the terms “person,” “patient” and singular “they” ([Moseson 2020](#)), except when reporting gender specific research.”
- Where possible, we also use “*Latinx/e*” to describe a diverse group of people who have roots in Latin America in order to challenge the gender binary. The objective of these terms is also to remove gender from Spanish, replacing it with a gender-neutral Spanish letter.

GLOBAL ABORTION FACTS AT A GLANCE

Abstracted from Guttmacher Institute's [Induced Abortion Worldwide 2022 Fact Sheet](#)

GLOBAL ABORTION DATA

- Approximately 1 in 4 pregnancies globally end in abortion ([Sedgh 2016](#)).
- Unintended pregnancy and abortion care occur across all countries' income groups.
- Legal restrictions do not decrease abortion rates, but make abortions much less safe.
- Many patients are denied abortion even where legal ([ANSIRH Turnaway Study](#)).

CONTRACEPTIVE USE

- Globally, about half of all women want to avoid a pregnancy; of these, about 75% are using modern contraceptives.
- A greater proportion of people in non-industrialized countries have an unmet need for contraception, accounting for 84% of unintended pregnancies in those regions.
- Reducing the unmet need for modern contraception globally can decrease rates of maternal and infant mortality ([Guttmacher 2017](#)).

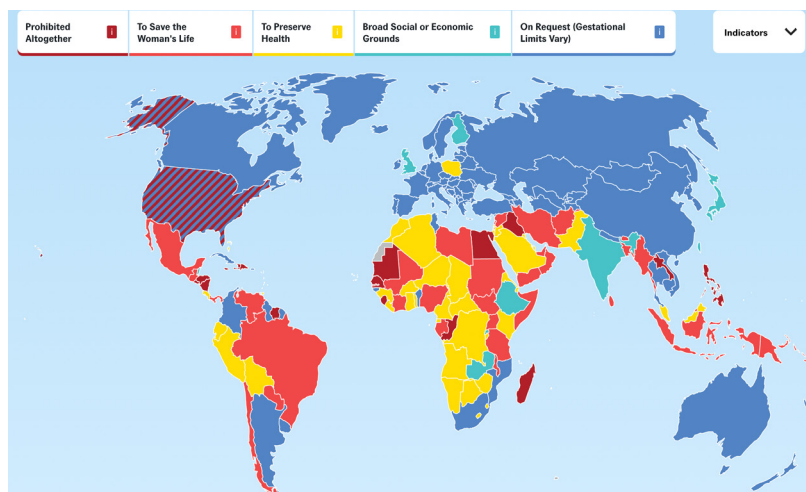
SAFETY OF ABORTION

- Abortions are safer where laws are less restrictive and also in countries with higher gross national incomes ([Singh 2018](#)).
- Stigma is a recognized contributor to maternal morbidity and mortality from unsafe abortion, even where abortion is legal.
- Between 4.7–13.2% of pregnancy related deaths worldwide are from unsafe abortion, and this is likely an underestimate ([WHO 2021](#)).

WORLD'S ABORTION LAWS

- In 1994, 179 countries signaled their commitment to prevent unsafe abortions and reduce pregnancy-related mortality by signing the first international consensus document recognizing reproductive rights as human rights ([CRR ICPD 2020](#)).
- The last 25 years have seen an overwhelming global trend toward the liberalization of abortion laws, with nearly 50 countries worldwide enacting laws expanding legality.
- Abortion laws vary widely. Laws by country are on the map below from June 2022 at the courtesy of the [Center for Reproductive Rights](#), where interactive versions are available.
- Many global efforts focus on providing accessible, affordable, and high-quality reproductive health care in ways that recognize autonomy.

The World's Abortion Laws



UNITED STATES ABORTION FACTS AT A GLANCE

Abstracted from Guttmacher Institute's [Induced Abortion in the United States 2022 Fact Sheet](#)

ABORTION BY THE NUMBERS

- Abortion is common and much safer than carrying a pregnancy to term, having a colonoscopy, or crossing the street ([Raymond 2012](#), [Pedbikeinfo](#), [Levin 2006](#)). Medication abortion and procedural abortion are safe, and the primary limits to safety are limits to access ([NASEM 2018](#)).
- 18% of U.S. pregnancies (excluding miscarriages) end in abortion ([Jones 2017](#)).
- Most abortions occur early in pregnancy; nearly 90% in first 12 weeks ([Jones 2017](#)).
- Medication abortions account for over half of all eligible U.S. facility-based abortions ([Jones 2022](#)).
- Data are limited, however, a significant number of people attempt to self-manage their abortions ([Fuentes 2020](#), [Moseson 2020](#)).
- Most U.S. counties (89%) lack an abortion provider; these counties are home to 38% of reproductive age women ([Jones 2017](#)).
- U.S. unintended pregnancy rates are higher (45%) than other developed nations.

WHO HAS ABORTIONS

- One of every four U.S. pregnancy capable people has abortions and they come from all backgrounds.
- Approximately 60% of abortions are among people who have had at least one child.
- Of people obtaining abortions, 30% identify as Protestant and 24% as Catholic.
- More than half are in their 20s, and 12% are in their teens ([Jerman 2016](#)).
- Of the people who have abortions, 39% identify as white, 28% Black, 25% Hispanic, 6% Asian or Pacific Islander, and 3% different race or ethnicity ([Jerman 2016](#)).
- 75% of people accessing abortion are low-income or poor ([Guttmacher 2016](#)).
- On average, people report ≥ 3 reasons for choosing abortion: 3/4 say a baby would interfere with work, school, or responsibilities; 3/4 say they cannot afford a child; and 1/2 do not want to be a single parent or report relationship problems ([Jerman 2016](#)).
- Nearly 60% of patients who experience a delay in obtaining an abortion cite the time it took to make arrangements and to raise money.
- Transgender and non-binary people may have undesired pregnancy after transitioning socially, medically, or both, and may seek prenatal or abortion care ([Moseson 2020](#)).

LONGTERM TURNAWAY OUTCOMES (ANSIRH TURNAWAY STUDY)

- Long-term research shows that abortion does not harm patients; there is no increased risk of depression, PTSD, low life satisfaction, or other mood symptoms when comparing patients who had abortion vs. those turned away.
- Patients denied an abortion have decreased financial security and four times the odds of living below the federal poverty level (FPL) compared to those who had an abortion.
- Patients denied an abortion are more likely to remain tethered to abusive partners, and more likely to experience pregnancy complications including eclampsia and death.
- The financial wellbeing and development of children is negatively impacted when their mothers are denied abortion.

WHO PROVIDES ABORTIONS

- At least 30% of providers now offer medication abortion services only (Jones 2017).
- The number of providers and clinics providing abortion has declined in recent years.
- The number of providers decreases with increasing gestational age: 95% offer abortion to 8 weeks, 34% to 20 weeks, and 16% to 24 weeks (Jones 2017).
- While most states allow healthcare professionals to refuse involvement in abortion on the basis of conscientious objection, many characterize their provision as conscience-based.

CONTRACEPTIVE USE

- Over 50% of patients having abortions used a contraceptive method during the month they became pregnant (Jones 2018).
- Of those not using a method the month they got pregnant, 33% perceived themselves to be at low risk for pregnancy, 32% had method concerns, 26% had unexpected sex, and 1% were forced to have sex (Jones 2002).
- 76% of pill users and 49% of condom users reported inconsistent use (Jones 2002).

SAFETY OF ABORTION

- The major report from NASEM (the National Academies of Sciences, Engineering and Medicine) concluded that all forms of abortion (medication, aspiration, dilation and evacuation, and induction) are safe and that the primary factors decreasing safety are those decreasing access (NASEM 2018, Upadhyay 2015, White 2015).
- Medication abortion care, administered by telehealth and delivered via mail, is feasible, safe, and efficacious (Upadhyah 2021).
- First trimester abortions pose no long-term risk of infertility, ectopic pregnancy, spontaneous abortion, or breast cancer (Guttmacher 2019).
- Abortion does not pose a hazard to patient's mental health (Biggs 2016, Horvath 2017). The most common emotional response following abortion is a sense of relief.
- Mortality associated with childbirth is 14 times that of legal abortion (Raymond 2012) though due to systemic racism, Black women – as with maternal mortality – have a risk of abortion-related death that is 3 times more than for white women (Zane 2015).
- In the U.S., the risk of abortion complications requiring hospitalization is less than 0.5% (NASEM 2018, White 2015).

THE IMPACT OF ABORTION-RELATED STIGMA

- Because abortion is highly stigmatized, patients who seek or undergo abortion may keep their decision a secret.
- A systematic review showed that patients who have had abortions experience fear of social judgment, self-judgment and a need for secrecy. Secrecy was associated with psychological distress and social isolation (Guttmacher 2016).
- A patient may choose not to disclose their decision to family or friends, exclude abortion in their medical history, or delay care or management of emergencies.
- “Stigma and silence produce a vicious cycle: when [patients do not disclose their experience or] providers do not disclose their work, their silence can perpetuate a stereotype that abortion remains rare, or that legitimate, mainstream providers do not perform abortions. This contributes to marginalization of patients and providers.” (Harris 2013)
- Stigma can lead to the social, medical, and legal marginalization of abortion care around the world and is a barrier to access to high quality, safe abortion care.

AN OVERVIEW OF U.S. ABORTION LAW

During the past 50 years, the Supreme Court of the U.S. (SCOTUS) has superseded states as the driving force in crafting abortion policy. On June 24, 2022, a decision was handed down by an ideological court to overturn protections and send decision-making back to the states..

In the 1973 *Roe v. Wade* decision, the court established:

- In the first trimester (up to 14 weeks), state laws cannot interfere with a woman’s right to end a pregnancy; decisions are left to a woman and her medical provider.
- During the second trimester (14 to 24 weeks), state laws may regulate abortion procedures only in order to protect the woman’s health.
- During the third trimester (after 24 weeks), state laws may prohibit abortion except when it is necessary to preserve the life or health of the woman.

The 1992 *Planned Parenthood of SE Pennsylvania v. Casey* case, the Court established:

- States can restrict abortions, even in the first trimester, as long as restrictions do not place “undue burden” on women.

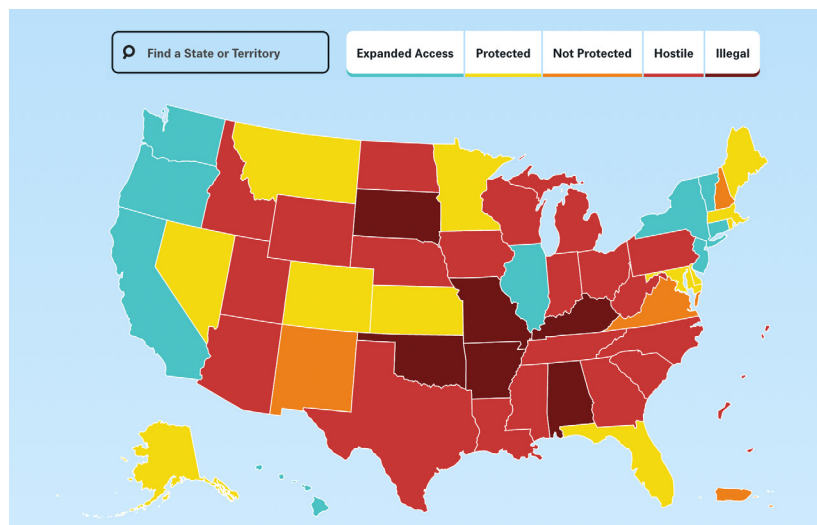
The 2016, *Whole Women’s Health v. Hellerstedt* case confirmed that compounding effects of multiple restrictions unfairly singled out abortion providers.

In 2021, SCOTUS failed to block a Texas ban on abortions when cardiac motion can be detected (roughly 6 weeks). As a result, the law went into effect, prohibiting most abortions in Texas, with other states following suit.

In 2021, a conservative activist SCOTUS heard arguments in ***Dobbs v. Jackson Women’s Health Organization***, a direct challenge to *Roe v. Wade*. The case evaluated an unconstitutional Mississippi law that ignores established precedent to ban abortion > 15 weeks of pregnancy.

- In June 2022, the US Supreme Court with a conservative majority overturned *Roe v. Wade*, with detrimental consequences for people seeking abortion care in many states. It is likely or certain that abortion will be banned in 26 U.S. states, including 13 states that triggered immediately. Current and anticipated changes in laws by state and territory are in the map below, current as of June 2022, at the courtesy of the [Center for Reproductive Rights](#), where interactive versions are available.

U.S. Abortion Laws After Roe



U.S. LAW AND POLICY HIGHLIGHTS

Abstracted from [Guttmacher Institute's](#) Overview of Abortion Law, June, 2022. (Note: Numbers accurate as of publication date and may change with pending cases and legislation.)

Record numbers of restrictive state laws were passed in the last decade.

- *Gestational Age Limits: State Bans Throughout Pregnancy:* 43 states prohibit abortions after a specified point in pregnancy, more than half prohibit abortion before fetal viability. Currently, 6 states have outright bans on all abortions, 3 states have 6 week bans. Most provide exceptions to protect the patient's life or health.
- *Public Funding:* The Hyde Amendment bars use of federal funds to pay for abortion unless pregnancy arises from incest or rape, or to save patient's life, which impacts communities of color disproportionately covered by public funding. 16 states use their own funds to pay for all or most medically necessary abortions for Medicaid enrollees in the state. 33 states and the District of Columbia prohibit the use of state funds except in those cases when federal funds are available: where the patient's life is in danger or the pregnancy is the result of rape or incest. In defiance of federal requirements, South Dakota limits funding to cases of life endangerment only.
- *Coverage by Private Insurance:* 12 states restrict coverage of abortion in private insurance plans, most often limiting coverage only to when the patient's life would be endangered if the pregnancy were carried to term. Most states allow the purchase of additional abortion coverage at an additional cost.
- *State-Mandated Counseling:* 18 states mandate that individuals be given counseling before an abortion that includes information on at least one of the following: the purported link between abortion and breast cancer (5 states), the ability of a fetus to feel pain (13 states) or long-term mental health consequences for the patient (8 states).
- *Waiting Periods:* 25 states require a specified waiting period, usually 24 hours, though 6 states require 72 hours; 12 of these require two separate clinic trips because the counseling must take place in person.
- *Medically Unnecessary Ultrasound:* 14 states require an ultrasound prior to an abortion regardless of medical necessity. In several states, patients are forced to view and listen to descriptions of ultrasound images despite their wishes.
- *Parental Involvement:* 37 states require parental involvement in a minor's decision to have an abortion; 27 require parental consent, while 10 require that one or both parents be notified.
- *Targeted Regulation of Abortion Providers (TRAP):* 24 states regulate abortion providers beyond what is necessary to ensure patients' safety; 17 of these even apply to sites where only medication abortion is provided. 14 states require providers to have hospital affiliation.
- *Telemedicine MAB Banned:* 18 states ban use of telemedicine for medication abortion.

- *Refusal*: 45 states allow individual health care providers to refuse to participate in an abortion. 42 states allow institutions to refuse to perform abortions, 16 of which limit refusal to private or religious institutions. 12 states allow institutions or providers including pharmacists to refuse to provide services related to contraception alone.
- *Physician Requirements*: 35 states require all abortions be performed by a licensed physician, & one (MS) restricts abortion provision to obstetrician gynecologists only. 17 states allow APCs to provide medication abortion, and 7 of these also allow APCs to provide aspiration abortion.
- *Hospital Requirements*: 19 states require an abortion to be performed in a hospital after a specified point in the pregnancy, and 17 states require the involvement of a second physician after a specified point.
- *Gag Rule*: Prohibits clinics that receive federal funding from providing referrals for abortions or providing options counseling.
- *Protection Against Clinic Violence*: The Freedom of Access to Clinic Entrances (FACE) Act is a federal law that was enacted in 1994 to protect clinics, medical personnel, and patients seeking reproductive health care against blockades and violence. Sixteen states and the District of Columbia have passed similar laws to prohibit specific actions or provide protected “bubble zones” outside of clinics.
- *Federal Abortion Ban*: In 2007 the “so-called Partial Birth Abortion Ban” Act was upheld. This decision retreats from an unbroken line of precedent that a woman’s health must remain the paramount concern in any abortion regulation, as it includes no health exception.

ADOPTION FACTS AT A GLANCE

THE ADOPTION PROCESS

- In adoption, a birth parent places the child in the care of another person or family in a permanent, legal agreement.
- The birth parent selects the type of adoption (open vs. closed) and may influence who will facilitate the process (agency, attorney, facilitator).
- Social workers are a helpful resource for patients navigating adoption.
- Prospective adoptive parents undergo an evaluative home study, which includes interviews, home visits, health evaluation, income, and references (NAIC 2022).
- The birth parent may be given a limited period of time during which they may change their mind. After that, the courts reverse few adoptions.

TYPES OF ADOPTION	
<i>Open</i>	<i>Closed</i>
In open adoption, there is a greater degree of openness and disclosure of information between the birth and adoptive parents and the adopted child .	In closed or confidential adoption, the birth and adopting parents have no contact, but may share relevant medical history. Court records are sealed.

INCIDENCE OF ADOPTION

- There is no updated central database on adoption and updated data are limited.
- 70% of all U.S. domestic adoptions are open adoptions (Adoption Facts 2022).
- Of U.S. infant adoptions, 59% occur through the child welfare system, 26% involve children born internationally, and 15% involve U.S.-born infants placed (Arons 2010).
- The proportion of infants placed for U.S. adoption declined from nearly 10% before 1973 (the year Roe v. Wade was decided) to 1% by 2002 (Jones 2009).
- Patients placing a child for adoption are more likely to be never married, young, higher income and more educated than those choosing parenting (Arons 2010).
- Of U.S. reproductive aged women, it is estimated that < 1% has relinquished a child for adoption (Sisson 2022) and < 1% has adopted a child (Ugwu 2015).
- Adoption rates translate to a lifetime relinquishment estimate of 0.9% of U.S. women.
- Adoptive parents are more likely to be > 35, ever married, to have previously used infertility services, or to be men, than people who have not adopted (Jones 2009).
- A 2017 SCOTUS ruling allowed same-sex spouses to be listed on birth certificates, and made adoption by same-sex couples legal in all 50 states (Adoption Facts 2022).
- LGBTQIA+ parents are estimated to be raising 4% of all adopted children in the U.S..
- Patients who have ever used infertility services are 10 times more likely to have adopted than those who have never used infertility services (Jones 2009).
- The rates of intercountry adoptions have decreased in the last 2 decades, and countries participating continue to change.
- The Hague Convention on Protection of Children was introduced in 1993 as an international treaty providing safeguards to protect the best interests of children, birth parents, and adoptive parents involved in intercountry adoptions.

PROGRAM OVERVIEW

PROGRAM OBJECTIVES

At the conclusion of the program, you should be able to:

- List key elements of pregnancy options and informed consent counseling
- Consider benefits of providing services in a primary care vs. specialty setting
- Describe management options for early pregnancy loss
- Describe the steps involved or provide early medication abortion care
- Describe the steps involved or provide uterine aspiration for abortion or early pregnancy loss
- Describe the management of complications related to early pregnancy loss, medication abortion, and uterine aspiration
- Provide patient-centered contraceptive counseling and management

TRAINING SUMMARY

Training will vary depending on the setting. We encourage use in professional training programs, clinics, or individual practice in the U.S. or abroad. When this curriculum is reviewed as part of hands-on clinical training, each trainee should:

- Meet with faculty for orientation and values exploration around pregnancy options
- Follow patient(s) through visits from counseling to recovery
- Review best practices and participate in person-centered reproductive counseling
- Review routine aftercare and follow-up including for those referred out
- Discuss cases involving routine care and rare complications
- Learn the contraceptive options, contraindications, side effects, initiation and removal
- Participate in counseling, evaluation, and management of early pregnancy loss

Those participating in abortion training will also:

- Review steps to evaluate and counsel patients for medication abortion
- Handle procedural instruments using the “no touch” technique
- Observe and perform first-trimester uterine aspiration procedures
- Perform tissue examinations to identify pregnancy elements accurately

LENGTH OF TRAINING

- We encourage evaluation focused on core competencies for individual learners rather than a specific number of procedures or sessions. Length of training can change depending on gestational age of pregnancy, procedural numbers obtained per learning session, and individual factors.

ADVANCED TRAINING OPPORTUNITIES

Those interested in gaining more in-depth skills and knowledge may also want to complete additional learning opportunities highlighted in the chart on the next page, as well as additional clinical sessions to gain further exposure to medication and aspiration abortion, complication management, and complex cases. Read Chapter 9 on Abortion Provision for more information on additional training, advocacy, and leadership opportunities.

TRAINING PLAN

NAME: _____

Date	Activity	Basic	Additional
1. ABORTION IN PERSPECTIVE			
	Discuss Chapter 1 and suggested videos		
	Clarify training goals		
	Discuss reproductive justice lens, professional ethics, and abortion in both global and U.S. perspective		
	Discuss policies and safety issues		
	Follow patient(s) through an abortion or early pregnancy loss visit		
	Discuss Chapter 1 Exercises including Values Clarification		
2. COUNSELING & INFORMED CONSENT			
	Discuss Chapter 2 and suggested videos		
	Observe or role play pregnancy options and abortion counseling		
	Discuss Chapter 2 Counseling and Consent Exercises		
	Textbook Chapter 5 & 16 (Paul): Informed Consent and Counseling and Answering Questions about Long-term Outcomes		
3. PRE-ABORTION EVALUATION			
	Discuss Chapter 3 and suggested videos		
	Review pregnancy testing and dating methods		
	Review medical history pertinent to abortion eligibility		
	Observe and perform early pregnancy ultrasound examinations		
	Perform pelvic examinations for uterine sizing and position		
	Discuss diagnosis of viable, non-viable and ectopic pregnancy		
	Discuss Chapter 3 Pre-Abortion Evaluation Exercises		
	Textbook Chapter 6 & 7 (Paul)– Clinical Assessment and Ultrasound in Early Pregnancy and Medical Evaluation		
4. MEDICATION ABORTION			
	Discuss Chapter 4 and suggested videos		
	Discuss various medication abortion regimens and access issues		
	Review counseling, patient information, and patient selection		
	Provide regimen and patient information		
	Review follow-up to assess completion of abortion		
	Discuss Chapter 4 Medication Abortion Exercises		
5. PAIN MANAGEMENT & OTHER MEDICATIONS			
	Discuss Chapter 5 and suggested videos		
	Review medications including antibiotics, & pain medications used for oral and IV sedation, patient selection, and monitoring		
	Review agents and methods used for cervical anesthesia		
	Administer effective cervical anesthesia		
	Discuss Chapter 5 Pain Management & Medications Exercises		
	Textbook Chapter 8 (Paul) – Pain Management		

Note: SHADING indicates optional activities depending on training goals.

Date	Activity	Basic	Advanced
6. UTERINE ASPIRATION PROCEDURE			
	Discuss Chapter 6 and suggested videos		
	Observe procedure, review use of equipment and instruments with faculty, and practice “no touch” technique		
	Perform accurate tissue examinations		
	Review strategies for minimizing and managing complications		
	Discuss Chapter 6 Uterine Aspiration Exercises		
	Perform MVA to competency		
	Perform EVA to competency		
	Textbook Chapters 10, 13, & 15 (Paul) – First Trimester Aspiration, The Challenging Abortion, & Surgical Complications		
7. CONTRACEPTION & ABORTION AFTERCARE			
	Discuss Chapter 7 and suggested videos		
	Review and practice patient-centered contraceptive counseling		
	Review tools for providing evidence-based contraception and determining medical eligibility		
	Perform IUD and contraceptive implant placement		
	Review aftercare instructions and precautions		
	Observe recovery room procedures		
	Discuss Chapter 7 Contraception and Aftercare Exercises		
8. MANAGEMENT OF EARLY PREGNANCY LOSS			
	Discuss Chapter 8 and suggested videos		
	Review counseling for Early Pregnancy Loss		
	Discuss management options for Early Pregnancy Loss		
	Discuss Chapter 8 Early Pregnancy Loss Exercises		
9. BECOMING A PROVIDER, ADVOCATE, AND LEADER			
	Discuss Chapter 9 and suggested videos		
	Complete Textbook supplemental readings to deepen knowledge		
	Discuss trainee aspirations and pertinent additional opportunities		
	Discuss Chapter 9 Exercises on Becoming a Provider		
10. BECOMING A TRAINER (Available online only)			
	Review Content, suggested videos, and exercises		
11. PRACTICE INTEGRATION (Available online only)			
	Review Content, suggested videos, and exercises		
12. EVALUATION (Available online only)			
	Review Skills Assessment with faculty		
	Complete Training Program Evaluation		
Note: SHADING indicates optional activities depending on training goals			

PARTIAL PARTICIPATION OR OPT-OUT CURRICULUM

This curriculum is designed to help trainees achieve their individualized learning objectives in reproductive health care. Not everyone will go on to provide abortion care, although it is important that all primary care providers become familiar with services their patients seek to help manage their follow-up care. Benefits commonly reported by partial participants who opt out of abortion training include improved counseling skills, gynecologic procedural exposure, and reflection on individual values (Steinauer 2014).

Professional organizations such as the AAFP, ACOG, ACNM, and NONPF recommend trainees receive exposure to many core skills covered in this curriculum, including:

- Evaluation of pregnancy dating and pregnancy risk
- Pregnancy options and contraceptive counseling
- Management of uncomplicated spontaneous abortion
- IUD and contraceptive implant counseling, placement, and removal
- First trimester uterine aspiration (considered advanced training by professional organizations of Family Physicians, Ob/Gyns, Nurse Midwives, Women’s Health Nurse Practitioners).

After initial orientation and values clarification, trainees benefit from discussing options with their faculty to arrive at a balanced appraisal of appropriate training content.

The alternative or opt out curriculum recommendation below is for partial participants to cover the foundation of values clarification, options counseling, contraception, follow-up care, complication management, and early pregnancy loss, with additional material as desired.

SUGGESTED EXERCISES FOR PARTIAL PARTICIPATION OR OPT OUT

Date	Chapter / Activity	Reading / Exercises	Initials
	1. ABORTION IN PERSPECTIVE	All / All	
	2. COUNSELING & INFORMED CONSENT	All / All	
	3. PRE-ABORTION EVALUATION	All / All	
	4. MEDICATION ABORTION	All / 4.3 (1-3)	
	5. PAIN MANAGEMENT & OTHER MEDICATION		
	6. UTERINE ASPIRATION PROCEDURE		
	7. CONTRACEPTION & ABORTION AFTERCARE	All / All	
	8. MANAGEMENT OF EARLY PREGNANCY LOSS	All / All	
	9. BECOMING A PROVIDER, ADVOCATE, & LEADER		

Note: Shading indicates optional activities depending on training goals.

CHAPTER 1 EXERCISES: ORIENTATION: ABORTION IN PERSPECTIVE

EXERCISE 1: Feelings about providing abortions

1. As you embark on this experience, consider how you might disclose this training to others. Are there parallels between the stigma that patients and providers experience?
2. Consider this quotation on the role of conscience in abortion provision, and not just the historical focus on the refusal to participate. What are your thoughts on how this view might decrease stigma?

"[Providers] continue to offer abortion care because deeply held, core ethical beliefs compel them to do so. They see women's reproductive autonomy as the linchpin of full personhood and self-determination, or they believe that women themselves best understand the life contexts in which childbearing decisions are made... among other reasons" (Harris 2012, "Recognizing Conscience in Abortion Provision," NEJM).

3. As you embark on this experience, consider the different backgrounds and identities of patients, yourself, and your trainer(s). Are there practices that can equalize power differentials and have information and feedback flow in both directions?

EXERCISE 2: Practice environment

1. Reflect on some pros/cons patients might experience receiving abortion services in a primary care setting compared to a specialty setting.
2. How would a one-week delay impact a patient's care in your setting? Consider impacts of mandatory waiting periods, or changes to legislation in your area.

EXERCISE 3: General feelings about pregnancy options

Adapted from *The Abortion Option: A Values Clarification Guide for Health Care Professionals*. (NAF 2005)

Despite our efforts to be objective, we all hold personal values and belief systems that can influence how we respond to patients. These exercises can help you explore your values about pregnancy options in the context of professional judgments you may be called to make. In multiple global settings, participants in abortion values clarification workshops demonstrate improved knowledge, attitudes, and behavioral intentions with regards to abortion care (Turner 2018). Some of these exercises may evoke strong emotions which may require time for individual reflection prior to discussion. In general, how do you feel about your patients choosing abortion, adoption, or parenting in each of these situations? Are you challenged to accept a patient's decision in the following circumstances?

EXERCISE 3.1: In general, how do you feel about your patients choosing abortion, adoption, or parenting in each of these situations? Are you challenged to accept a patient's decision in the following circumstances? Were you surprised by any of your reactions? How have your life experiences contributed to these feelings? For a full set of Values Clarification Questions see A Values Clarification Guide for Health Care Professionals (NAF 2005)

- If the pregnancy threatens their physical health or life
- If the pregnancy involves a fetal abnormality (minor vs. incompatible with life)
- If the patient has an active substance use disorder
- If the patient is in a surrogacy contract
- If you, as the provider, are pregnant

EXERCISE 3.2: Your feelings about gestational age and abortion

1. At what gestational age do you start feeling uncomfortable about your patient choosing to have an abortion?

2. Does it matter if you are making a referral vs. performing an abortion? Or the reason for the abortion? If so, why?

EXERCISE 3.3: Your feelings about patients' reasons or situation

1. How would you feel about referring or providing an abortion for a patient who:
 - a. is ambivalent about the pregnancy but whose partner wants them to terminate
 - b. wishes to obtain an abortion because they are carrying a female fetus
 - c. has had a number of previous abortions
 - d. indicates that they do not want any birth control method to use in the future
 - e. conceived using assisted reproductive technology, but changed their mind
 - f. is in a surrogacy contract and decided to end it
 - g. tried unsuccessfully to end their pregnancy on their own before seeing you
2. How might you handle your discomfort when caring for patients under these circumstances?

CHAPTER 1 TEACHING POINTS: ABORTION IN PERSPECTIVE

EXERCISE 1: Feelings about training and abortion provision

Purpose: This exercise will help clarify your feelings about training and abortion provision.

1. As you embark on this experience, consider how you might disclose this training to others. Are there parallels between the stigma that patients and providers experience?

- As you explore your level of involvement with options counseling and abortion care, consider if and / or how you will disclose this to family, friends, or acquaintances.
- A “prevalence paradox” is a phenomenon affecting patients and providers alike ([Harris 2013](#)). The less something is talked about, the more stigmatized and rare it seems, when in fact it is very common. Silence creates a vicious cycle that often distorts the true nature of things. Research supports that having a safe space to discuss the stigma around abortion may alleviate burdens on providers ([Debbink 2016](#)).
- Utilize faculty support to discuss whether you experience a sense of burden or stigma.

2. Consider the following quotation on the role of conscience in abortion provision, and not just the historical focus on the refusal to participate. What are your thoughts on how this view might decrease stigma?

“[Providers] continue to offer abortion care because deeply held, core ethical beliefs compel them to do so. They see women’s reproductive autonomy as the linchpin of full personhood and self-determination, or they believe that women themselves best understand the life contexts in which childbearing decisions are made, among other reasons.” ([Harris 2012](#))

- It is important to recognize the conscience in abortion provision and not just in the refusal to participate. The goal of this exercise is to assess how provision can address stigma and impact clinical practice, law, religion, and bioethics.
- Some learners find it helpful to hear about other providers’ path to abortion care. See [Physicians for Reproductive Health, Clinicians in Abortion Care](#), or [Ho 2019](#).

3. As you embark on this experience, consider the different backgrounds and identities of patients, yourself, and your trainer(s). Are there practices that can equalize power differentials and have information and feedback flow in both directions?

Keep in mind the following questions:

- How can we frame questions with patients that center their preferences and acknowledge them as experts in their own lives?
- How can we promote dialogue that fosters inquiry, collaboration, and mutual feedback between faculty and trainees?
- How can we create safe spaces in which issues of power are addressed in more transparent ways?

EXERCISE 2: Practice environment

1. Reflect on the pros/cons of patients receiving abortion care in a primary care setting compared to a specialty setting.

- Studies evaluating abortion setting preferences have varied, but many patients prefer primary care environment for abortion care ([Amico 2018](#), [Logsdon 2012](#)).
- Some potential advantages of receiving abortion care in a primary care setting:

- Personalized care with a provider they know and trust
- Continuity of care
- Decreased stigma and normalized abortion in health care context
- Not having to travel or face protesters
- Attention to preventive care integrated into abortion care (i.e. pap test)
- Demonstrated safety in primary care environments
- Potential disadvantages of receiving abortion care in a primary care setting:
 - There may be less privacy in a smaller community
 - There may be more consequence of judgment
 - There may be more memory of an abortion during ongoing care
 - The staff or provider may be less specifically trained for every situation
 - Possibly more need to refer out for complex issues
- While most primary care providers (PCPs) believe PCPs have an obligation to provide abortion referrals, only one in four in a national sample reported routine options counseling compared to 60% who routinely discuss prenatal care (Holt 2017), highlighting a need for professional guidelines and training.

2. How would a one-week delay impact a patient’s abortion care? Consider impacts of mandatory waiting periods, or changes to legislation in your area.

- A one-week delay in abortion care might:
 - Put a patient over the gestational limit for a provider or type of abortion
 - Change the cost or travel needs for an abortion
 - Increase complication risk with additional delays (NASEM 2018).
 - Force a patient to be pregnant longer than they want to be

EXERCISE 3.1: General feelings about pregnancy options

Values exploration exercises can be challenging, satisfying, and thought provoking. Consider the origin of your beliefs. How do your feelings affect the interactions you have with a patient? How could recognizing these feelings have a positive impact upon patient care? How do you anticipate your feelings could change with this training experience? For Full Questions see A Values Clarification Guide for Health Care Professionals. NAF 2005.

1. In general, how do you feel about your patients choosing abortion, adoption, or parenthood in each of these situations? Are you challenged to accept a patient’s decision in the following circumstances? Were you surprised by any of your reactions? How have your life experiences contributed to your feelings?

Consider the following key points:

- There are no right or wrong answers to this exercise.
- Patients have the right to make decisions for themselves, follow their own moral authority, and to receive legally available medical services supporting these decisions.
- You serve patients best by providing active listening and accurate information. Even subtle negative reactions to patient behavior may harm the provider-patient relationship.
- Each of us is shaped by our life experiences, families, communities, class, ethnicity, religious beliefs, and other factors that may affect our judgments.
- Self-exploration helps us promote a non-judgmental climate for patient care.
- We cannot know the best decision for each patient.
- Family planning recommendations by providers are found to vary by patient ethnicity and socioeconomic status, contributing to healthcare disparities (Dehlendorf 2010).

- Family planning decisions are well served by a shared decision-making approach that integrates the patient's priorities with the best scientific evidence.
- If you feel uncertainty about one of these scenarios, consider what patient situation would change your view.

EXERCISE 3.2: Your feelings about gestational age and abortion

1. At what gestational age do you start feeling uncomfortable about your patient choosing to have an abortion?

- Consider what happens between the gestational age that feels acceptable and the one that doesn't.
- Does your response have to do with your understanding of fetal development, concerns about fetal pain, physical risk to the patient, what it feels like doing the procedure as a provider, or other perceived ethical concerns?
- When (if ever) you first saw a gestational sac or fetal parts, how did you feel about it? Were there any factors that influenced how you felt?

2. Does it matter if you are making a referral vs. performing an abortion? Or the reason for the abortion? If so, why?

- If you are struggling with the idea of making referrals, consider if the situation differs from other medical circumstances where we value accurate, evidence-based information and patient autonomy.
- Are there ways to respect the moral autonomy of the patient, without undermining your own?
- What if no other alternative abortion services were accessible? What kind of patient hardship would motivate you to offer services?
- Each provider is different and needs to find their own comfort level.

EXERCISE 3.3: Your feelings about patient's reasons or situation

1. How would you feel about referring or providing an abortion for a patient who:

a. Is ambivalent about having an abortion but whose partner wants them to terminate the pregnancy

- While this decision is important for both partners, the pregnant person not only has the legal right to the decision but will bear the ultimate responsibility for whatever decision they make; including the risks of pregnancy and childbearing, should they choose to continue.

b. Wishes to obtain an abortion because they are carrying a female fetus

- Sex selection brings up complicated ethical and cultural issues. It might be helpful to ask if there are medical or cultural reasons that support their preference (i.e. sex-linked genetic conditions or family pressure to have a male child). Discussing these with the patient may help you better understand their position.

c. Has had a number of previous abortions

- Over half (54%) of patients obtaining abortions used a contraceptive method during the month they became pregnant ([Jones 2018](#)). Patients have multiple abortions for many reasons. Discussion may help you better understand their personal barriers to avoiding undesired pregnancy. However, it is important to remember that patients are not responsible for making you comfortable with their decision.

- Patient-centered counseling may help them find a method that meets their needs and preferences. However, many patients prefer not to engage in contraceptive counseling while navigating an unexpected pregnancy.

d. Indicates that they do not want any birth control method to use in the future

- Remember that many patients will not desire contraceptive counseling at the time of an abortion (Brandi 2018). And patients often wish to avoid sex after abortion. Remind the patient that their choice to be sexually active and their choice to become pregnant are two separate considerations. Considering contraception doesn't mean they intend to or will have sex sometime soon. Alternatively recommend they return if their situation changes.

e. Conceived using assisted reproductive technology, but changed their mind

- Think about why your feelings about abortion might differ in a pregnancy conceived by assisted reproductive technologies (ARTs). Are there ways to respect the moral autonomy of the patient, without undermining your own?
- Patients facing infertility may pursue ART but may still face pregnancy indecision in the face of changing relationships, stressors, or pregnancy abnormalities (Daar 2015).

f. Is in a surrogacy contract and decided to end it

- Surrogacy is a method used for treating patients with infertility caused by uterine factors, and by LGBTQIA+ individuals. Most surrogacy arrangements are successfully implemented and most surrogate mothers are well-motivated, psychologically balanced, and have little difficulty separating from children born (Söderström-Anttila 2016).
- The criteria which influence surrogacy relationships are the expectations of both parties, the type of exchange involved in surrogacy arrangements, the frequency and character of contact pre- and post-birth, and cultural, legal, and economic contexts (Payne 2020)
- Consider if your feelings about abortion differ in a pregnancy conceived for the purposes of surrogacy, and which party in the surrogacy relationship you identify with.

g. Tried unsuccessfully to end their pregnancy on their own before seeing you.

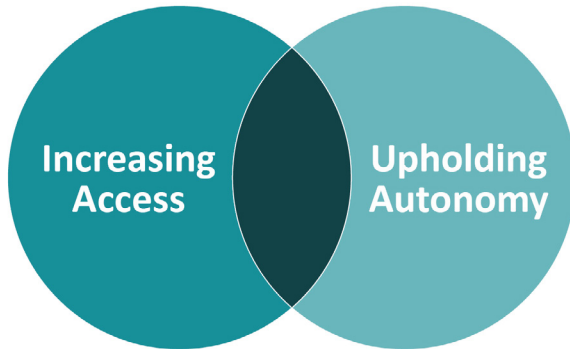
- Self-managed abortions are criminalized in some countries and U.S. states and people can face prosecution.
- No blood tests confirm whether a patient took abortion medications, although misoprostol used vaginally may sometimes be detected on exam, should ER care be needed.
- No states require providers to report suspected self-managed abortion.

2. How might you handle your discomfort when caring for patients under these circumstances?

- Many providers avoid asking patients the reasons for an abortion, which allows for patient autonomy. Are there ways to respect the moral autonomy of the patient, without undermining your own?
- Recognizing personal discomfort with a situation is also an important step towards providing unbiased care. Remember there may be more to the situation than the patient communicates directly.
- Sometimes referral is the best option for a patient. Sometimes talking with colleagues may be helpful. Consider how best to provide appropriate support for the patient.

2. COUNSELING AND INFORMED CONSENT

Updated June 2022 by Monica Agarwal, MD, Sheila Attaie, DO, Anna Sliwowska, MD



This chapter is inspired/informed by the reproductive justice movement and centers the desires and autonomy of communities that have been historically marginalized to provide guidance for person-centered counseling and care. It will include issues related to identifying and addressing bias, and the use of person-centered counseling to uphold a person's autonomy when faced with pregnancy decisions. The chapter will also touch upon care of people across the gender spectrum and provide exam, counseling, and procedure techniques that respect and support people who have experienced reproductive coercion and/or sexual trauma.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

- Give pregnancy test results in a neutral, supportive manner.
- Counsel by focusing on outcomes consistent with patients' needs and preferences.
- Help patients navigate indecision by centering respect, dignity, and bodily autonomy.
- Provide information on the spectrum of abortion care including medication, aspiration, telemedicine, and self-sourced medication abortion.
- Help patients navigate barriers to receiving abortion care (e.g., lack of financial resources, childcare, transportation, social support).
- Use language that is mindful, sensitive and unassuming - which supports patients through the reaffirmation of their choices during counseling and/or procedures

VIDEOS

- [Informed Consent, Decision Assessment, and Counseling in Abortion Care](#) (IERH)
- [Counseling for Pregnancy Ambivalence](#) (IERH)

RESOURCES:

- Perrucci, A. "Your Patient Has the Answer"
- Perrucci A. [Decision Assessment and Counseling in Abortion Care: Philosophy and Practice](#). Lanham, Maryland: Rowman and Littlefield, 2012.
- The Doula Project. [DIY Doula: Self-Care for Before, During, and After your Abortion](#).
- Reproductive Health Access Project. [Sam's Medication Abortion](#)
- Options Counseling Resources:
 - [Ferre Institute Pregnancy Options Workbook](#)
 - [All-Options' Pregnancy Options Workshop](#)
 - [RHAP Pregnancy Options Counseling Model](#)
- Paul et al (eds). [Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care](#) (Wiley-Blackwell, 2009)
 - Chapter 5: Informed Consent, Counseling, and Patient Preparation
 - Chapter 16: Answering Questions About Long-Term Outcomes

SUMMARY POINTS

SKILLS

- Support each person's decision-making process by eliciting and being responsive to their unique needs and preferences.
- Be aware of assumptions you make about a person's personal situation, communities, and feelings.
- Explore how bias may show up in our work, and review strategies for self-reflection.
- Be mindful of tone, terminology, and body language (for example, sit at a patient's eye level to communicate an equal power dynamic when culturally appropriate).
- Ask a person for their name, pronouns, and their preferred anatomical terminology; ensure staff are aware of preferences and that they are reflected in patient records.
- Use open-ended questions and nonjudgmental listening. Allow time for a patient to think, talk further, and ask additional questions.
- Know when and how to provide more time to allow patient time to think or consult with people they trust.

SAFETY

- Address each patient's individual preferences for pain management, avoiding assumptions about pain tolerance.
- Screen for coercion, intimate partner violence, and human trafficking, providing local resources as appropriate.
- When submitting mandated reporting, consider risk of criminalization to patients, providers, and anyone involved in abortion care in your state. To date, there is no mandated reporting state law to report an abortion and doing so could be a HIPAA violation.

ROLE

- Support people in choosing pregnancy options consistent with their needs, values, and preferences. Know when and how to refer for services beyond what you can provide.
- Confirm that the desired outcome of the pregnancy is determined freely and without coercion.
- Provide the opportunity for each patient to be seen alone, and the option to involve a support person when feasible and requested.
- Direct your attention to the patient and include them in any conversations while in the procedure room.

ADDRESSING PERSONAL AND SYSTEMIC BIAS

Adapted from UCSF Bixby Beyond the Pill CME Course # MMC20087

INTRODUCTION

There are several structural and interpersonal factors that impact the reproductive and sexual health and well-being of communities. Bias has been shown to be a contributing factor to racial health disparities and outcomes with childbirth, pain management, contraception, and pregnancy options (Saluja 2021, Hirsh 2015). Bias refers to attitudes or stereotypes that affect our understanding, actions, and decisions. These biases can be unconscious or conscious and may not necessarily align with our declared beliefs (Marcelin 2019, Zestcott 2016, Blair 2011). It is easier to see biases in others than ourselves.

Both unconscious and conscious biases can result in discrimination and health disparities, especially in communities subject to structural violence and systems of oppression such as racism. Some important historical examples include the widespread stereotype that “poor people are unable to care for children and so should limit their family size.” This bias has fueled forced sterilization, incentivized use of long-acting reversible contraception (LARC), coverage of LARC placement but not removal, and lack of insurance coverage of infertility services among people living with low-incomes or that have been subject to multiple interlocking systems of oppression (Guttmacher 2014). In studies using standardized videos, providers have demonstrated biases about who should use intrauterine contraception based only on patient race/ethnicity and socioeconomic status (Dehlendorf 2010).

REFLECTION, IMPLICIT AND SYSTEMIC BIAS

In order to minimize the harm that biases can have on the care we provide, we must bring awareness to their influence on our care. To begin to incorporate self-reflection, consider some of the following questions:

- To what privileged groups (i.e. educated, heterosexual, citizenship) and what marginalized groups (i.e. low-economic status, immigrant) do you belong?
- Do you find yourself wanting people in specific groups to make certain contraceptive or pregnancy decisions?

Some best practices that help providers and institutions:

- Avoid making assumptions, as they often reflect cultural stereotypes and bias.
- Listen more than you speak; people are the experts in their own lives.
- Practice cultural humility rather than impose your values and beliefs on your patients.
- Cultivate partnerships with local reproductive justice and social advocacy groups.
- Commit to lifelong self-evaluation and self-critique (Waters 2013).
- Racism is not just a problem requiring an individual intervention, but a structural and organizational problem that will require much work to change. Invest in diversity, equity and inclusion efforts within your institutions. as well as efforts to reverse structural aspects of racism within your communities (Green 2020, BMMA 2020).



Additional Resources:

- [Diversity Toolkit: A Guide to Discussing Identity, Power and Privilege \(USC\)](#)

PREGNANCY OPTIONS COUNSELING TECHNIQUES

Adapted from: [Perrucci A. Options Counseling 2012](#)

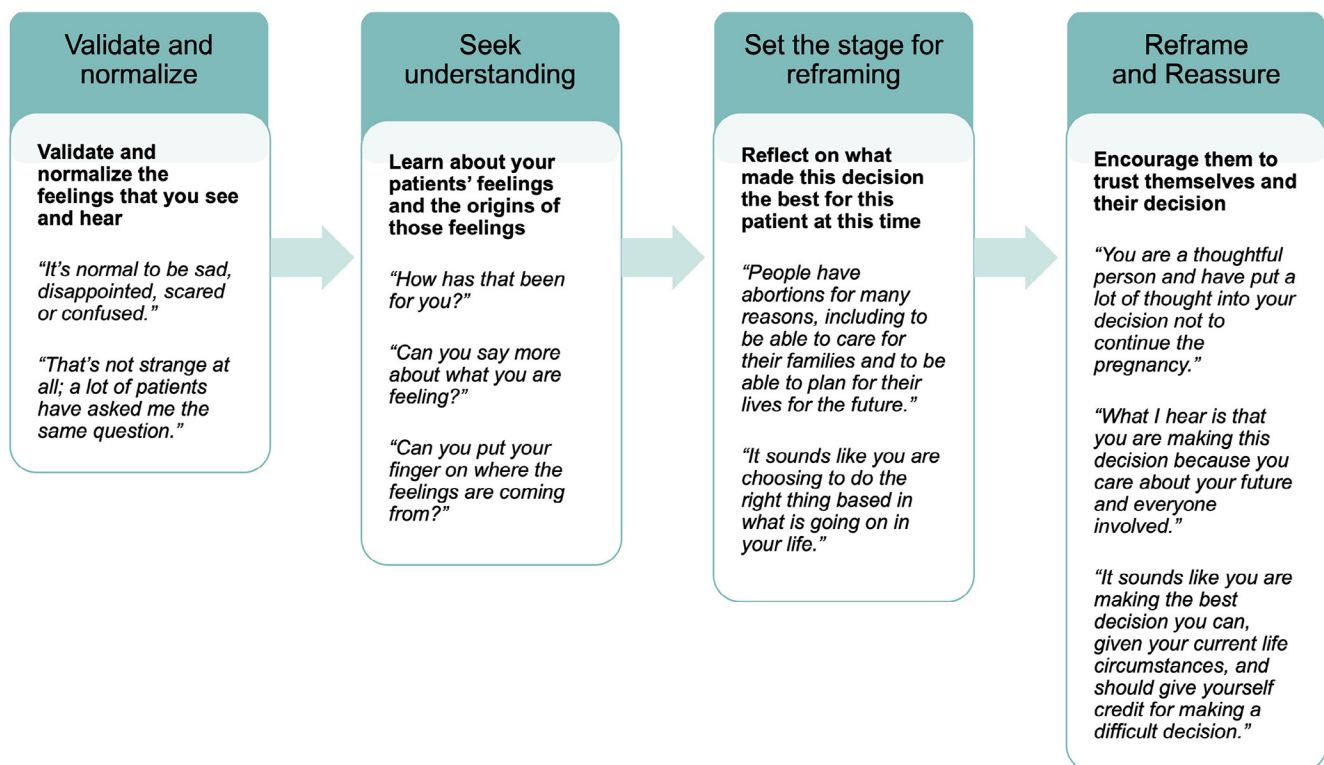
When providing pregnancy test results, it is important to hold space for the range of reactions a person may have. Some people will be surprised while others will have taken a test at home and are seeking confirmation. Some may feel a spectrum of emotion, including sadness, happiness, guilt, or conflict. Others may feel no emotion related to their pregnancy. It is also important to avoid assuming that an abortion itself will be a sad experience, even if a patient shows sadness. Some people may be sad about their life circumstances leading to them having an abortion, and ultimately feel relief ([Rocca 2015](#)). In fact, relief is the most common emotion one week and five years post-abortion, and the overwhelming majority continue to feel it was the right decision for them ([Rocca 2020](#)).

Our role when providing options counseling is to listen and provide appropriate decision support about the pregnancy, as needed ([Perucci 2012](#)). When providing positive results:

- Be explicit: “Your pregnancy test came back positive, which means you are pregnant.”
- Allow some time for the patient to process the information.
- Use open-ended questions to start, such as “How do you feel about this result?”
- Avoid assuming how a patient will react to the result.

Although we may use language like “choice” or “decision,” a person’s pregnancy outcome may not be experienced as a choice at all, but the only mechanism of upholding dignity, bodily autonomy, or safety. For some the decision to have an abortion is also clear. They won’t need options counseling; we can help them with planning the next steps.

The following framework may assist in your counseling conversation ([Perucci 2012](#)).



HELPFUL CONSIDERATIONS FOR PATIENTS WHO ARE UNDECIDED

For patients who are less sure, provide basic information including when they need to decide in order to have a medication or aspiration abortion, ask questions in a non-directive manner, and provide reassurance. These conversations can take time, so providers and staff may have to be creative on how to manage this within the constraints of a busy clinic.

In counseling, consider the following statements:

- *Some people feel conflicting emotions, and that is completely normal.*
- *What aspects of this are challenging for you?*
- *On a scale of 1 to 10, 1 being sure that continuing the pregnancy is the best decision, and 10 being that abortion is the best decision, where are you now?*
- *I recognize that you are trying to make the best decision for you and your family, given the circumstances.*
- *You are in charge of this decision. Nothing happens today, unless you want it to.*
- *Sometimes neither decision feels good, and that's okay.*

Another exercise for people who are unsure regarding their pregnancy is to invite them to imagine their life, now and in a few years, and how it might be different depending on the outcome of this pregnancy. “What is your picture of the next year or five years of your life? How would each outcome change, affect, or support your goals?”

	Continuing Pregnancy	Ending Pregnancy
Pros:		
Short term		
Long term		
Cons:		
Short term		
Long term		

WORKING THROUGH RELIGIOUS, SPIRITUAL, OR MORAL CONFLICT

People of all religious and spiritual backgrounds have abortion and you do not need any background in these matters to talk to people about abortion. You truly cannot know the answer to the person's dilemma; instead, explore what this conflict means for them. People may experience moral conflict around abortion for multiple reasons. Some may feel that life begins at conception and that abortion is an act of murder. Others may feel that higher power(s), elders, or others important in their community may not forgive them for their abortion. The counseling framework discussed above can be helpful to explore the person's beliefs and options for spiritual reconciliation and healing. It may also be beneficial to suggest readings including online faith-based resources below, texts, discussions with their own clergy and/or a supportive religious group, or other counseling referrals.

Additional resources:

- [Catholics for Choice](#)
- [Religious Coalition for Reproductive Choice](#)
- [Faith Aloud](#)
- Maguire, DC. Sacred Choices: A Right to Contraception & Abortion in 10 World Religions. Minneapolis, Fortress Press, 2001

COUNSELING QUICK GUIDE

TRY TO	
Ask open-ended questions	<i>"What questions do you have for me?"</i>
Clarify the facts	<i>"Knowing how far along you are will let you know how much time you have to decide."</i>
Reflect/Normalize	<i>"Many people feel... "I hear that is difficult for you." "It is okay to cry here."</i>
Seek to understand	<i>"Can you tell me more about that?"</i>
Validate, don't fix	<i>"That sounds really challenging. I'm sorry you're feeling..."</i>
Frame the situation	<i>"It sounds like you are being thoughtful and making the best possible decision for yourself." "Deciding what's best for you can be hard - but that doesn't make it wrong."</i>
Reassure the patient	<i>"I trust and respect your feelings. You are the best person to make decisions for you and your family"</i>
Check in about support people	<i>"It may be helpful to tell someone you trust and who will support your decision, no matter what it is. Do you have someone like that to talk to?" If not, "What might happen if your partner/family/friend found out about the abortion?"</i>
Communicate acceptance with tone and body language	Be mindful of your tone, facial expression, and body language. Use eye contact (if culturally appropriate). Sit at their level.
Use silence	Give them time to finish their sentences and thoughts.
Give the patient control; keep them informed about next steps	<i>"Which would you prefer?" "You are in control. Let me know when you're ready to proceed."</i>
Address common fears Pain Impact on Health	<i>"Tell me more about your fears or worries."</i> Review options for pain control and relaxation. Review safety and lack of impact on fertility, mental and overall health.
Consider language and literacy level	Always use interpreting services when needed. Approach counseling using culturally appropriate language and exercises based on literacy level.

WORDS MATTER	AVOID	USE INSTEAD
Over-identification	<i>I know exactly how you feel</i>	<i>Many patients feel that way</i>
Medical or stigmatizing jargon	<i>Elective abortion It's your choice Are you planning to have a medical abortion or surgery?</i>	<i>Abortion (or mirror the patient's terminology) I support whatever decision you make about this pregnancy. Are you planning to have a medication abortion (with pills) or in-clinic abortion?</i>
Loaded statements	<i>Your family supports your decision, right?</i>	<i>Who can support you through this, without judgment?</i>

EARLY ABORTION OPTIONS

Adapted from, 2014 RHAP/RHEDI, and Management of Unintended and Abnormal Pregnancy

	Medication Abortion with Mife/Miso	Aspiration Abortion
Quick Summary for Patient	<p><i>“Both work very well, are safe, and do not change your chances of having a safe and healthy pregnancy in the future if that is something that you’d want.”</i></p> <p><i>“You take one pill first, then take 4 different pills later which will cause cramping and bleeding. The pregnancy will usually pass within a few hours. Different people experience this method differently; we can give you some pain pills to help with any discomfort you might feel”</i></p>	<p><i>“This is a 5-10 minute procedure in the office where we empty the contents of the uterus. There are several options for reducing procedure-related pain that I can review with you”</i></p>
Gestational Age	Up to 11 weeks in most U.S. practices Beyond 11 weeks in some countries	Aspiration to 14-16 weeks Dilation and Evacuation beyond 14-16 weeks
Advantages	<ul style="list-style-type: none"> Patient has control over where the abortion takes place Avoids procedure 96-98% of the time More support options possible May be perceived as more natural, like a miscarriage Options for personalizing the experience 	<ul style="list-style-type: none"> Procedure takes 5 -10 minutes Usually less post-procedure bleeding Options for mild, moderate or deep sedation Able to leave the office visit not pregnant Medical and nursing staff are there to support with patient No routine follow up needed
Disadvantages	<ul style="list-style-type: none"> Process takes 1-2 days (sometimes longer) May experience heavier and longer bleeding and cramping Less control over the time during which bleeding and cramping occurs May see fetal tissue May require follow up 	<ul style="list-style-type: none"> Requires in-person clinical setting Risks of instrumentation Risks of sedation/anesthesia, if used Will need a driver if using anesthesia May be fewer options for personal support person(s) during procedure Suction machine may be audible
Protocol	Take medication at home/private space or clinic	Procedure in office or hospital
Effectiveness	<ul style="list-style-type: none"> < 63 days, 95-99% (see ch 4 table page 71) 64-77 days, with 2nd miso dose 99.6% 71-77 days, with 2nd miso dose 97.6% If fails, will need repeat dosing or aspiration 	<ul style="list-style-type: none"> Over 99% If fails, will need repeat aspiration
Duration	One to several days to complete	One visit (with the exception of mandatory waiting periods); 5-10 minute procedure
Pain	Mild to strong cramps after taking the 2nd misoprostol, lasting a few hours or days	Mild to strong cramps during and just after the procedure
Bleeding	<ul style="list-style-type: none"> Possible heavier bleeding with clots Bleeding, possibly with small clots, can persist on and off for 1-2 weeks or more 	<ul style="list-style-type: none"> Heaviest bleeding during procedure Light bleeding can persist for 1-2 weeks or more; may also pass clots during this time
Pain management	Oral pain medication	<ul style="list-style-type: none"> Options include: Oral pain medication Local anesthesia Moderate or deep sedation (may require travel or more \$)
Safety	<ul style="list-style-type: none"> Used safely for > 25 years At least 10-fold safer than continuing a pregnancy to term 	<ul style="list-style-type: none"> Used safely for > 45 years At least 10-fold safer than continuing a pregnancy to term

A person-centered approach to discussing medication versus aspiration abortion includes discussing timing of completion, amount of bleeding, instrumentation, and need for privacy/discretion. These may impact external factors like childcare, work/school schedule, housing situation and are important in determining the best option for their abortion.

CONFIDENTIALITY AND INFORMED CONSENT

Patient information should be confidential and only shared with people directly involved in the person's care, if they give permission to do so, or by exception, such as to comply with:

- Health department laws about required infectious disease reporting
- Mandated reporting of suspected child abuse
- Mandated reporting of domestic violence
- A formal subpoena
- Insurance company (if patient consents to submitting claim)

Disclosure of information under any other circumstance is a breach of confidentiality (Paul 2009). For those submitting insurance claims, consider that the claim could be made visible or mailed to the home of other members on the insurance plan. Medications mailed to the home may jeopardize confidentiality.

It is important when submitting mandated reporting to consider risk of criminalization to patients, providers, and anyone involved in abortion care in your state. To date, there is no mandated reporting state law or policy to report an abortion to law enforcement and doing so could be a HIPAA violation.

Voluntary and informed consent must be obtained. Use appropriate translation services for comprehension, privacy, and true informed consent. Consider a patient-centered approach for consent to trainee involvement in counseling and abortion care. If State-Mandated Counseling is legally required, and includes scientifically inaccurate information, the patient should be informed of the factual discrepancies.

MAKING REFERRALS

All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a person's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities (ACOG 2007).

Referral begins by providing information to your patient if they need services beyond what you can provide in your clinic. It is important to regularly vet referral resources for quality control (consider making "mystery shopper" calls to referral sites). While referral practices and motivations varied, one national study showed few clinicians facilitate referral for abortion beyond verbally naming a clinic if an abortion referral was made at all (Homaifar 2017).

In areas where access is limited, patients may face multiple obstacles to obtaining an abortion, and good care coordination is critical to ensure that people receive the services they need. Taking a more active role in referrals can help clear up misperceptions or misinformation about the legality and safety of abortion, and can assist with complex social or medical circumstances (Zurek 2015).

Important steps to fully assist the patient may include:

- Scheduling an appointment
- Helping access supportive services such as funding (i.e. abortionfunds.org), travel support (i.e. brigidalliance.org), childcare, insurance coverage, or interpreter services.
- Following up on the patient's satisfaction and outcomes with the care received
- Following up with patients that were referred out

In addition to referrals for services you don't offer, making a referral may also involve:

- A pregnancy options talk line for people who are ambivalent or are needing more support after an abortion (e.g. [All Options Talkline](https://alloptions.org))
- Prenatal care or adoption facilitators (open and closed adoption)
- Intimate partner violence specialists
- Human trafficking specialists
- Referral for a judicial bypass for a minor
- Sexual abuse care
- Mental health services
- Substance use services
- Post-abortion counseling referrals
- Social support services

CONSIDERATIONS FOR PERSON-CENTERED CARE

CHALLENGING ASSUMPTIONS ABOUT SEXUAL ORIENTATION

While it is good practice to elicit sexual orientation for SOGI (sexual orientation and gender identity) data collection purposes, people of all sexual orientation experience pregnancy, and sexual orientation does not always match sexual behavior and practice. Providers should avoid assumptions about sexual orientation or sexual practices, provide the same approach to pregnancy counseling to all people regardless of sexual orientation, and offer contraceptive and sexual health services that are relevant to the person's sexual practices.

GENDER IDENTITY AND PREGNANCY

Everyone has a gender identity—an internal understanding of their gender—and thus, people across the gender spectrum may require sexual, reproductive, and pregnancy-related care. “Cisgender” is used to describe someone whose gender identity aligns with their sex assigned at birth. “Transgender” or “trans” is an umbrella term for people whose gender identity does not correspond to the sex assigned at birth or with the expectations associated with that sex ([Transgender Law Center 2011](https://www.transgenderlawcenter.org)). Trans and gender diverse (TGD) people are clinically underserved, and face barriers to routine health care and transition-related care such as a lack of insurance coverage and mistreatment by health care providers ([James 2016](https://www.james.org)).

TGD people with ovaries and a uterus can experience pregnancy if they engage in sex with a partner who produces sperm, even after social and/or hormonal transition. Menstruation is an unreliable marker for fertility. Testosterone may be used for masculinization in TGD patients and may lead to amenorrhea but should not be considered contraception as there can be breakthrough ovulation resulting in pregnancy. ([Light 2018](https://www.light.org), [Light 2014](https://www.light.org)). All hormonal and non-hormonal contraceptive options may be safely used by TGD patients and do not interact with testosterone.

In order to provide gender-affirming, person-centered care, providers should create a space that is welcoming, use inclusive language, that consider the potential physical and emotional trauma specific to this population when performing physician exams (Bonnington 2020). TGD people attempt abortion without clinical supervision at higher rates, highlighting the importance of reducing barriers by implementing gender-inclusive care and the need for providers to be trained on support after self-managed abortion (Moseson 2022). Note that a person's name and gender identity may not be accurately reflected on their identification, medical record, or insurance documents. Avoid making assumptions about anatomy and identity, and practice trauma-informed care, considering high rates of negative and traumatizing experiences with accessing gynecological and general health care. Also consider that many clinics are still gendered spaces that may not be comfortable or acceptable to patients, and making changes to clinic decor, clinic name, and paperwork can help create a gender-inclusive space.

- [Pre Pregnancy Counseling for People of All Genders](#)
- [Euki App](#)
- [Sam's MAB Zine](#)
- [Transgender Law Center. "10 Tips for Working with Transgender Patients"](#)
- [Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People](#), UCSF Center of Excellence for Transgender Health
- [Human Rights Campaign- Glossary of Terms](#)
- [WPATH: Standard of Care](#)
- [Transline](#)
- See ["Contraceptive Care across the Gender Spectrum"](#) on page 132

COUNSELING FOR PEOPLE WHO USE SUBSTANCES

Substance Use Disorder (SUD) is a treatable, chronic illness. However, people with SUD face profound stigma, barriers to care, and even criminalization when interfacing with the medical industrial complex. Understanding this stigmatization and numerous injustices people who use substances face can help us understand how people choose to engage with the healthcare system, as we know people with SUD have higher rates of unintended pregnancy, sexually transmitted diseases, infertility, and mortality related to pregnancy; and lower rates of contraceptive use (Zwick 2020).

Clinicians can help reduce these health disparities by supporting people who use substances. Reproductive care should be provided alongside comprehensive preventative, harm reduction, and primary care services. This does not include urine toxicology, which is not medically indicated before providing contraceptive or abortion care, does not diagnose acute intoxication or a use disorder, and is an expensive test with false-positive and negative results which can have serious consequences (Kale 2021). It is also important to note that SUD, in itself, does not impair one's ability to make medical decisions. Any person who can understand the risks and benefits of a procedure is able to consent. Counseling should also include that chronic substance use can cause oligo or amenorrhea so pregnancy may occur even when periods are infrequent (Flannagan 2020). For people with SUD who want to conceive, trauma-informed care and medication for addiction treatment should be considered to support people in having safe and healthy pregnancies.

Additional resources:

- [California Bridge Program](#)
- [Substance Abuse and Mental Health Services Administration](#)
- [Substance Use Disorder and Family Planning Care Webinar](#)
- See ["CONSIDERATIONS FOR PEOPLE WHO USE OPIOIDS"](#) on page 94

COUNSELING FOR PEOPLE WITH DISABILITIES

A disability can be defined as a long-term physical, mental, intellectual, or sensory condition which substantially impairs a person's full participation in society on an equal basis with others (United Nations 2014). Approximately 15% of people worldwide and 25% in the U.S. are living with some kind of disability, of whom <5% experience significant difficulties in functioning (WHO 2020, CDC 2020; note differences likely represent reporting issues).

People with disabilities have similar sexual and reproductive health needs as the general population however, they are less likely to receive contraception counseling, sexually transmitted disease testing, cervical and breast cancer screening, and prenatal care (Taouk 2018). People with disabilities are at higher risk of sexual coercion, assault, and of contracting HIV. They face significant barriers in access including lack of provider training, provider bias, harmful stereotypes (e.g. that they are not sexually active or are unable to get pregnant), and inaccessibility in health care facilities and equipment (Taouk 2018).

People with disabilities are active health care participants and have medical decision making capacity unless a severe cognitive impairment is present. In those cases, it may be appropriate to facilitate supportive decision making, which is an alternative to guardianship allowing people to choose someone they trust to assist with making decisions regarding specific topics (NDRN 2019).

Many guardians will request contraception or even permanent sterilization for people with cognitive impairment, either for hygiene purposes or to avoid pregnancy. In cases of mild to moderate cognitive impairment providers should request the person be seen without their guardian to best assess their personal wishes. Permanent sterilization of people with severe cognitive impairment is always an ethical dilemma and providers should seek guidance from an experienced ethics committee when faced with such requests (ACOG 2016).

Clinician recommendations:

- Assume intellectual and medical capacity. Do not mistake speech impairment for intellectual impairment; motor disorders alone can hinder articulation.
- For adolescents/young adults with mild to moderate cognitive impairment, conduct sexual health screening questions without the parent/guardian present if possible.
- Advocate for inclusive facilities and equipment in waiting and exam rooms for people using wheelchairs or other mobility equipment, and for those who have larger bodies. Plan ahead and move things to accommodate.
- Consider purchasing at least one mechanical exam table with adjustable height and padded leg rests (not foot rests).
- Ask each individual how they want to be assisted in transferring and/or positioning on the exam table.
- Allocate extra time for visits so that the person's needs can be met.

EARLY PREGNANCY LOSS

If a pregnancy loss or threatened pregnancy loss is diagnosed, be sure that the person understands the diagnosis, implications, and various management options. Reassure them that most pregnancy loss is caused because the pregnancy was not developing correctly, not because of something they might have done, thought, or wished for. Do not assume how the person will feel. Some people feel relief, others sadness or guilt, and others may have concerns about their health or fertility. People may also feel a number of emotions simultaneously.

See "[Counseling Tips for Early Pregnancy Loss](#)" on page 150

MULTIPLE PREGNANCIES

Multiple pregnancies currently make up approximately 2-3% of all pregnancies but occur at higher rates with assisted reproductive technologies and increasing maternal age. Miscarriage and complication rates are higher among multiple pregnancies. It is common to discover previously unrecognized multiple gestations during the ultrasound evaluation. Some patients may want to know if they have a multiple pregnancy, others may not. Anecdotally, this information may occasionally change a person's decision in either direction. Unless local law requires viewing or describing ultrasound findings, routinely ask each patient, prior to the ultrasound examination, if they would want to know about multiple gestations, so you can honor their wishes. Selective reduction may be an option in some settings.

CONTRACEPTION COUNSELING IN THE SETTING OF ABORTION CARE

It can be helpful to offer contraceptive counseling while remaining aware that some people prefer not to discuss contraception at the time of abortion ([Matulich 2014](#), [Kavanaugh 2011](#)). Patients from historically marginalized communities may feel coerced to use contraception in abortion settings ([Brandt 2018](#)), making it particularly important to give enough time to think about choices. Advanced notice of method availability has been shown to be acceptable, and provides abortion patients more time and knowledge for decision-making ([Roe 2018](#)). Those who do desire contraceptive counseling report wanting to hear about methods that are easier to use and more effective than previous methods and want to leave the clinic with a method ([Matulich 2014](#)). See “[Evidence-Based Contraceptive Guidance](#)” on page 129.

REPRODUCTIVE COERCION

Reproductive coercion (RC) is common. Internationally, nearly 20% of respondents in family planning clinics reported previous pregnancy coercion and 15% reported birth control sabotage by a partner ([Grace 2016](#), [Silverman 2014](#)). RC may include explicit attempts to pressure a partner to have sex without a contraceptive method, either explicit or covert interference with contraceptive methods, or attempts to control outcomes of a pregnancy. RC can come from intimate partners, family members, clinicians, or community members. These actions limit a person's reproductive autonomy and compromise their ability to make decisions around contraception, pregnancy, and abortion. While many clinical settings have integrated intimate partner violence screening tools, it may be challenging to identify subtle acts of power and control in relationships.

In addition to asking generally about your patient's support people, you might ask them if anyone has tampered with or prevented their contraceptive use or is pressuring them to make a decision about this pregnancy. Offer support and resources if they are being coerced.

SEXUAL TRAUMA

It is not uncommon to encounter patients who have experienced sexual trauma such as sexual abuse, rape, incest, or human trafficking ([National Center for PTSD](#)). These individuals may have had little control over the abusive situation and may feel especially vulnerable and powerless.

Some groups are particularly at risk of sexual trauma. Transgender individuals as well as those with disabilities are 2-3 times more likely to be raped ([Office of Justice Programs 2014](#), [Basile 2016](#)). In addition, victims of human trafficking are often forced or tricked into working in dangerous conditions or having sex with others against their will. Trafficking occurs in every country. It is estimated that 80% of trafficking victims are people capable of pregnancy, over 50% are children, and 40% are within the person's country of origin ([NCADV 2014](#)). Many victims of

sex trafficking do not recognize that they are the victims of trafficking and may simply believe they are in a bad situation, relationship, or job, and are often at high risk of unplanned pregnancy (Lederer 2014). It is important to screen for sex trafficking and have a planned response to assist.

If a patient discloses they have been raped, consider supporting them by suggesting:

- *“This isn’t your fault. No one ever deserves for this to happen to them.”*
- *“I’m so sorry that happened to you.”*
- *“Thank you for telling me; you’re brave to do that.”*
- *“I want you to know that you are safe here.”*

If any patient is interested in reporting a sexual assault, access the [sexual assault service providers](#) most familiar with your local reporting laws and counseling. Consider developing and instituting forensic policies and procedures.

SELF-SOURCED MEDICATION ABORTION

Self-sourced medication abortion (SSMA) refers to the act of obtaining abortion pills outside of the clinical setting for the purpose of ending a pregnancy (e.g. from online sources or available over the counter in some countries). This is sometimes referred to as self-managed abortion (SMA), though self-managed abortion includes any method of self-managing, such as herbs, medications, substances by mouth or vagina, and deep abdominal massage.

Self-sourced medication abortion is known to occur in countries worldwide irrespective of the legal climate surrounding abortion (Moseson 2019). Reported reasons include perceived greater bodily autonomy, distrust of medical providers and/or institutions, social stigma, cost, distance or lack of access to abortion care, and legal restrictions. For some it is preferred while for others, it is their only option. While self-managed abortion is not new, medication abortion and therefore self-sourced medication is becoming more common, and studies show that it is simple, safe, and effective (Jones 2019, Moseson 2022 and Moseson 2021).

Additional Resources:

- [DecidoY](#)
- [How to Use the Abortion Pill](#)
- [Miscarriage and Abortion Hotline](#)
- [Ipas](#)
- [Médecins Sans Frontières](#)
- [Plan C](#)
- [SASS](#)
- [Women on the Web](#)
- [WHO Abortion Care Guidelines](#)

RESPONDING TO CHALLENGING PATIENT QUESTIONS

It can be challenging to respond to complex patient questions. Here we will review some of the most common questions that arise. General guidelines are that you:

- Avoid assumptions
- Provide accurate information
- Remain sensitive to both verbal and non-verbal expressions of emotion
- Validate the person’s feelings
- Mirror the patient’s language (for example, if the person uses the term “procedure” for abortion, use the term “procedure”)
- Ask clarifying questions to assess person’s specific question

“What do you do with the pregnancy after the abortion?”

Examples of provider responses:

“A lot of people ask about that.”

- *“I examine the pregnancy tissue to make sure that you are no longer pregnant.”* There is value to mirroring the patient’s language here. For example, if they used the term “baby”, you can mirror that language respectfully.
- If there are follow up questions you can say the pregnancy tissue is handled like tissue from any medical procedure. Sites have different policies for handling tissue based on local, state, and hospital policies.

“Can I see it?”

Many providers start by normalizing this desire, and showing the patient the pregnancy tissue. Many providers show it to the patient after clearing blood and decidual tissue, in a small open container. If asked what they can expect to see, consider describing what the tissue looks like at that stage, so they can make an informed choice about seeing it.

“Will this hurt the baby?”

Evidence regarding the capacity for fetal pain indicates that fetal perception of pain is unlikely before the third trimester (Lee 2005). For people having a first-trimester abortion procedure, explaining the facts may alleviate this concern. For example, *“No, this will not hurt the baby. At this point in the pregnancy, the fetal nervous system is not developed enough to feel pain.”*

POST-PROCEDURE SUPPORT

After the procedure, you can reassure the patient that the procedure went smoothly and that they are no longer pregnant. Let them know that the cramps they are feeling are a sign that the uterus is healthy and returning to its non-pregnant size. Reassure them that emotions arising with abortion are normal, that you are there with them, and the staff will also be available to them. Most clients do not regret their decision to have an abortion, but it can be difficult to deal with any lack of support, stigma or isolation the person may experience. They can be offered a follow-up visit if desired or helpful though it is not routinely indicated (Grossman 2004).

Additional ideas:

- Many patients respond well to encouragements of artistic expression, through writing, visual art, or music.
- If desired, patients can read/hear the stories of others or share their stories through [shoutyouraboriton](#) or [we testify](#)
- Consider providing a journal in the clinic where patients can share their thoughts or art. Keep in mind people may share content that could be difficult or disturbing to others.
- All patients can be offered post-abortion support through:
 - All Options (1-888-493-0092; <https://www.all-options.org/>)
 - Exhale (1-866-4 EXHALE, www.exhaleprovoice.org/)
 - Faith Aloud (1-888-717-5010; <http://www.faithaloud.org/>)
 - Connect and Breathe (1-866-647-1764; <http://www.connectandbreathe.org>)

CHAPTER 2 EXERCISES: COUNSELING AND INFORMED CONSENT

EXERCISE 2.1: Pregnancy options counseling and screening

Purpose: The following exercise is designed to review pregnancy options counseling. Consider role-playing the following scenarios.

1. One of your patients presents with an unexpected positive pregnancy test during clinic or in the ED. How would you approach this?
2. When you ask a patient what questions they have, they want to know if an abortion will affect their ability to have children in the future. How would you respond?
3. A patient is leaning toward adoption but is trying to decide, and wants to know more about the process and options. How would you respond?
4. While you are explaining the protocol for a medication abortion to a patient, they mention that their boyfriend “absolutely cannot find out about this pregnancy.” What concerns does this raise and how can you explore the situation further? What assurances can you give them, what support may you want to offer them?
5. You receive a phone call from a man who would like to schedule a medication abortion for himself. What questions should you ask during intake and counseling?
6. You have a 19-year old patient who has been to the clinic for several abortions in the past. Their first abortion was when they were was 14. They are always accompanied by an older male relative. You are concerned they may be the victim of sex trafficking. What questions might you ask? What should you do if you find out they are the victim of trafficking?

EXERCISE 2.2: Counseling around clinical care

Purpose: Discuss what you might do or what you might say to the person in each of the following situations in the context of a uterine aspiration for abortion or early pregnancy loss..

1. As you enter the exam room you hear the patient's partner criticizing them for "acting stupid" and telling them angrily to "just shut up." The partner is looking at the wall and ignores your efforts to introduce yourself.
2. When you come into the room and ask the patient how they are feeling, the patient starts crying uncontrollably. They have their head turned away from you and do not make eye contact.
3. The patient is a 14-year-old rape survivor who is 7 weeks pregnant. Every time you attempt to insert the speculum, they raise their hips off the table.
4. You are about to see a 22-year-old G0 patient with a mild motor and cognitive disability. They arrive in the clinic in a wheelchair with a parent. During intake, the parent states that they would like to discuss birth control that will assist them with periods.
5. You have just completed an aspiration for a patient at 8 weeks gestation. The patient asks, "*Can I see what it looks like?*" How would you respond? How would your response differ at 12 weeks gestation?

CHAPTER 2 TEACHING POINTS: COUNSELING AND INFORMED CONSENT

EXERCISE 2.1: Pregnancy options counseling and screening

Purpose: The following exercise is designed to review pregnancy options counseling. Consider using role-play in the following scenarios.

1. One of your patients presents with an unexpected positive pregnancy test during clinic or in the ED. How would you approach this?

- If a pregnancy test is being discussed or requested in advance, some providers will ask patients what result they hoped for. Once you have given the result, wait for the patient to respond. If it's not clear how they're feeling, or what they want to do, you can ask open-ended questions:
 - *"How do you feel about this result?"*
 - *"What do you know about your options?"*
 - *"What would it be like for you to continue a pregnancy/have an abortion at this time?"*
- Explain that because symptoms can be vague, a pregnancy test may be suggested for pregnancy capable people; obtain consent. Explain the result was positive, meaning they are pregnant. Ask if they had at all suspected that they might be pregnant.
- Your role is to listen, support, and ask questions. A patient may clarify one way or the other, and may not need (or appreciate) full options counseling.
- If they need time, ask if they'd like to explore more with you, whether now or at another visit, or if they'd rather discuss it with a trusted person. Consider giving them space to imagine their life now and a few years from now, and to reflect on how each outcome might change those circumstances. For a more comprehensive exploration of thoughts, feelings, dreams and goals, offer them the [Pregnancy Options Workbook](#).
- Video Resource: [Decision Counseling for the Positive Pregnancy Test](#) (IERH).

2. When you ask a patient what questions they have, they want to know if an abortion will affect their ability to have children in the future. How would you respond?

- Uncomplicated uterine aspiration and medication abortion has been shown to have no effect on a person's future reproductive health, including the ability to get pregnant or have a healthy pregnancy. There is no increased risk of infertility, spontaneous abortion, or pre-term delivery.
- Available data suggest that multiple abortions pose little or no increased risk compared to a single procedure.
- You might say *"There is a lot of misinformation out there about this issue, so I want to reassure you and be very clear — abortion is extremely safe and will not affect your ability to get pregnant in the future if and when you want to."*

3. A patient is leaning toward adoption, but is trying to decide, and wants to know more about the process and options. How would you respond?

- Giving birth and raising a child are two different things. It is important to consider what both would be like for you
- A birth parent can think of adoption as a way to select parents for the baby, as opposed to giving the baby to adoptive parents.
- Birth parents may feel sadness about relinquishing a child, even if they feel it is the best decision for them. Feeling sad does not mean that the decision is wrong.
- Introduce differences between open and closed adoptions, and give resources and [local/national referrals](#) as appropriate. See [“Adoption Facts at A Glance 1”](#) on page 12.

4. While you are explaining the protocol for a medication abortion to a patient, they mention that their boyfriend “absolutely cannot find out about this.” What concerns does this raise and how can you explore this further?

- Use open-ended questions to explore the relationship dynamics, as there may be reproductive coercion or intimate partner violence occurring.
- *“Tell me a little more about your relationship, and how your partner might feel about the pregnancy.”*
- Validate and normalize the patient’s feelings about the situation and remind the patient that you will support their decision no matter what.
- You can explore options for birth control that their partner would not know about or be able to control.
- If intimate partner violence is a concern, make a safety plan.
- Offer to refer the patient for further counseling around these issues if needed.

5. You receive a phone call from a man who would like to schedule a medical abortion for himself. What questions should you ask during counseling and intake?

- Transgender patients can experience desired and undesired pregnancy, even if amenorrheic from hormone use, and may need abortion services.
- Hormone therapy is not a contraindication to medication abortion. If a person decides to continue their pregnancy, they should connect with their prescribing provider to discuss any recommended changes in hormone therapy.
- Work to create a safe gender-affirming environment by asking about pronouns and preferred terms for specific parts of their body or their menstrual cycle. Make sure all staff and providers are aware of language to use.
- As with all patients, ask standard questions to accurately date the pregnancy and ensure that their decision is free of coercion.
- Ask, if relevant, whether they are interested in contraception. Counsel that people can ovulate on testosterone even if amenorrheic. TGD patients can safely use any form of birth control they might like. Some may want to avoid estrogens, due to the potential for either undesired feminizing side effects or increased VTE risk.

6. You have a 19-year old patient who has been to the clinic for several abortions in the past and their first abortion was when they were 14. They are always accompanied by an older male relative. You are concerned they may be the victim of sex trafficking. What questions might you ask? What should you do if you find out they are the victim of trafficking?

- Make sure to see all your patients privately for a few minutes at the beginning of each visit to assess for intimate partner violence and reproductive coercion.
- Ask about their relationship to the older man; look for cues that they might be deferring decision making to them.
- If they indicate (either through verbal or non-verbal cues) that they feel trapped in the relationship, ask about what might be keeping them—assess for fear of violence or other negative consequences of leaving.
- Ask about work: are they being forced to work, is payment ever withheld based on performance? Are they being coerced into sleeping with other people?
- If the answers to any of the above questions lead you to think they are a victim of human trafficking, explain what human trafficking is, that you think they may be in a situation where they are being trafficked. Offer support and access to confidential resources. If the victim is a minor, immediately call child protective services.

EXERCISE 2.2: Counseling around clinical care

Purpose: Discuss what you might do or what you might say to a person in each of the following situations when you come into the procedure room.

1. As you enter the exam room you hear the patient’s partner criticizing them for “acting stupid” and telling them angrily to “just shut up.” The partner is looking at the wall and ignores your efforts to introduce yourself.

It is essential to talk to the patient without the partner present. Explain that you routinely do an exam with the patient alone and have the partner go out to the waiting room.

- Ask the patient about the tension you observed and how they are feeling about the decision.
- A domestic violence screen is appropriate, and you should know the reporting laws for your state or country.

2. When you come into the exam room and ask the patient how they are feeling, they start crying uncontrollably. They have their head turned away from you and do not make eye contact.

- Crying can be normal. Check in with the patient about how they are feeling. *“It’s ok to cry and to have feelings. Is there any way I can help you now?”*
- The patient may be afraid, or experiencing sadness or loneliness, but could still be sure of their decision. Alternatively, they may be unsure, or feeling pressured and trapped.

- Make space for the patient to discuss their feelings while also not assuming that they do want to talk. You may add something like, *“We’re here to make sure that we’re providing the best care for you. Would it be helpful to talk about how you’re feeling about this decision today? Would you like to tell me more about what you’re experiencing?”*

3. The patient is a 14-year-old who has experienced sexual trauma and is 7 weeks pregnant. Every time you attempt to insert the speculum, they raise their hips off the table.

- Ask if the patient would like to continue with the aspiration procedure or if they would like to consider other options. Continue checking in with the patient about their decision to proceed.
- Offer, “I’m sorry this is uncomfortable. Would any of these options help? How would you feel about inserting the speculum yourself or raising the head of the exam table?”
- Offer to practice a Kegel, pushing their hips downward, or visualize softening or melting of muscles downward during the exam. Reinforce that they are in control of their own body, and give suggestions about what they can focus on to help keep the procedure safe.
- Consider asking for a staff person to provide dedicated support. Talking about other topics may help with comfort.
- Have the patient tell you when they are ready for each step of the procedure. For example, ask them to tell you when they are ready for the speculum insertion and when to advance the speculum beyond the introitus. Consider using a pediatric speculum.
- If the patient continues to have discomfort, consider topical lidocaine. If they are available at your location, consider anxiolytics, pain medication other than NSAIDs. Consider a referral out for deep sedation.
- Familiarize yourself with the mandated reporting laws in your state. Most states require reporting for any minor (<18 years old) who reports sexual abuse or if the partner is significantly older than the minor. For state laws: <http://aspe.hhs.gov/hsp/08/sr/statelaws/statelaws.shtml>.

4. You are about to see a 22-year-old G0 patient with a mild motor and cognitive disability. They arrive in the clinic in a wheelchair with a parent. During intake, the parent states that they would like to discuss birth control that will assist them with periods.

- Counseling on reproductive topics for adolescents and young adults with disabilities can be complex given possible medical comorbidities, intellectual disabilities that may raise concerns regarding consent, and the involvement of families or caregivers who may seek to support such decision-making (Ernst 2020). It is important not to assume that people with disabilities are not sexually active or do not wish to be.
- Assess intellectual competence. Do not mistake problems with speech for intellectual incapacity; this patient’s motor disorder may hinder articulation.
- If possible, conduct part of the interview alone to discuss sexual health screening questions, the patient’s own priorities, and comfort with a supportive decision-making role of the parent.

- Allocate extra time and consider special issues for the visit so that the patient's needs can be appropriately addressed.
- If an exam is needed, consider using a mechanical exam table with leg rests, and always ask the patient how they would like to be assisted in transferring, and discuss alternative positions for doing a gynecologic exam or procedure.
- For more in depth information on contraceptive counseling in patients' with disabilities, see [Ernst 2020](#), [ACOG 2016](#), this helpful video ([University of Michigan 2017](#)), and Chapter 7: "Contraceptive Counseling" on page 127.

5. You have just completed an aspiration (for abortion or early pregnancy loss) for a patient at 8-weeks gestation. The patient asks, "Can I see what it looks like?" How would your response differ at 12-weeks gestation?

- Normalize the request. While you do not need to know the reason for their request, it may be helpful to clarify what they are interested in and set expectations. Sometimes a patient is asking to see the tissue; sometimes they are interested in what you do with the tissue. You may say *"That's a common question. Tell me more about what you'd like to know."* Patients often have an inaccurate image of what an early pregnancy looks like and are reassured by what they see. Some may be curious, and some may want time to mourn or pray.
- Before 9 weeks it is difficult to visualize fetal parts. You can say, *"The pregnancy may look like a blood clot or a cotton ball."*
- For later gestations, consider asking tactfully what the patient expects to see. Alert the patient that the fetus may not be intact and that some recognizable parts will be visible, and confirm they still want to see.
- If you are asked about fetal tissue donation and a tissue donation program exists at your facility, let them know that it is entirely voluntary and in accordance with ethical and legal standards. Federal law requires a separate consent, that there be no patient payment or control over what the tissue is used for, and no changes to how or when the abortion is done in order to obtain the tissue.
- If the patient is still sedated after moderate or deep sedation, address the request after the patient's procedure is safely completed, they are alert, and in a private area.

3. PRE-ABORTION EVALUATION

*Updated June 2022 by Chelsea Faso MD, Mayra Hernandez Schulte, MD,
and Caitlin Weber, MD, MS*

This chapter will address history, physical exam, and testing prior to abortion to ensure that a patient is eligible and the chosen method is safe. The pre-abortion evaluation is focused on pregnancy dating and pertinent medical history. Pregnancy dating is usually done by asking a patient their last menstrual period (LMP). Depending on the setting, and if needed, this can be done with the addition of a bimanual exam or ultrasound (US). Although persons of childbearing age are typically healthy and eligible for outpatient abortion, this chapter will address when referral is preferred for safety.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

- Use clinical findings to confirm intrauterine pregnancy and accurately date pregnancy
- Gather appropriate historical, physical exam, and lab information as needed to safely perform uterine aspiration or medication abortion in an outpatient setting, and know when to consult/refer
- Determine when US is useful in confirming an intrauterine pregnancy, and when further assessment is needed to evaluate a possible ectopic pregnancy or pregnancy of unknown location (PUL).
- List clinical, lab, and sonographic findings that constitute red flags for ectopic pregnancy

VIDEOS

- [Speculum Care without Stirrups](#) (This is How I Teach Series: IERH)
- [Ultrasound Training Videos](#) (University of Washington)
- [Ultrasound Lecture Series: Obstetrics and Gynecology](#) (AUIM)

READINGS / RESOURCES

- [Paul et al \(eds\). Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care](#) (Wiley-Blackwell, 2009)
 - Chapter 6: Clinical Assessment and Ultrasound in Early Pregnancy
 - Chapter 7: Medical Evaluation and Management
- Hendricks, E, MacNaughton, H, Mackenzie, M. [First Trimester Bleeding: Evaluation and Management](#). Am Fam Physician. 2019 Feb 1;99(3):166-174.

SUMMARY POINTS

SKILL

- Accurate pregnancy dating is a key component of the pre-abortion evaluation.
- Using a patient's last menstrual period (LMP) is accurate, with low rates of both under- and over- estimation up to 8 weeks LMP (Kapp 2020, Ipas 2021, Macaulay 2019, Raymond 2015, Schonberg 2014). Asking additional questions may improve this accuracy (Ralph 2021). When pregnancy dating cannot be assessed using LMP, a series of questions and/ or ultrasound can be used (Ralph 2021).
- Providing medication abortion (MAB) using medical history alone has high rates of safety and efficacy up to 10-11 weeks LMP (Upadhyay 2022).
- US aids in pregnancy dating and the detection of abnormal pregnancy. It is important to recognize and understand management strategies for pregnancy of unknown location (PUL), including differentiation and management of potential ectopic pregnancy and early pregnancy loss.

SAFETY

- Patients with chronic medical conditions planning an abortion should be encouraged to continue their regular medications, with rare modifications, as needed.
- Pre-abortion evaluation may reveal conditions that determine a patient's eligibility for outpatient medication or aspiration abortion or indicate need for a higher level of care.
- If ectopic pregnancy is clinically suspected, diagnostic testing may include pelvic exam, serial serum hCG levels, transvaginal US, and / or diagnostic aspiration. A "normal" rise or fall in hCG levels alone is insufficient to exclude ectopic pregnancy.
- Increasing access by decreasing barriers to low risk medication abortion and abortion by vacuum aspiration is a critical way to increase safety.

ROLE

- Trusting that patients are the experts in their bodies and their pregnancies can improve provider confidence in eliminating unnecessary diagnostics prior to an abortion.
- Streamlining or avoiding unnecessary labs and visits can improve access and patient experience, without jeopardizing safety. This will be even more important in environments with legal restrictions or bans.

PREGNANCY CONFIRMATION AND DATING

PREGNANCY TESTS

- High sensitivity urine pregnancy test (HSPT):
 - Widely available, inexpensive urine tests available over the counter or in clinics
 - Simple, accurate qualitative test detecting hCG at concentrations of 20-25 mIU/mL.
 - Usually positive by cycle day 32-35 (95% of pregnancies)
 - May remain positive for 4 or more weeks following an uncomplicated abortion
 - May be used after 4 weeks to monitor for completion of a medication abortion
- Serum quantitative hCG test:
 - Available in clinics only with an order from a healthcare provider
 - Detects serum levels of hCG as low as 2-10 mIU/mL
 - Not used to determine EGA as range in level is wide & variable for any GA
 - Serial measurements often used to evaluate suspected ectopic, abortion completion (i.e. when products of conception are not visualized following aspiration), or in management of molar pregnancy
- Other hCG assays in limited availability and use in the United States:
 - Low sensitivity urine test (detects hCG of at least 1000-2000 mIU/mL)
 - Multi-level pregnancy test (MLPT; a urine test measuring hCG levels within specified ranges).

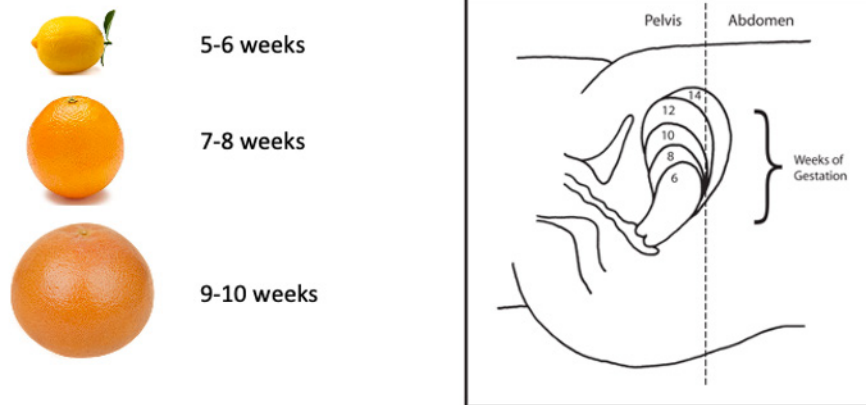
LAST MENSTRUAL PERIOD (LMP)

- Providers can confidently use clinical dating (LMP +/- exam) for most patients with known LMP to determine eligibility for abortion type and setting.
- First day of LMP alone (+/- 1 week of certainty) is an accurate means of estimating gestational age, with low rates of under- or over- estimation to 8 weeks LMP ([Kapp 2020](#), [Ipas 2021](#), [Macaulay 2019](#), [Raymond 2015](#), [Schonberg 2014](#)).
- In settings where US access is limited, LMP maintains high accuracy for abortions performed at or above 13 weeks ([Kapp 2020](#), [Ipas 2021](#), [WHO 2022](#)).
- Of note, while asking history of irregular periods and hormonal use may increase specificity of accurate dating, it also increases false negatives, resulting in unnecessary ultrasounds for patients that were in fact eligible for medication abortion ([Ralph 2021](#)).
- Using medical history alone including LMP dating for medication abortion has high rates of safety and efficacy up to 10-11 weeks LMP ([Upadhyay 2022](#)).
- If LMP is unknown, a series of questions (Are you >10 weeks pregnant? Have you missed >2 periods? Are you >2 months pregnant?) may be used to determine eligibility for medication abortion. ([Ralph 2021](#)).

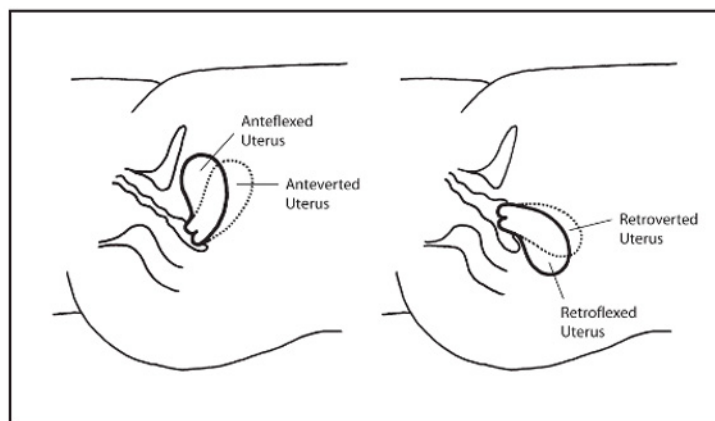
BIMANUAL EXAM

Bimanual exam may improve estimation of gestational age over LMP alone		
Dating by uterine size in centimeters	<ul style="list-style-type: none"> • After 4 weeks, uterus increases by approximately 1 cm per week • After 12 weeks, uterus rises out of pelvis • At 15-16 weeks, uterus reaches midpoint between symphysis and umbilicus • At 20 weeks, uterus reaches umbilicus • After 20 weeks, fundal height from symphysis in cm is approximately = weeks 	
Dating by uterine size in fruit comparisons	lemon medium orange grapefruit	5-6 weeks 7-8 weeks 9-10 weeks
Limitations of bimanual sizing: (Consider US guidance or additional management)	<ul style="list-style-type: none"> • Fibroids • Multiple gestations • Molar pregnancy • Uterine retroversion • Obesity • Abdominal scarring from cesarean section; associated with less uterine mobility 	

Uterus Size By Week (Margulies 2001)



Uterine Position and Flexion



MEDICAL EVALUATION PRIOR TO ASPIRATION

HISTORY AND PHYSICAL

- Review medical history, sexual and reproductive history, meds, substance use and allergies. A screening tool can ensure a thorough history is obtained ([Raymond 2020](#)).
- Review information for the following medical conditions ([Guiahi 2012](#)):
 - Cardiovascular (hypertension, valvular disease, arrhythmias)
 - Pulmonary (asthma, active respiratory infection)
 - Hematologic (bleeding and clotting disorders, anticoagulants, severe anemia)
 - Hemorrhage risk factors: See Chapter 5 [page 100](#): Managing Complications Table
 - Endocrine (diabetes, hyperthyroidism)
 - Renal and hepatic disease (affecting drug metabolism and clearance)
 - Neurologic (seizure disorder) or psychiatric (severe depression or anxiety)
- Abortion is an essential and urgent service. Minimize delays, especially in people with significant medical problems, as risk increases with advancing gestational age. Medical conditions warrant management or referral prior to abortion.
- Physical exam as indicated by history and patient symptoms
- Pelvic exam is not necessary for medication abortion with sure LMP ([WHO 2022](#)).
- Bimanual and speculum exam may be performed immediately prior to an aspiration.
 - Bimanual for uterine size / position (see Limitations in Table above)
 - Speculum exam can assess cervicitis warranting testing / treatment

LAB TESTS IF INDICATED

No routine pre-abortion lab testing is needed in patients without underlying conditions. Some labs are indicated by history, exam or dating. Lack of testing should not be a barrier to access.

- Tests pertinent to underlying conditions:
 - Glucose for patients with IDDM
 - INR for patients on certain anti-coagulants (Warfarin) > 12 weeks
- Rh(D) testing standards are evolving: < 12 weeks from LMP, may forego Rh testing and Rh-D IG for MAB ([NAF May 2022](#); [WHO 2022](#)) (See Ch 5 [page 87](#) Rh Isoimmunization)
 - May forego Rh testing if patient wants no future children or declines testing.
 - Document Rh status or informed waiver if declining Rh testing
 - If Rh negative, can use donor card, chart, patient report, or lab.
- Hemoglobin: If history / symptoms of anemia (fingerstick; not complete CBC).
- Chlamydia (CT) / Gonorrhea (GC): asymptomatic patients ≤ 25 or at increased risk (i.e. new or multiple sexual partners in last year). May refer for testing if not at your facility.
 - If cervicitis on exam, test (GC/CT), and treat empirically
 - Universal antibiotic prophylaxis is evidence-based for aspiration abortion ([Low 2012](#); [Achilles 2011](#)); unclear for EPL aspiration ([Lissauer 2019](#)). See Chap 5 “PROPHYLACTIC ANTIBIOTICS” on [page 89](#).

ULTRASOUND (US) OVERVIEW, METHODS, TIPS & IMAGES

US is not a requirement for medication abortion or uterine aspiration. US can be used when clinical dating is uncertain, to determine pregnancy location, and / or provide procedural support.

Whether to use transabdominal or transvaginal US depends on patient preference, equipment availability, gestational age, and sonographer skill. Transabdominal US may be used to confirm intrauterine pregnancy (IUP) and assess gestational age; it is often preferred by patients, although transvaginal US is often helpful with earlier pregnancies (Fu 2018).

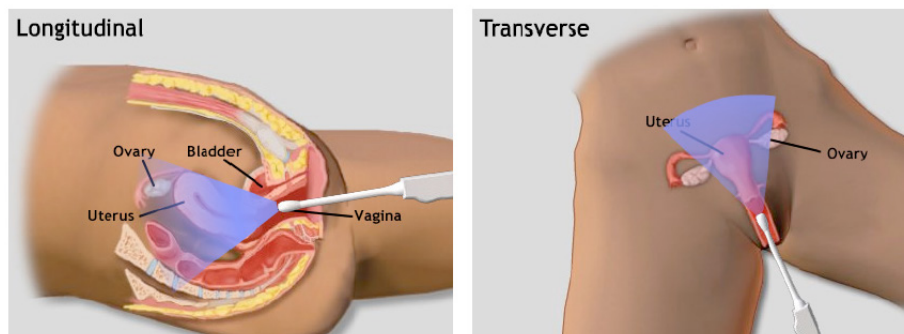
Transabdominal Probe	Transvaginal Probe
<ul style="list-style-type: none">• External probe• Easy to prepare and clean probe• Better view with full bladder• Difficult to detect pregnancy <6 weeks LMP• Good for later pregnancy scanning• Body habitus and bladder may affect image quality	<ul style="list-style-type: none">• Internal probe• Need to prepare and clean probe properly• Better view with empty bladder• May detect pregnancy as early as 4.5-5 weeks LMP• Can see early pregnancy landmarks• With probe close to pregnancy, body habitus does not affect images• Improved ability to perform systematic scan

A limited first trimester US exam must include: (NAF CPGs 2022)

- Uterine scan in both longitudinal and transverse planes to confirm IUP
- Evaluation of pregnancy number (singleton or multiple gestation)
- Measurements to document pregnancy dating
- Evaluation of pregnancy landmarks, such as yolk sac, embryonic pole, and the presence or absence of fetal/embryonic cardiac activity

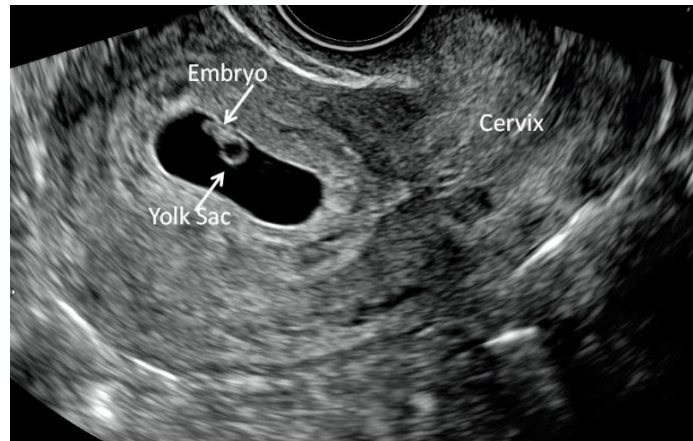
When Performing US

- Ask if the patient wants to view the image, and be informed of multiple gestations or other pregnancy findings.
- Inform the patient that US is being used only to confirm the location and dating of the pregnancy and is not a diagnostic US.
- Consider starting your scan with transabdominal US, and switching to vaginal US only if you are unable to effectively visualize the pregnancy.
- For vaginal US, use a non-latex probe cover, with US gel inside and lubricating jelly outside. Ask if the patient would prefer to self-insert the probe.
- Systematically scan in the longitudinal and transverse planes.
- Use clear and simple language to discuss the US findings with the patient.



TVUS planes (Image ARMS 2007)

- Longitudinal view is used to confirm pregnancy is intrauterine. For longitudinal view, marking is up (12 o'clock) and uterus is scanned side to side, from ovary to ovary. This view should show uterine fundus connected to cervix with pregnancy inside the uterus.



(Images AIUM Image Library: Obstetrics 2018)

- Transverse view is used for dating and pregnancy landmarks, to evaluate for multiple gestations, and to obtain a full 3D image of the uterus. For transverse view, the probe is turned 90 degrees to the patient's right (counterclockwise or notch turned to 9 o'clock) and uterus is scanned anterior to posterior, from fundus to cervix.

Clinicians should understand the sonographic pregnancy features that should be visible based on the patient's last menstrual period.

Pregnancy Landmarks by Weeks LMP	
Gestational Sac	4.5 – 5 weeks LMP
Yolk Sac	5.5 weeks LMP
Embryonic Pole	6 – 6.5 weeks LMP
Cardiac Activity	6 – 6.5 weeks LMP

*Above landmarks are better characterized using transvaginal US

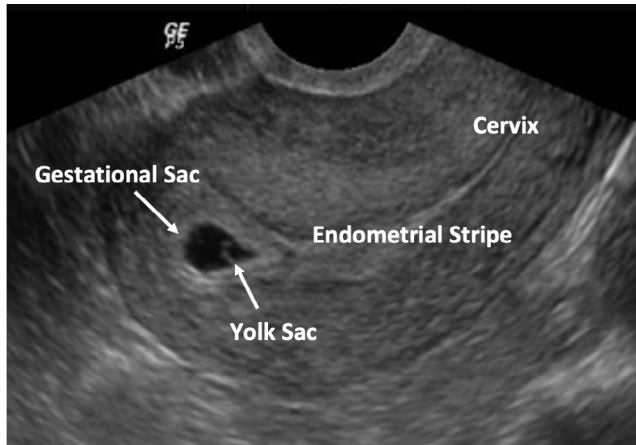
ULTRASOUND LANDMARKS IN EARLY PREGNANCY

The Gestational Sac

- Gestational Sac (GS) is the first evidence of pregnancy on US, as early as 4.5 weeks LMP; should always be seen by 5 weeks 5 days LMP by TVUS ([Barnhart 2012](#)).
- Although location of a pregnancy cannot definitely be diagnosed as intrauterine until a yolk sac or embryo is seen ([Richardson 2015](#)), a gestational sac still has a high likelihood of being an IUP even in the absence of certain sonographic features if there is no adnexal mass ([Phillips 2020](#), [Benson 2013](#)).
- A true gestational sac should be located in the mid to upper portion of uterus, be eccentric (not midline) to endometrial canal, be round or oval in shape, and have a double decidual (or double ring) sign, as demonstrated by the FEEDS mnemonic.

- Meeting these criteria does not completely exclude ectopic pregnancy (Fjerstad 2004)
 - **F** – Fundal (in mid to upper uterus)
 - **E** – Elliptical or round shape in 2 views
 - **E** – Eccentric to the endometrial stripe
 - **D** – Decidual reaction (surrounded by a thickened choriodecidual reaction; appears like fluffy white cloud or ring surrounding sac)
 - **S** – Size > 4 mm (soft criteria)

Gestational Sac vs. Pseudosac



Gestational Sac

Compared to the GS, the pseudosac is more irregular, central, smaller, and without a decidual reaction, and can be seen with an ectopic pregnancy. Note the “beak-shaped” appearance of the pseudosac. This can look similar to an early GS, although only may meet the F (fundal) criteria of FEEDS. Pseudosac may also appear as a mid-uterine small fluid collection.

Pseudosac (May be associated with ectopic) pregnancy)

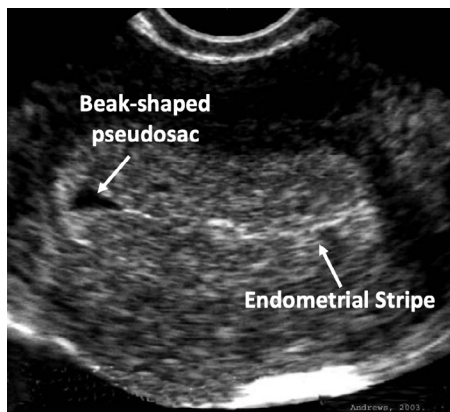


Image: Fjerstad M, et al. CAPS, 2004

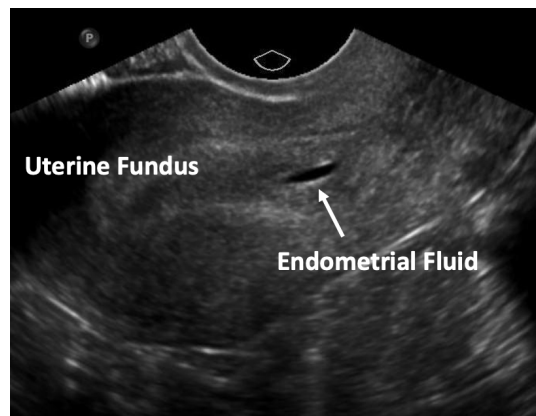


image: M.A. Morgan, Radiopaedia.org, rID: 34217

The Yolk Sac

The Yolk Sac (YS) is the first single US finding that confirms an IUP. The YS is a round echoic ring with anechoic (dark) center seen within GS. It appears typically at 5 1/2 weeks when the MSD is 5-10 mm. The YS should not be included when taking a measurement of the embryo. The size of the YS is not diagnostic.

The Embryo and Cardiac Activity

The embryo follows predictable development and therefore size can be used to date a pregnancy. The embryo appears at approximately 6 weeks and grows 1 mm per day until 12-14 weeks. See pregnancy dating below using embryonic and fetal measurement. Cardiac activity appears around 6 1/2 weeks.

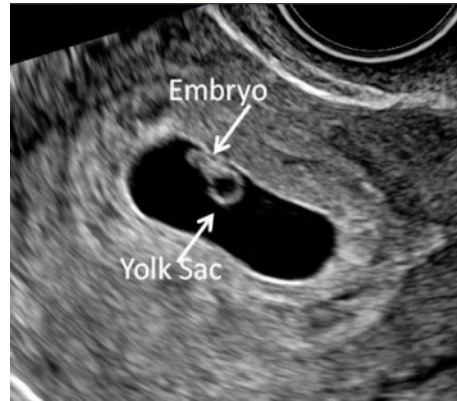


Image from AIUM 2018

Establishing Pregnancy Viability

The following data on viability evaluated patients who **desired to continue** their pregnancies (Doubilet 2013). If the patient does not desire to continue the pregnancy, there is no reason to delay an abortion to wait for confirmation of viability. If the patient **desires to continue** the pregnancy, and findings are suggestive of early pregnancy loss (see table below), repeat US in 7-10 days.

Guidelines for TVUS Diagnosis of Early Pregnancy Loss in a Patient with an IUP of Uncertain Viability (Adapted from Doubilet 2013, ACOG 2018)

US findings DIAGNOSTIC of EPL	US findings SUGGESTIVE of EPL
<ul style="list-style-type: none"> • CRL 7+mm and no cardiac activity • MSD 25+mm and no embryo • Absence of embryo with cardiac activity: <ul style="list-style-type: none"> ○ 2+ weeks after a scan that showed a gestational sac without a yolk sac ○ 11+ days after a scan that showed a gestational sac with a yolk sac 	<ul style="list-style-type: none"> • CRL 5-7mm and no cardiac activity • MSD 16-24mm and no embryo • MSD 13 mm or more and no YS • Absence of embryo with cardiac activity: <ul style="list-style-type: none"> ○ 7-13 days after a scan that showed a gestational sac without a yolk sac ○ 7-10 days after a scan that showed a gestational sac with a yolk sac • Absence of embryo 6+ weeks after LMP • Empty amnion (amnion seen adjacent to yolk sac with no visible embryo). • Enlarged yolk sac (>7mm) <ul style="list-style-type: none"> ○ Small gestational sac in relation to the size of the embryo (<5mm difference between MSD and CRL)

EARLY PREGNANCY DATING USING ULTRASOUND

Gestational Sac Measurement and Calculation of Gestational Age:

Mean sac diameter (MSD) is used for pregnancy dating before embryo is visible.

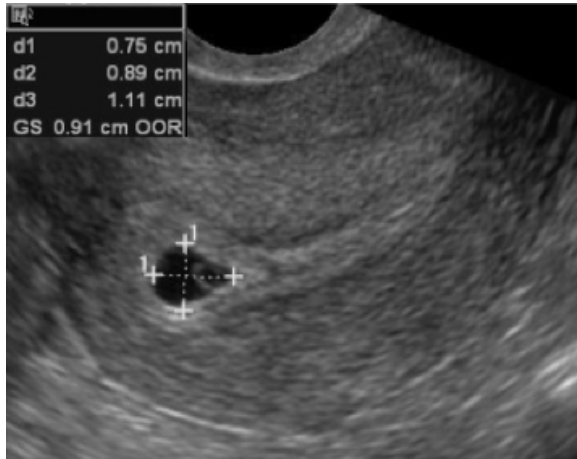
Measure 3 dimensions in 2 planes (from inside double ring to inside double ring):

Longitudinal Plane: Length (L) & Height (H)

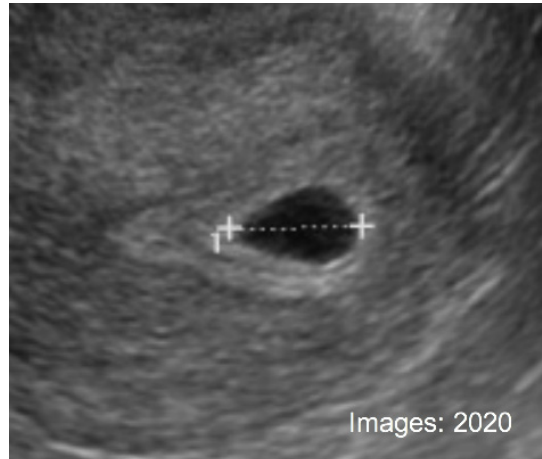
Transverse Plane: Width (W)

Calculate the Mean Sac Diameter (MSD): $MSD = (L + W + H)/3$

Calculate the Gestational Age (GA): $GA \text{ (in days)} = MSD \text{ (in mm)} + 30$



Length and height measured in longitudinal view.

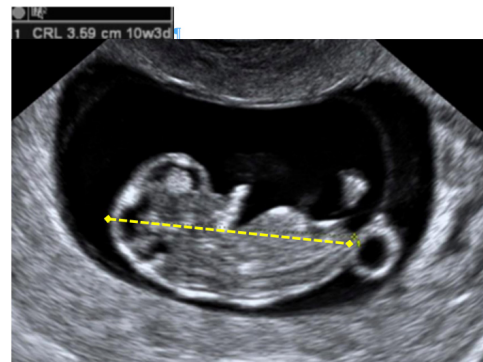


Width measured in transverse view.

Crown Rump Length (CRL) Measurement and Calculation of Gestational Age:

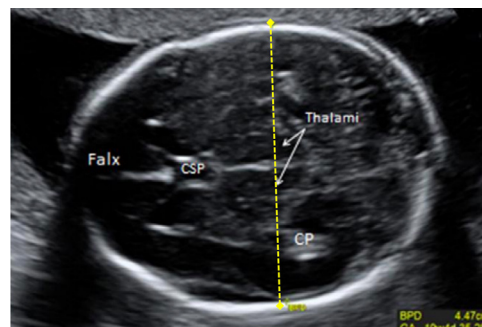
- CRL = fetal pole (in mm)
- Long axis not including limbs or YS

Calculate: $GA \text{ (days)} = CRL \text{ (mm)} + 42$



BIPARIETAL DIAMETER (BPD) MEASUREMENT

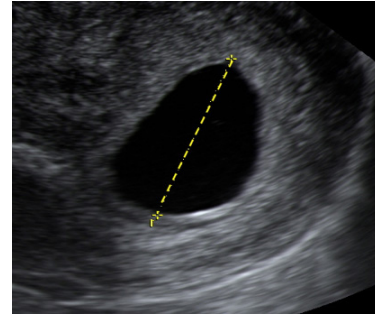
- ≥ 14 weeks, using the fetal BPD is preferred to CRL.
- Inside to outside of skull circumference
- At the level of the thalamus
- No nuchal or eye structures



ULTRASOUND FINDINGS WITH ABNORMAL PREGNANCIES

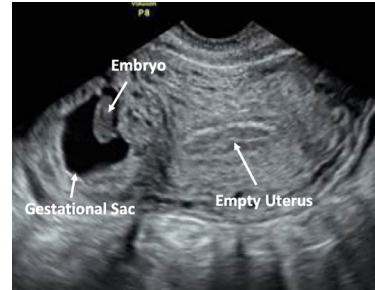
ANEMBRYONIC PREGNANCY

Empty gestational sac without fetal pole.
Need three views (length, width and height) to calculate MSD. An empty gestational sac with a MSD of ≥ 25 mm is diagnostic of an anembryonic pregnancy. Early pregnancy loss occurs in approximately 10-20% of clinically recognized pregnancies.



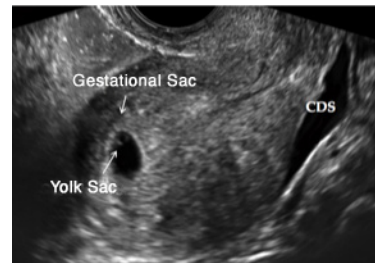
ECTOPIC PREGNANCY

Note that this gestational sac with fetal pole is not intrauterine (no cervix is seen in the same plane). Ectopic pregnancy occurs in approximately 1-2 % of pregnancies, and is even more uncommon among pregnant people seeking abortion (0.25%) (Duncan 2020).



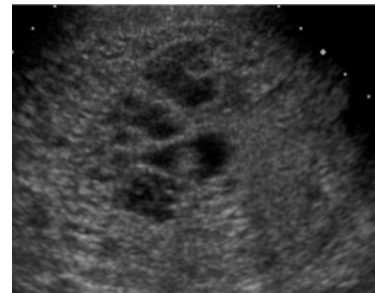
FREE FLUID IN CUL-DE-SAC

Longitudinal view of the uterus. Note the presence of anechoic (dark) fluid in the posterior cul-de-sac. This may be a finding consistent with blood from an ectopic pregnancy or uterine perforation.



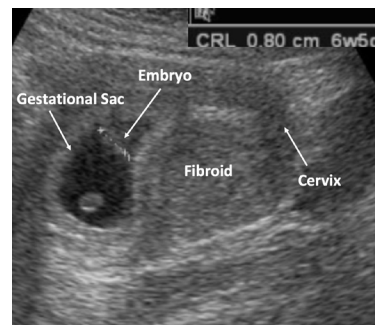
GESTATIONAL TROPHOBLASTIC DISEASE (MOLAR PREGNANCY)

Image of complete mole (no embryo). A complete mole generally has a cystic intrauterine mass with no distinct gestational sac with yolk sac or fetal pole. Often has a swiss cheese, snowstorm, or moth-eaten appearance on US. Consider referral for inpatient management > 12-week size due to increased bleeding risk. Gestational trophoblastic disease occurs in approximately 0.1% of pregnancies.



FIBROID UTERUS

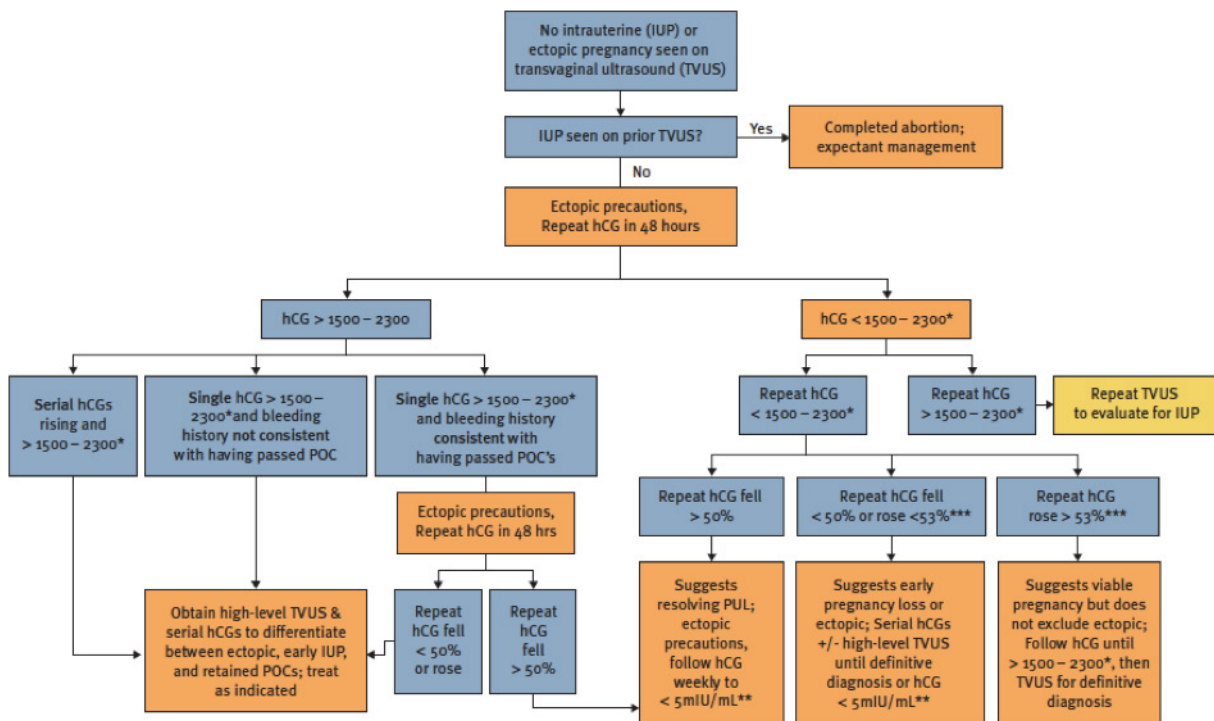
Uterine fibroids are a common pelvic tumor that may enlarge or distort the cervix or uterine cavity, presenting technical difficulty. US can help identify the size, location, and orientation to the pregnancy.



PREGNANCY OF UNKNOWN LOCATION (PUL) EVALUATION

A patient with a positive pregnancy test and no visible pregnancy on US is said to have a pregnancy of unknown location (PUL). The differential diagnosis for PUL includes early viable intrauterine pregnancy, EPL, or ectopic pregnancy. Patients with PUL should be followed until a diagnosis is made. Patients may present in early pregnancy with symptoms of bleeding and / or pain and require evaluation for ectopic pregnancy according to local protocol—for example with US, serial hCGs, exam and / or diagnostic aspiration. Referral for formal diagnostic US and / or emergency attention may be indicated.

Evaluation of first trimester bleeding with no intrauterine pregnancy on transvaginal ultrasound



June 2016 / www.reproductiveaccess.org



PUL DIAGNOSIS

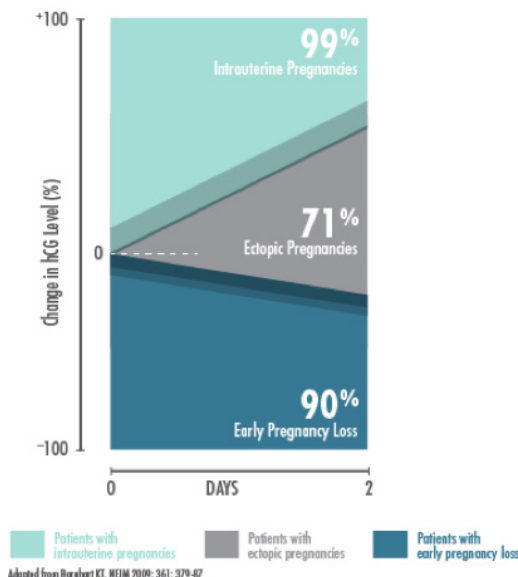
Ultrasound

- The hCG level at which an intrauterine pregnancy should be seen on transvaginal US is referred to as the discriminatory zone.
- An intrauterine gestational sac will be detected at a hCG level of 3510 mIU per mL with 99% probability (Connolly 2013).
- A gestational sac is rarely visualized in an early pregnancy <35 days from LMP, and therefore not expected. Follow up US in 7 days with ectopic precautions is appropriate management for PUL < 35 days, if not managed with diagnostic aspiration.
- Serial serum hCG levels can be utilized in addition to US for PUL evaluation, especially if hCG level is below discriminatory zone.

Serial Serum hCG Levels

A viable IUP typically has an hCG trend characterized by an expected hCG increase of 53% over 48 hours, however this trend can be as slow as a 35% increase in 48 hours (Butts 2013, Prine 2011). While using a threshold of a 53% increase is 99% sensitive for detecting viable IUPs, consider using a lower threshold in patients with desired pregnancies to avoid misclassification of an early IUP as an ectopic or EPL.

- The rate of hCG increase and trends may be unpredictable, especially at low levels. Three serial hCGs are typically needed to establish a trend, typically on days 0, 2, and day 4 or 7. The change in hCG level for patients experiencing an IUP, ectopic pregnancy, or EPL is quite nuanced, and hCG levels must always be correlated with the full clinical picture.
- The minimum rate of decline expected for EPL depends on the initial hCG at presentation, but it ranges from 35-50% at 2 days (Butts 2013).
- Rate of hCG rise with ectopic is usually slower than expected for a viable IUP.
- Among patients diagnosed with ectopic pregnancies:
 - The majority had serial hCG rise below the normal range for a viable IUP (i.e. level rose < 35-53% in 2 days).
 - For those with declining hCG, the rate of decline is usually slower than that expected for EPL.
 - However, 21% of ectopics have a hCG rise similar to viable IUP and 8% have a decrease that is normal for EPL (Silva 2006).
- Therefore, use caution when following patients in early pregnancy with possible symptoms of ectopic pregnancy, i.e. intermittent bleeding/spotting, pelvic pain.
 - A “normal” rise or fall in levels is not sufficient to exclude ectopic – but should be used in conjunction with other clinical data including exam, US or diagnostic aspiration.



Change in the hCG Level in Intrauterine Pregnancy, Ectopic Pregnancy, and EPL

(Note: Studies from ED not abortion care setting; therefore ectopic rate is higher)

An increase or decrease in the serial hCG level in a patient with an ectopic pregnancy is outside the range expected for that of a patient with a growing IUP or an EPL 71% of the time. However, the increase in the hCG level in a patient with an ectopic pregnancy can mimic that of a growing IUP, and the decrease in the hCG level can mimic that of an EPL.

Barnhart NEJM 2009

PUL MANAGEMENT

A patient-centered approach, prioritizing desired pregnancy outcome, can be used to guide decision-making and approach to managing a pregnancy of unknown location (Flynn 2020).

- If patient desires to terminate the pregnancy, management options include:
 - **Medication Abortion:** various protocols allow MAB in setting of PUL with ectopic precautions & serum hCG trend to confirm completion (Goldberg 2022).
 - **Diagnostic Uterine Aspiration:** can be offered at same visit of PUL identification, if pregnancy tissue (gestational sac or villi) found in aspirate, an ectopic pregnancy is ruled out and management is complete. If no pregnancy tissue identified, review ectopic precautions, collect hCG, and trend with repeat hCG in 24-48 hours until able to confirm diagnosis of completed abortion or ectopic pregnancy. Referral for ectopic pregnancy management is warranted if patient becomes symptomatic or if hCG does not drop by 50%.
 - **Methotrexate:** Methotrexate 50 mg/m² can be effective in treating early ectopic pregnancy when the diagnosis of viable IUP or EPL cannot be confirmed (persistent PUL) if criteria are met. Managing a persistent PUL with methotrexate or uterine aspiration is more likely to result in a successful pregnancy resolution compared to expectant management (Barnhart 2021). Efficacy is determined with serial hCG testing, clinical exams and progression of signs and symptoms. (Seeber 2006)

- If patient **desires to continue** the pregnancy:
 - Serial hCG and / or US to continue evaluation for diagnosis of EPL or ectopic. If EPL or ectopic is conclusively diagnosed, offer appropriate management and / or referral (see Chapter 8 “Management Options For EPL” on page 152, RHAP Diagnosis and Treatment of Ectopic Pregnancy).

CHAPTER 3 EXERCISES: PRE-ABORTION EVALUATION

EXERCISE 3.1

Purpose: To review key steps in early pregnancy evaluation and pregnancy dating.

1. A 25-year-old G1P0 patient calls your office for a telehealth visit about options for an undesired pregnancy, following a positive home pregnancy test.
 - a. How will you establish the patient's pregnancy dating?
 - b. What additional diagnostic data would you consider obtaining?

EXERCISE 3.2

Purpose: To review appropriate uses for different types of pregnancy tests, indicate whether you would use clinical assessment alone, a high sensitivity urine pregnancy test (HSPT), or a serum quantitative hCG test and why; or answer related questions.

1. A 20-year-old G2P1 patient at 4 weeks 2 days by LMP comes to your office requesting pregnancy confirmation and to discuss options.
2. A 27-year-old G3 P2 patient is 6 weeks by LMP with a pregnancy of unknown location (transvaginal US examination shows no intrauterine gestational sac and no ectopic pregnancy). The patient has been spotting intermittently but is otherwise asymptomatic. A quantitative hCG is 1000, 48 hours later it is 1400.
 - a. What is the differential diagnosis?
 - b. Would your approach to care differ with a desired vs. undesired pregnancy?
3. A 32-year-old G2P0 patient returns for a follow-up visit 5 weeks after a first-trimester aspiration because of intermittent bleeding since their procedure, and has been sexually active since the aspiration.

EXERCISE 3.3

Purpose: To review key information about ultrasound in early pregnancy.

1. What is the differential diagnosis of the following US findings? What steps would you take to clarify the diagnosis?
 - a. A 36-year-old G4P2 patient at 5 weeks by LMP. In the longitudinal view of the uterus, a gestational sac is elliptical, fundal and eccentric to the midline. Mean sac diameter is 18 mm with no yolk sac or embryo visible.
 - b. Embryonic pole length 8 mm with no visible cardiac activity.
 - c. A 24-year-old G2P1 patient at 5 weeks and 3 days by LMP reports having intermittent right-sided pelvic pain and cramping. On US, you visualize a small 3 mm x 3 mm intrauterine fluid collection in the endometrial canal. The shape of the collection is triangular and there is no double decidual sign.
 - d. A 30-year-old G3P0 patient reports they are 10 weeks by LMP and having intermittent spotting. On US, there is a flattened gestational sac without embryo or yolk sac, with cystic changes in the decidua present resembling "swiss cheese".

EXERCISE 3.4

Purpose: To consider management of case scenarios prior to an abortion. Not all material is covered in the Chapter.

1. A 41-year-old G4P4 patient presents for uterine aspiration at 5 weeks by LMP. Pelvic examination reveals an irregular uterus that is 17 weeks in size. Ultrasound examination shows a 5-week intrauterine gestation and multiple uterine fibroids.
2. A 17-year-old G1P0 patient who is 5 weeks pregnant presents for uterine aspiration. As you insert the speculum, the cervix looks inflamed and friable and has pus at the os.
3. A 40-year-old G4P3 patient at 7w4d presents for an abortion procedure. They have a BMI of 35 and a history of 3 previous cesareans.
4. A 29-year-old G5P2 patient presents for uterine aspiration, with history of venous thromboembolism, now anticoagulated on warfarin; last INR was in therapeutic range. How would your management change if 10 wk vs. >14 wk EGA?
5. A 26-year-old G2P1 patient with a history of insulin-dependent diabetes presents for a uterine aspiration at 8 weeks gestation. A pre-procedure glucose level is 520 mg/dL.

CHAPTER 3 TEACHING POINTS: PRE-ABORTION EVALUATION

EXERCISE 3.1

Purpose: To review key steps in early pregnancy evaluation and pregnancy dating.

1. A 25-year old G1 P0 patient calls your office for a telehealth visit about options for an undesired pregnancy, following a positive home pregnancy test.

a. How will you determine the patient's estimated gestational age?

- In early pregnancy, LMP alone has been shown to be an accurate means of estimating gestational age with low rates of under- or over-estimation in abortion evaluation to mid first trimester or 63 days ([Kapp 2020](#), [Ipas 2021](#), [Macaulay 2019](#), [Raymond 2015](#), [Schonberg 2014](#))
- Pairing bimanual exam with LMP dating may increase the accuracy of gestational age estimation but is not required to proceed with a medication or aspiration abortion.
- If LMP is unknown, a series of questions (Are you >10 weeks pregnant? Have you missed >2 periods? Are you >2 months pregnant?) may be used to determine eligibility for medication abortion ([Ralph 2021](#)).
- If pregnancy dating is uncertain, or if there are any signs or symptoms of ectopic pregnancy, US may be warranted ([Raymond 2020](#)).

b. What additional diagnostic data would you consider obtaining?

- No labs are required unless:
- Rh if indicated (See Chapter 3 “[Rh-D IG for MAB](#)” on page 49 or Chapter 5 [page 89](#): Rh Isoimmunization)
- Hgb or Hct only if recent history and / or symptoms of anemia
- CT / GC if symptoms or risk factors (See Chapter 5 “[PROPHYLACTIC ANTIBIOTICS](#)” on page 89)
- Tests pertinent to underlying conditions if needed
 - Glucose for patients with insulin-dependent diabetes mellitus
 - INR for patients on certain anti-coagulants (Warfarin) > 12 weeks

EXERCISE 3.2

Purpose: To review appropriate uses for different types of pregnancy tests. For each scenario, indicate whether you would use clinical assessment alone, a high sensitivity urine pregnancy test (HSPT), or a serum quantitative hCG test and why; and / or answer related questions.

1. A 20-year-old G2 P1 patient at 4 weeks 2 days by LMP comes to your office requesting pregnancy confirmation and to discuss options.

- A HSPT is the most useful test to confirm an early pregnancy, both for home and office-based confirmation of pregnancy.
- A HSPT can detect levels as low as 20 mIU/ml. These levels may be seen in urine as early as a week after conception or before a missed period (although 95% sensitivity may not be reached until cycle day 32-35). Up to 10% of pregnancies have a negative HSPT at the time of missed menses, often due to delayed ovulation & implantation and to variable hCG concentrations in urine ([Paul 2009](#); p.67).

Furthermore, not all HSPT tests are equal; with detection hCG levels varying from 20-30 mIU/ml.

- If **positive**, assess if the patient desires to continue the pregnancy, and proceed with clinical dating.
- If **negative**, patient should retest in a week if menses does not start.

2. A 27-year-old G3 P2 patient is 6 weeks by LMP with a pregnancy of unknown location (transvaginal US examination shows no intrauterine gestational sac and no ectopic pregnancy). The patient has been spotting intermittently but is otherwise asymptomatic. The quantitative hCG you draw comes back at 1000, and another 48 hours later comes back at 1400.

a. What is the differential diagnosis?

- Research indicates that the minimum expected hCG rise for a viable IUP is 35-53% at 48 hours ([Butts 2013](#)). This patient's hCG rise is 40% in 48 hours. The differential still includes early pregnancy loss, ectopic, and early viable pregnancy. The hCG patterns need to be combined with EGA and clinical symptoms when clinically managing patients.

b. Would your approach to care differ if the patient desires to terminate vs continue the pregnancy?

- According to prediction models ([Morse 2012](#)), 99.9% of viable IUPs will have a rise in hCG of at least 35% in 48 hours. However, because some viable IUPs will have a slower rise, it is important to obtain a third hCG measurement and repeat the US if the intent is to continue the pregnancy ([Zee 2014](#)).
- If the patient desires to terminate the pregnancy, offer a diagnostic uterine aspiration, because that will expedite the evaluation for possible ectopic pregnancy. If pregnancy tissue is found in the aspirate, an ectopic pregnancy can be ruled out. In the more likely case that pregnancy tissue is not found, a repeat hCG level 24-48 hours after the aspiration will be helpful. If the gestational sac was aspirated, the hCG level will drop by more than 50%. If the patient is symptomatic or the hCG does not drop by 50%, an ectopic pregnancy becomes more likely, and a referral is warranted.

3. A 32-year-old G2 P1 patient returns for a follow-up visit 5 weeks after a first trimester aspiration because of intermittent bleeding since their procedure, and has been sexually active since the uterine aspiration.

- The HSPT is helpful if negative, but can stay positive 4 + weeks post-abortion.
- If there are ongoing symptoms or signs of pregnancy or retained tissue, consider serial hCGs to assess trend. Repeat US may also be helpful.

EXERCISE 3.3

Purpose: To review key information about ultrasound in early pregnancy.

1. What is the differential diagnosis of the following ultrasound findings? What steps would you take to clarify the diagnosis?

a. A 36-year-old G4 P2 patient at 5 weeks by LMP. In the longitudinal view of the uterus, a gestational sac is elliptical, fundal and eccentric to the midline. Mean sac diameter is 18 mm with no yolk sac or embryo visible.

- This is an intrauterine gestational sac. The mean sac diameter of 16-24 mm with no yolk sac or embryo is highly suggestive of a non-viable pregnancy in this case, although early viable pregnancy and ectopic are still in the differential. If the mean sac diameter was ≥ 25 mm without an embryo, it would be diagnostic of early pregnancy loss (anembryonic pregnancy).
- Based on what the patient desires to do with the pregnancy, may use shared decision making to offer either aspiration procedure or medications. Aspiration procedure should not be delayed for diagnosis and can help confirm pregnancy location (RHAP 2017) . If patient prefers medication, can be offered with ectopic precautions and paired with serum hCG trend and close follow-up.
- If patient desires to continue the pregnancy, diagnosis will be clarified by repeating US in 7-10 days.

b. Embryonic pole length 8 mm with no visible cardiac activity

- Embryonic pole length > 7 mm with no cardiac activity is diagnostic for early pregnancy loss (Doubilet 2013). Management options including aspiration, medication, or expectant management. See Chapter 8 [page 152](#) for more on EPL counseling and management.

c. A 24-year-old G2 P1 patient at 5 weeks and 3 days by LMP reports having intermittent right-sided pelvic pain and cramping. On ultrasound, you visualize a small 3 mm x 3 mm intrauterine fluid collection in the endometrial canal. The shape of the collection is triangular and there is no double decidual sign.

- This case is concerning for ectopic pregnancy. By $5 \frac{3}{7}$ weeks, or 38 days, the mean sac diameter should be 8 mm. A normal sac should also be eccentrically placed and not centrally located in the uterine cavity. Combined with the unilateral cramping pain, findings consistent with a pseudosac should prompt ectopic pregnancy workup and management.

d. A 30-year-old G3 P0 patient reports they are 10 weeks by LMP and having intermittent spotting. On ultrasound, there is a flattened gestational sac without embryo or yolk sac, with cystic changes in the decidua present resembling “swiss cheese”.

- This suggests **molar pregnancy**, which may appear with heterogeneous or mixed-density echoes on US. The classic moth-eaten, “swiss cheese” or “snowstorm” appearance on US may not be visible until 9-10 weeks EGA.
- For suspected molar pregnancy, tissue diagnosis is needed, so uterine aspiration is recommended over medication abortion. If uterine size is over 12 weeks, refer for inpatient management due to increased bleeding risk.
- When aspiration is performed, tissue should be sent for pathologic examination, and baseline serum hCG obtained. If molar pregnancy is confirmed, hCGs should be monitored according to established protocols (ACOG 2004).

EXERCISE 3.4

Purpose: To consider management of case scenarios prior to uterine aspiration. Not all material is covered in the Chapter.

1. A 41-year-old G4 P3 patient presents for aspiration at 5 weeks LMP. Pelvic examination reveals an irregular uterus that is 17 weeks in size. Ultrasound examination shows a 5-week intrauterine gestation and multiple uterine fibroids.

- Discuss additional considerations for aspiration vs. medication in setting of fibroids, given increased risk of incomplete aspiration procedures. A small gestational sac can occasionally be high in the fundus “behind” the curve of large or multiple fibroids, and it may be very difficult to reach.
- Consider performing the procedure under US guidance. Refer to a higher-level setting with an experienced provider if necessary.
- Consider checking hemoglobin if symptomatic, as patients with fibroids can have anemia, and may have a higher risk of increased bleeding during abortion.

2. A 17-year-old G1 P0 patient who is 5 weeks pregnant presents for uterine aspiration. As you insert the speculum, the cervix looks inflamed and friable and has pus at the os.

- CT / GC testing and initiation of empiric pre-procedural treatment is indicated, as cervical infection with these pathogens increases risk of postabortion endometritis (Achilles 2011). Uterine aspiration should not be postponed. An appropriate treatment regimen ([CDC 2021 Guidelines](#)) includes:
 - Chlamydia: Doxycycline 100 mg orally twice daily for 7 days is the recommended regimen. Alternatively can use Azithromycin 1 gm single oral dose OR Levofloxacin 500 mg daily for 7 days
 - Gonorrhea: Ceftriaxone 500 mg intramuscular* PLUS treatment for Chlamydia.
*For persons weighing ≥ 150 kg dose is Ceftriaxone 1 g intramuscular.
- Symptomatic BV at the time of aspiration should be treated with metronidazole 500 mg orally twice daily for 7 days, without need to delay the abortion.

3. 40-year-old G4P3 patient at 7w4d presents for an abortion procedure. They have a BMI of 35 and a history of three previous cesareans.

- The patient’s BMI and previous cesarean sections put this patient in the moderate risk category for hemorrhage ([Kerns 2013](#)) and a possibly challenging uterine aspiration. Consider medication abortion for this patient.
- If considering aspiration abortion, the following should be considered:
 - Have uterotonic medications and supplies accessible to manage bleeding.
 - Add vasopressin to paracervical block.
 - Consider intraoperative US guidance.
 - With additional risk factors, consider referring to a center with transfusion capability, anesthesia, and / or interventional radiology. BMI alone does not require transfer from an outpatient facility ([Benson 2016](#)).

4. A 29-year-old G5 P2 patient presents for aspiration, with history of venous thromboembolism, currently anticoagulated on warfarin; last INR was in the therapeutic range. How would your management change if 10 wk vs. >14 wk EGA?

- Procedural abortion is generally preferred over medical management for individuals with bleeding disorders or who are on anticoagulation. First-trimester procedural abortion in an individual on anticoagulation can generally be done without interruption of anticoagulation (Lee 2021). Additional blood loss in anticoagulated patients was not clinically significant in a small study of anticoagulated patients seeking aspiration < 12-weeks gestation compared with matched controls (Kaneshiro 2011). A likely explanation is that myometrial contraction is the primary mechanism of hemostasis after uterine aspiration.
- If the patient is 14+ weeks EGA or has other bleeding risks, consider referring to higher level of care.

5. A 26-year-old G2 P1 patient with a history of insulin-dependent diabetes presents for an aspiration at 8 weeks gestation. A preoperative glucose level is 520 mg/dL.

- For patients with insulin dependent diabetes, check blood sugar, and if > 400, take history for diabetic control medications and whether taken today, trends, A1c, and history of recent care.
- **Mild hyperglycemia** (200-400 mg/dL) is not a contraindication for uterine aspiration.
- **Above 400**, assess for ketoacidosis (including urine dip for ketones and assess volume status); if + ketones or poor volume status, stabilize or refer prior to the procedure.
- **Hypoglycemia** (<70 mg/dL) warrants a patient to be given dextrose or food prior to a procedure.

4. MEDICATION ABORTION

Updated June 2022, by Deyang Nyandak MD, Hannah Biederman MD,
and Hannah Rosenfield MD

Medication abortion (MAB), which includes the use of mifepristone and misoprostol or misoprostol alone, provides a safe, effective method of pregnancy termination. MAB is increasing globally and in the U.S. It can be offered in diverse settings without special equipment. This process allows for significant patient autonomy with appropriate education and follow-up as needed.

CHAPTER LEARNING OBJECTIVES

At the end of this chapter you should be able to:

- Evaluate patients prior to MAB
- Effectively counsel patients regarding MAB
- Discuss criteria for needing additional MAB follow-up, and manage it as needed
- Provide teleMAB (telemedicine medication abortion) to appropriate patients

VIDEOS

NEW VIDEO-BASED CME: MEDICATION ABORTION IN PRIMARY CARE

Here you can learn evidence-based ways to:

1. “See, do and teach” model for counseling patients on MAB
2. Evaluate patients in your everyday practice for MAB
3. Discuss the need for additional clinical services after MAB

- Medication Abortion (IERH): <https://bit.ly/3dQc0ii>
- Telemedicine for Medication Abortion (IERH): <https://bit.ly/3exCBB2>

READING / RESOURCES

- NAF Clinical Practice Guidelines – Early Medication Abortion (NAF 2022)
- WHO Abortion Care Guideline (WHO 2022)
- Medical Management of First-Trimester Abortion (SFP Clinical Guidelines 2014)
- Ipas Clinical Updates in Reproductive Health: Medication Abortion (Ipas 2021)
- Mifepristone manufacturers (with on-call networks)
- Danco (<https://www.earlyabortionpill.com>) and GenBioPro (<https://genbiopro.com>)
- Additional helpful resources for providers and patients:
 - Access Delivered Medication Abortion Provider Toolkit
 - RHAP Provider Abortion Resources
 - RHAP Patient Resource: Sam’s Medication Abortion Zine
 - Euki App – a private sexual and reproductive health app

SUMMARY POINTS

SKILLS

- Medication abortion (MAB) is technically simple - skills include assessment of eligibility, counseling, evaluation of successful passage of the pregnancy, and evaluation and management of rare complications.
- MAB is increasing globally. In 2020, over 50% of eligible U.S. patients chose MAB (Jones 2022). MAB increases access to abortion services, and 1 in 4 U.S. abortion providers offer only MAB (Jones 2019).
- Combined mifepristone/misoprostol regimens are more effective than misoprostol alone or methotrexate/misoprostol (Kulier 2011, NAF 2022).
- Misoprostol alone can be used in multiple doses for MAB when mifepristone is not readily available (Ipas 2021).
- Mifepristone 200 mg followed by misoprostol 800 mcg (buccal or vaginal) or 400 to 800 mcg (sublingual) is an effective regimen. A second dose of misoprostol 800 mcg appears to extend efficacy through 77 days gestation (Dzuba 2020; NAF 2022).
- MAB can be offered to patients who desire an abortion in cases of pregnancies of unknown location, with close follow-up. See Chapter 3 page 58 for details.
- MAB regimens up to (and over) 24 weeks of gestational age are being used in various global settings (Ipas 2021).

SAFETY

- MAB is safe and effective, with over 95% success rate without need for further intervention (Reeves 2016). Rarely, incomplete abortion or heavy bleeding may require outpatient treatment or uterine aspiration up to several weeks later.
- MAB can be provided in office or via telemedicine in most U.S. states (KFF 2022). Medications can be mailed, sent via mail order pharmacy, or prepared for drive-by pick up with demonstrated safety and efficacy (Aiken 2021, Upadhyay 2022).
- Self-managed medication abortion (SMMA) includes the use of abortion medications without licensed clinician oversight. Evidence demonstrates safety and efficacy of SMMA (WHO 2022, Aiken 2017, Murtagh 2017). U.S. abortion care sites increasingly report seeing one or more patients who had attempted SMMA (18%) (Jones 2019), and SMMA demand increased after Texas Senate Bill 8 in 2021 (Aiken 2022). No states require providers to report known or suspected SMMA. Patients in some states may face prosecution if reported.

ROLE

- MAB can easily be integrated into your clinical practice and help expand access to abortion care

COMPARISON OF MEDICATION ABORTION REGIMENS

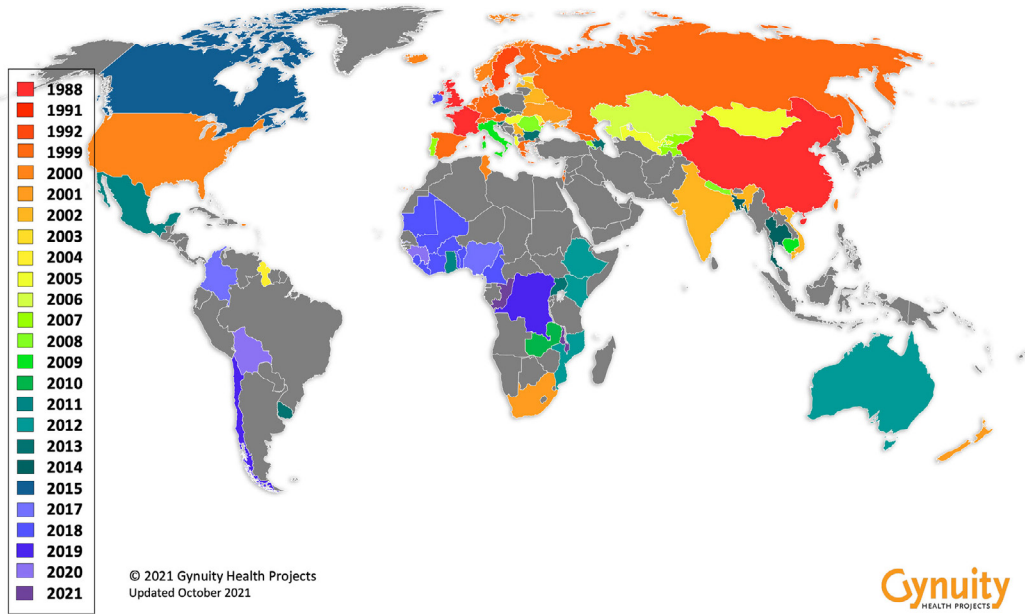
MIFEPRISTONE WITH MISOPROSTOL REGIMENS

- Mifepristone, in a regimen with misoprostol, was approved by the FDA for abortion in 2000. The label was updated in 2016 to reflect best evidence at the time and facilitate improved efficacy, safety, convenience, and side effects ([FDA label 2016](#)).
- Mifepristone 200 mg and misoprostol 800 mcg has an efficiency of 95-99% prior to 63 days gestational age. Data has demonstrated high rates of success of mifepristone 200 mg and misoprostol 800 mcg followed by a 2nd dose of misoprostol 4 hours later, at 63-77 days gestational age ([NAF 2022](#), [Dzuba 2020](#)).
- In light of COVID-19, many organizations implemented telemedicine MAB which has been demonstrated to be safe and effective ([Aiken 2021](#), [Upadhyay 2022](#)). Sample protocols can be adapted for practice setting in office or via telemedicine.
 - [No-Test Medication Abortion: Sample protocol during a pandemic and beyond](#)
 - [RHEDI Checklist for Minimal Contact Medication Abortion](#)
 - [RHAP Telehealth for Medication Abortion Protocol](#)

Evidence-Based Mifepristone Regimens				
Based on evidence up to 2022, Partially adapted from NAF Clinical Practice Guidelines 2022				
Gestational Age	Mifepristone Dose (Day 1) ⁶	Misoprostol Dose & Route	Efficacy	Core References
<63 days	Mifepristone 200mg PO	Misoprostol 800 mcg buccal, vaginal ^{1, 2} or sublingual ³ 24-48 hours after mifepristone	95-99%	Creinin 2004 , Schmidt-Hansen_2020 , Schaff 2000 , Schaff 1999, 2002 Ashok 1998 , Middleton 2005 , Chai 2013 , Tang 2003 , Gatter 2015
64 – 70 days		Consider 2nd misoprostol 800mcg 4 hours after 1st dose for patients over 63 days	1 dose: 92-95% 2 doses: 99.6%	Danco 2016 , Chen 2015 , Bracken 2014 , Winikoff 2012 , Boersma 2011 , Sanhueza Smith 2015 , Hsia 2019 , Dzuba 2020, 2020
71 – 77 days ⁴		Recommend 2nd misoprostol 800mcg 4 hours after 1st dose for patients >70 days	1 dose: 86.7% 2 doses: 97.6%	Dzuba 2020 , Larsson 2019 , Kapp 2019

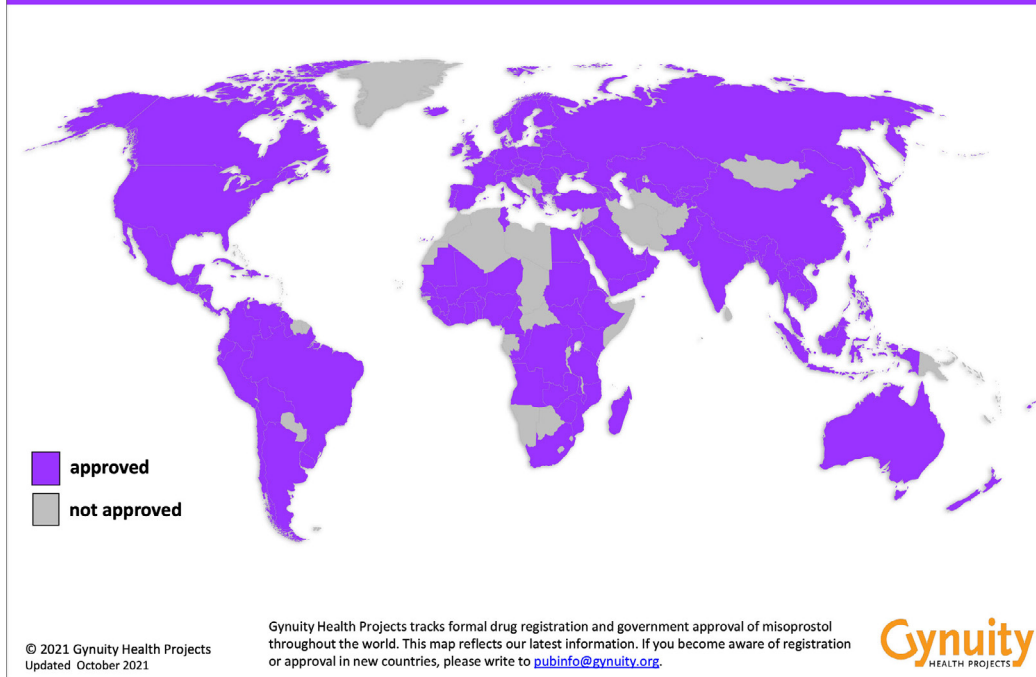
1. Vaginal route enables wider time frame for use of misoprostol, 0-72 hours after mifepristone, with highest efficacy rates between 24-48 hours.
2. Primary studies demonstrating efficacy from 64-70 days used buccal and sublingual misoprostol regimens; updated evidence confirms similar efficacy with vaginal route in this gestational age range ([Hsia 2019](#)).
3. Sublingual misoprostol dose range 400-800mcg. Fewer side effects shown with lower dose though may have lower efficacy rates ([Von Hertzen 2010](#)).
4. Medication abortion at 71-77 days LMP is evidence-based, and success rates in the late first trimester are higher with repeat misoprostol doses ([Kapp 2019](#), [Dzuba 2020](#)).
5. Protocols > 77 days, used in some global settings, tend to require multiple doses of misoprostol ([Hamoda 2003,2005](#); [Lokeland 2010](#), [Kapp 2019](#), [Ipas 2020](#), [WHO 2018](#)).
6. Ongoing studies are evaluating telehealth protocols that mail mifepristone in the U.S. and abroad.

Mifepristone Approved



CLICK ON THE MAPS TO SEE LARGER VERSIONS

Misoprostol Approved



MISOPROSTOL- ONLY REGIMENS

- Misoprostol-only is another safe regimen ([Moseson 2021](#), [Stillman 2020](#)), though may take more time but can be nearly as effective as regimens with mifepristone ([Moseson 2021](#), [Blum 2012](#), [Kulier 2011](#)). Recommended regimen: misoprostol 800 mcg buccally, vaginally, or sublingually; repeat every 3 hours as needed until expulsion of pregnancy. ([Ipas 2021](#), [Sheldon 2019](#), [Raymond 2019](#)).
- Misoprostol is available over the counter in many countries, and by prescription in the U.S. and is approved to treat arthritis and ulcers. Misoprostol alone may be easier for many to obtain, more widely available, and less expensive than the combination with mifepristone. The misoprostol-only protocol can be useful for those who choose SMMA. People choosing to self-manage their abortion may source it through online pharmacies, veterinarian supply shops, or other means. More information about self-managed abortion safety and access is available at the following sites: [World Health Organization](#), [Aid Access](#), [Women on Web](#).

Gestational Age	Misoprostol Dose & Route	Efficacy	Core References
≤ 63 days	Misoprostol 800 mcg vaginal, sublingual ¹ , or buccal every 3 hours x 3 doses until expulsion	84-96%	Moreno-Ruiz 2007 , Von Hertzen 2007 Gynuity 2013 , Ipas 2020 , WHO 2018
64 – 70 days	As above. Additional doses may be used if bleeding does not start.	84- 87% 93% with 4 th dose	Sheldon 2019 , Ipas 2020 , WHO 2018
Up to 91 days		75-81%	Raymond 2019 Kapp 2019 , Ipas 2020 , WHO 2018

1. Increased efficacy demonstrated with sublingual compared to buccal misoprostol in misoprostol-only regimens through 70 days gestation, though with increased incidence of side effects ([Sheldon 2019](#)).

METHOTREXATE REGIMEN

Methotrexate (50 mg/m²) injection when combined with misoprostol can be used for termination of pregnancy or with pregnancy of unknown location (PUL). It is also an effective treatment for early unruptured ectopic pregnancy with eligibility that includes hCG <5000. Success is determined by serial hCG testing and clinical improvement ([Barnhart 2021](#), [Seeber 2006](#)).

LETROZOLE REGIMEN

A new MAB protocol for <12 weeks includes using letrozole 10 mg orally daily for three days followed by misoprostol 800mcg sublingually on day 4. More research is needed on this regimen ([WHO 2022](#)).

MIFEPRISTONE/MISOPROSTOL ABORTION: STEP BY STEP

*Steps for telemedicine are the same as in-clinic care. Additional details for telemedicine are highlighted in italics. Also consider checking [state-based regulations](#) and/or consulting [legal resources](#) regarding telemedicine MAB.

FIRST VISIT - DAY 1

Initial Counseling

- Introduce and build rapport with the patient
- Discuss pregnancy / abortion options (medication vs. aspiration) and patient concerns
- Reassure patient that abortion is safe, and does not interfere with future pregnancy if so desired.
- Telemedicine visit can be done via audio only or with video if available
 - Determine if eligible for telemedicine MAB and if patient desires using telemedicine
 - Consider disparities in access to electronic devices and reliable phone and internet service on the ability of patients to access care via telemedicine.

Patient Eligibility

- Determine pregnancy dating. MAB is appropriate for ≤ 77 days from anticipated day of mifepristone use (within 1 week of certainty) in addition to the following:
 - Regular menses
 - First positive pregnancy test less than 6 weeks ago
 - No ectopic risk factors (previous ectopic, history of PID or tubal ligation, IUD in place at the time of conception, bleeding since LMP, or unilateral pelvic pain).
 - If LMP is unknown, a series of questions (Are you >10 weeks pregnant? Have you missed >2 periods? Are you >2 months pregnant?) may be used to determine eligibility for medication abortion ([Ralph 2021](#)).
- If above criteria are not met and /or GA remains uncertain, US dating is recommended to confirm gestational age ≤ 77 days from anticipated day of mifepristone use. Some providers use a lower gestational age limit to allow for error when US is not used.
- Review medical history for absolute & relative contraindications to MAB:
 - IUD in place (must be removed prior to administration of the medications)
 - Allergy to a medication (eg mifepristone or misoprostol)
 - Chronic adrenal failure or long-term use of systemic corticosteroid therapy
 - Known or suspected ectopic pregnancy
 - Hemorrhagic disorders or concurrent anticoagulant therapy or symptomatic anemia
 - Inherited porphyria
 - No severe or unstable chronic condition that increases risk of outpatient procedure
- *Telemedicine visit: Determine if eligible for telemedicine MAB. If a patient has sure LMP of ≤ 77 days and no history or symptoms concerning for ectopic pregnancy, they are eligible for telemedicine MAB without US. US can be used in cases where uncertainty exists to confirm pregnancy location and gestational age.*

No labs required, unless

- Rh (D) testing standards are evolving: If < 12 weeks from LMP, may forego Rh testing and Rh-D IG for MAB (NAF May 2022; WHO 2022). (See Ch 5 page 89 Rh Isoimmunization)
- Hemoglobin or hematocrit: If recent history or symptoms of anemia. Rare for clinically significant drop in hemoglobin after MAB.
- Chlamydia/gonorrhea screen: If symptoms, risk factors, or by patient preference.
- For US requirements, see criteria listed above for patient eligibility.
- *Telemedicine visit: same guidelines as above*

Informed Consent

- Confirm confidential contact information.
- Discuss safety of MAB and review risks (see Complications Table page 79)
 - Overall, early MAB is at least tenfold safer than continuing a pregnancy to term, although the magnitude of safety varies across global settings.
 - Additional misoprostol doses or aspiration with their risks, if indicated
 - Heavy or prolonged bleeding can occur in up to 3% of cases; Management options include misoprostol, NSAIDs, and non-urgent uterine aspiration. Rarely emergent uterine aspiration or transfusion indicated.
 - Endometritis (<1%) is uncommon. Atypical Clostridial infection is very rare.
 - There is no evidence-based regimen for mifepristone reversal. Not taking misoprostol after mifepristone may be associated with heavy bleeding (Grossman 2015, Creinin 2020).
 - Mifepristone is not associated with teratogenicity.
 - Advise patient about the potential teratogenicity of misoprostol (associated with increased congenital deformities, Möbius syndrome, and limb defects).
- In the U.S., patients must review and sign required consents and agreements:
 - Manufacturer's Patient Agreement and Medication Guide: Danco (<https://earlyabortionpill.com>), or GenBioPro (<https://genbiopro.com>)
- *Telemedicine visit: patients can electronically sign consent forms and the patient agreement through an electronic platform such as DocuSign. Alternatively, the consents can be reviewed over the phone and the patient can sign the forms at the clinic in-person without an additional provider visit.*

Counseling on Abortion Process

1. Provide anticipatory guidance for the abortion process and medication side effects:
 - Ask if the patient wants to have a support person available.
 - Some patients may experience vaginal bleeding after mifepristone, and should be advised to continue to use misoprostol as directed.
 - Cramping/pain occurs in >90% of patients, varies in intensity, peaks after misoprostol dose, and is typically improved by NSAIDs and warm compress/heating pad.
 - Common side effects of misoprostol include: nausea, vomiting, diarrhea, low-grade fever, chills and myalgias, and usually resolve within 6 hours of use.
 - If mifepristone or misoprostol are vomited (or fall out) less than 30 minutes after use, consider repeat dosing. Antiemetic medications can be used ahead of misoprostol if the patient has significant pregnancy-related nausea.
 - Vaginal bleeding is usually heaviest within 4-6 hours after misoprostol, often heavier than normal menses and accompanied by the passage of large clots.

- Average bleeding duration is 9 days (range 1-45 days). A clinically significant drop in hemoglobin is rare. Intermittent spotting may last for up to one month.
 - A heavy first menses is common following MAB.
 - Patients bleeding > two pads per hour for > two consecutive hours need to be evaluated in-person.
2. Review use of medications:
- Mifepristone:
 - Works by interrupting progesterone, the primary hormone that prepares the endometrium for implantation. This results in menstrual bleeding and disruption of the endometrium.
 - One 200 mg tablet is swallowed
 - Misoprostol:
 - Stimulates uterus to contract and expel the pregnancy
 - Describe options for misoprostol so patient can choose their optimal route for home administration:
 - Buccal: place four 200 mcg tablets between gum & cheek for 30 minutes; then swallow remaining fragments. Patients may place 24-48 hours after mifepristone.
 - Vaginal: place four 200 mcg tablets as high as possible in the vagina. Patients may place 0-72 hours after mifepristone.
 - Sublingual: place 2-4 200 mcg tablets under the tongue for 30 minutes. Swallow remaining fragments. Patients may place 24-48 hours after mifepristone
 - If >63 days LMP, a second dose of 800 mcg misoprostol 4 hours after the first dose can be considered; and if >70 days LMP, a second dose is recommended.
 - Can forgo Rho(D)-IG for MAB (See Chapter 3 “Rh-D IG for MAB” on page 49 or Chapter 5 page 89).
 - Pain management
 - NSAIDs are mainstay: Ibuprofen 600-800 mg PO q6-8h or equivalent.
 - Adjunct therapies:
 - Heating pads or hot water bottles can help (Akin 2001).
 - Acetaminophen may be added, though evidence lacking.
 - Transcutaneous electrical nerve stimulation improves MAB pain (Goldman 2021) if accessible.
 - Tramadol (Dragoman 2021) and pregabalin (Friedlander 2018) studies show trending but not statistically significantly improved pain
 - Oxycodone was not found to be superior to NSAIDs in pain scores or duration (Colwill 2019). If given, 4-6 tablets are likely adequate.
 - Engage in a shared decision making with patients to discuss the pros and cons of pain control options and offer what is feasible and reasonable.
 - There is no difference in pain management strategies for individuals with opioid use disorder except that opioid prescriptions should be avoided, adjunct therapies should be maximized, and medication-assisted treatment should be continued as prescribed (Synder 2018).
 - For antiemetics, may offer ondansetron, promethazine, or metoclopramide for patient comfort and medication absorption.
 - Prophylactic antibiotics are not recommended (NAF 2022, WHO 2022, SFP 2014)

3. Offer to discuss contraception, remaining aware that some patients prefer not to discuss at time of abortion ([Brandi 2018](#)). If interested, review options and timing for initiation. Reassure patients that abortion does not affect future fertility and that fertility may resume within a week of an abortion.
 - Implant: placement at time of mifepristone enhances patient satisfaction without increasing MAB failure rates ([Raymond 2016](#)).
 - IUD: placement at follow-up visit after confirming MAB completion; may have slightly increased risk of expulsion ([Sääv 2012](#)).
 - Sterilization: consents must be signed (30-180 days prior to procedure in the U.S. for patients with public insurance), refer and offer an acceptable bridge method.
 - Injection: may start at any time, may be provided IM in clinic or SQ for home use. Advise that injection at time of mifepristone is associated with a slightly increased rate of continuing pregnancy on the order of 1-3% ([Raymond 2016](#)).
 - Hormonal contraceptives: may start at any time ([Tang 2002](#)).
 - Barrier methods: as soon as the patient resumes intercourse.
 - Offer emergency contraception and dispense or prescribe for future use if desired.
4. Home instructions: Discuss how to reach provider on call, especially if the patient has:
 - No bleeding within 24 hours of misoprostol (a repeat dose of misoprostol or an US if not initially performed may be indicated)
 - Soaked >2 maxi-pads for two or more consecutive hours or symptoms of hypovolemia
 - Unmanageable pain despite taking analgesics prescribed
 - Sustained fever >100.4° F or onset of fever >24 hours after misoprostol
 - Abdominal pain, weakness, nausea, vomiting or diarrhea > 24 hrs after misoprostol
 - Plans to go to a hospital or emergency department. Most patients' concerns can be addressed with reassurance and anticipatory guidance. Many patients can wait to see you in the office rather than be referred to an ER. If ER is needed, facilitation may help improve the patient experience and reduce unnecessary interventions.

DISPENSING MIFEPRISTONE

- FDA Mifepristone REMS requires that a certified healthcare provider or pharmacy registered with the distributors dispenses the medication to patients. Other clinicians working directly with registered providers may also directly dispense.
 - Prescribers must certify with Danco or Gen Bio Pro and complete a prescriber agreement and [account setup](#) form
 - If a MAB visit occurs in person, the medications can be directly dispensed in the office, but the patient does not need to take the mifepristone in the office.
 - *For telemedicine visits, the clinic can set up a medication delivery system.*
 - *In late 2021, the FDA removed the in-person dispensing requirement and added a requirement that pharmacies that dispense the medication be certified.*
 - Please see [Access Delivered Provider Toolkit](#) for more information on setting up mail-order pharmacy distribution

FACT SHEET : HOW TO USE ABORTION PILLS

1. MAKE SURE YOU ARE PREGNANT
Take a urine pregnancy test.



2. CHECK YOUR DATES
Use a calendar or a gestational age calculator. Measure the time from the first day of your last period to today. Medication abortion works up to 11 weeks from the first day of your last period.



3. BE SURE THAT YOU DO NOT HAVE:
IUD in place (must be removed before abortion)
Long term treatment with steroids (nasal, inhaled, or topical steroids are ok)
Ectopic pregnancy
Bleeding problem or treatment with a blood thinner (aspirin is ok)

4. THE PILLS
You need two types of pills. The first is mifepristone. The second is misoprostol.



5. FIRST DAY: TAKE MIFEPRISTONE
Swallow one 200-mg pill.



6. SECOND DAY: TAKE PAIN MEDICATION
Up to four 200-mg ibuprofen pills, up to two 220-mg naproxen pills, or up to two 500-mg acetaminophen pills. You can take any of these pain pills before misoprostol. You can take more if needed – follow the directions on the package.



7. KNOW WHAT TO EXPECT
The second pills cause strong cramps and heavy bleeding. You may see blood clots. You may have loose stools, fever, or chills.



FACT SHEET : HOW TO USE ABORTION PILLS

8. USE MISOPROSTOL
Put four 200-microgram misoprostol pills inside your cheeks, under your tongue, or in your vagina. Do this at any time 24-48 hours after taking mifepristone. If your period was less than nine weeks ago, only take four 200 microgram misoprostol pills. If your period was 9 to 11 weeks ago, you should insert a second dose of four misoprostol pills four hours later.
• Mouth: Put two pills inside each cheek or put four pills under your tongue. Hold them there for 30 minutes. Then swallow the pills with a drink.
• Vagina: Put the pills in your vagina. Lie down for 30 minutes. If the pills fall out after 30 minutes, throw them away.



9. EXPECT BLEEDING
Cramps and bleeding should start within 24 hours after misoprostol. If you have no cramps or bleeding, you can try more misoprostol. If this does not work, you should contact your clinician.



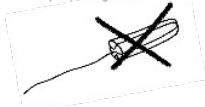
10. HOW MUCH BLEEDING IS TOO MUCH?
If you soak through two maxi-pads per hour, two hours in a row, you should contact a clinician.



11. WHEN TO START BIRTH CONTROL
You can start the pill, patch, or shot the day after misoprostol. You can start the ring three days after using misoprostol. You can get an IUD or implant a few days after misoprostol.



12. DO NOT INSERT ANYTHING IN VAGINA FOR THREE DAYS
This includes the birth control ring, tampons, and vaginal sex.



April 2020 / www.reproductiveaccess.org



(Source: Reproductive Health Access Project)

FOLLOW-UP TELEHEALTH OR OFFICE VISIT – DAY 7 – 14

1. Review patient’s course since taking medications, including timing and extent of bleeding and cramping, and resolution of pregnancy symptoms. Symptoms requiring an in-person evaluation:
 - No bleeding and cramping heavier than a period
 - Continued heavy bleeding without improvement
 - Patient does not feel that the pregnancy has passed
 - Continued symptoms of pregnancy (nausea, breast tenderness)
 - Significant pain unrelieved by usual measures
2. Success of abortion must be assessed by a) clinical history in conjunction with home urine pregnancy tests, b) by serial hCG testing, or c) by ultrasound (NAF 2022).
 - a. Clinical history (assessing symptoms by telehealth or phone) is acceptable, when paired with home urine pregnancy test at one month (Grossman 2011, Oppegaard 2015, Schmidt-Hansen 2019). May give patient an additional pregnancy test so that they do not need to purchase one.
 - b. When serial hCG protocol is used, a decrease from baseline hCG of 50% by 72 hours, 60% by 4-5 days (Pocious 2016), and 80% by 7 days from initiating treatment (Fiala 2003) is consistent with a successful MAB.
 - As hCG has physiologic decline in later first trimester, assess symptoms in conjunction with hCG results if clinical suspicion for ongoing pregnancy.
3. When ultrasound is used, success is determined by demonstrating the absence of the previously identified pregnancy (gestational sac or embryo).

4. Review clinical course and results, if any, with patient. Have patient contact clinic for late-onset heavy bleeding or other concerns warranting evaluation and treatment.
5. Review contraceptive plan if desired
6. Because of the safety and efficacy of medication abortion, some providers consider follow-up optional. If planned follow-up is not completed, it is recommended to attempt to contact the patient and to document in accordance with your clinical protocols.

Proposed Criteria for Aspiration after Medication Abortion
<p>Emergent</p> <ul style="list-style-type: none"> • Excessive active bleeding with orthostatic hypotension or significant drop in hemoglobin/hematocrit • Signs or symptoms of endometritis with an US consistent with incomplete MAB <p>Non-emergent</p> <ul style="list-style-type: none"> • Continuing pregnancy (consider repeat dose of misoprostol, or repeat mifepristone and misoprostol as a patient-centered approach, though data on efficacy minimal) • Symptomatic problematic bleeding / cramping unresponsive to medical treatment with US suggestive of retained tissue • Patient preference

ULTRASOUND AS NEEDED WITH MEDICATION ABORTION

Once pregnancy is confirmed by a urine hCG, pregnancy dating should be established. When pregnancy dating cannot be reasonably determined by other means, US should be used (NAF 2022). US use is not a requirement for MAB provision (NAF, SFP, ACOG, FDA, Ipas, WHO). Studies demonstrate the safety of eliminating routine US from MAB care (Raymond 201, Schonberg 2014, Bracken 2011). This helps streamline care, and avoid cost and delays.

Limited Ultrasound Indications for Medication Abortion	
(Adapted from RHEDI, NAF)	
Pre-Abortion	Post-Abortion
<ul style="list-style-type: none"> ● Possible pregnancy dating >77 days¹ ● Size/date discrepancy on bimanual ● Uncertain LMP (irregular menses, or no menses after delivery / abortion, hormonal contraceptive use) ● Adnexal mass or pain ● History of, risk factors for, or current symptoms or signs suggestive of ectopic pregnancy 	<ul style="list-style-type: none"> ● History not consistent with successful MAB (no or scant bleeding or cramping), especially if no dating US performed ● Patient still feels pregnant ● If used, serum hCG not declining appropriately ● Provider uncertainty with history

1. Data supports accuracy of pregnancy dating by LMP alone with low rates of over- and under-estimation through mid-first trimester (<63 days LMP) (Kapp 2020).

SUCCESSFUL ABORTION

The absence of the pregnancy (gestational sac or embryo depending on the US findings prior to MAB) and the presence of thickened endometrial stripe are typical after successful MAB. The size of the endometrial stripe has no clinical significance in assessment of success of a MAB in the absence of abnormally prolonged or heavy bleeding, and incorrect interpretation can lead to unnecessary intervention ([SFP 2014](#)).



PERSISTENT GESTATIONAL SAC AFTER MEDICATION ABORTION

This transvaginal ultrasound shows the presence of an empty gestational sac. Patients can choose their preferred management option: waiting for spontaneous completion, repeat misoprostol (expels GS > 60% of time ([Reeves, 2008](#)), or an aspiration procedure. (Or repeat mifepristone and misoprostol but minimal data on efficacy).



MANAGING COMPLICATIONS OF MEDICATION ABORTION

Complication	Clinical Presentation	Management Options	Occurrence Rate
Problematic bleeding and/or cramping	<ul style="list-style-type: none"> • Prolonged cramping, pain and/or bleeding • Retained gestational sac or tissue may be seen on US; inappropriate decline in hCG 	<ul style="list-style-type: none"> • Expectant management • Repeat misoprostol • Uterine aspiration 	2-9% (varies by study & GA)
Continuing Pregnancy	<ul style="list-style-type: none"> • May have scant bleeding after medications, persistent pregnancy symptoms • Ongoing viable intrauterine pregnancy (growing gestational sac or cardiac activity on US; rapidly rising hCG) 	<ul style="list-style-type: none"> • Uterine aspiration • Repeat misoprostol (if embryonic pole seen, expulsion occurred in 36% with and 54% without gestational cardiac activity)¹ • Repeat mifepristone and misoprostol (patient-centered approach but lacking evidence) 	≤63 d: <1% ^{2,3} 64-70 d: 3.6% with 1 dose, 0.4% with 2 doses ^{2,3} 71-77 d: 1.6% with 2 doses ³
Endometritis	<ul style="list-style-type: none"> • Typical endometritis: fever (>24 hours after misoprostol), pelvic/abdominal pain, vaginal discharge with odor, uterine/ adnexal tenderness • Atypical endometritis: included here for historical importance. <ul style="list-style-type: none"> ○ Incidence: extremely rare; 0.58 per 100,000 MABs in U.S. ○ Etiology: <i>Clostridium sordelii</i>- or <i>perfringens</i>-mediated toxic shock syndrome; can be severe or fatal. ○ Occurs 2-7 days after MAB ○ Symptoms: nausea, abdominal bloating, diarrhea, pain, malaise ○ Signs: usually afebrile, tachycardic, hypotensive, elevated WBC & hgb 	<ul style="list-style-type: none"> • Follow <u>CDC guidelines</u> for antibiotic therapy • Uterine aspiration if retained tissue present • Immediate hospitalization and aggressive treatment for atypical infection 	0.01-0.5% ^{2, 5} < 10 case reports by CDC ⁴
Ectopic Pregnancy	<ul style="list-style-type: none"> • May be asymptomatic or present with minimal bleeding or inappropriate decline in hCG after misoprostol, persistent positive urine pregnancy test • May present with pelvic/abdominal pain, history of bleeding or spotting during the pregnancy, shoulder pain, tachycardia/ hypotension. 	<ul style="list-style-type: none"> • Treat or refer as appropriate 	0.6% (in study of GA < 6 weeks in the U.S.) ²
Excessive Bleeding	<ul style="list-style-type: none"> • Heavy or prolonged vaginal bleeding with associated signs or symptoms (may include Hgb drop >2 points, orthostatic hypotension, tachycardia) • True hemorrhage is life-threatening emergency; rare but can occur • May result from retained pregnancy tissue; may present 2-5 weeks after mifepristone 	<ul style="list-style-type: none"> • Medical management (misoprostol, NSAIDs) 	
		<ul style="list-style-type: none"> • Uterine aspiration • FeSo4 	<1% ²
		<ul style="list-style-type: none"> • Blood transfusion • FeSo4 	<0.02-0.6% ^{2,5}

1. Reeves 2008 2. SFP ACOG 2014 Clinical Guidelines 3. NAF Clinical Practice Guidelines 2020 4. Meites 2010 5. Chen 2015

CHAPTER 4 EXERCISES: MEDICATION ABORTION

The exercises refer to mifepristone and misoprostol regimens unless otherwise stated.

EXERCISE 4.1

Purpose: To practice responses to questions that may arise during counseling.

What would you tell patients who ask the following questions?

1. I live 4 hours from the clinic. Can I still get the abortion pill? Can it be delivered?
2. What are my chances of needing an aspiration abortion?
3. How will I know if I'm bleeding too much?
4. What will I see when the pregnancy passes?
5. My partner wants me to keep this pregnancy. Will they know that I had an abortion?
6. I got a judicial bypass and my parents don't know I'm pregnant and having an abortion. Is this the right method for me?
7. I took abortion medications that I ordered online from a website. Does my provider have to report it?
8. I had a positive pregnancy test - a surprise because I am on testosterone which I'm taking as a transgender male. I am unsure of my LMP due to irregular spotting. I am interested in abortion pills being delivered to my home.
 - Do I qualify for a telemedicine medication abortion?
 - What additional workup do I need?
 - I received the medications in-person after an US showed a 6 wk pregnancy. I get telemedicine follow up in 1 week. In addition to confirming abortion completion, what else will I need?

EXERCISE 4.2

Purpose: To practice responding to follow-up questions that may arise by telephone.

How would you respond to the following questions?

1. I took the misoprostol 2 hours ago. Now my temperature is 100.5° F and I feel like I have the flu. Should I be concerned?
2. I took the misoprostol 30 hours ago and passed the pregnancy 24 hours ago, but now my temperature is 101.5 ° F.
3. I used the medication vaginally, but I think one of those pills just fell into the toilet (or vomited if using buccal or sublingual misoprostol). What should I do?
4. I took the mifepristone in the clinic yesterday and started to bleed like a period this morning. I have not taken the misoprostol yet. What should I do?
5. I vomited three hours after using the mifepristone, what should I do?
6. I am having new really heavy vaginal bleeding. It has been 4 weeks since my medication abortion. What should I do?

EXERCISE 4.3

Purpose: To practice follow-up and management of complications after medication abortion.

How would you manage the following situations?

1. A 29 year-old G3P1 patient requests medication abortion and is 6 weeks by LMP. Serum hCG level is 782 IU/L. Following mifepristone and misoprostol, the patient has moderate bleeding and cramping. When the patient returns on Day 4, serum hCG level is 5530 IU/L.
2. A 25 year-old G2P1 patient returns for follow-up after taking mifepristone and misoprostol. They report moderate bleeding and cramping a few hours after taking misoprostol, and have had no complaints since then. On a follow-up ultrasound, there is a moderate amount of heterogeneous debris in the endometrial cavity.
 - What management would you suggest for uterine debris?
 - How would you manage this patient differently if they were symptomatic with ongoing moderate vaginal bleeding and/or cramping?
3. A 19 year-old G4P0 patient who took mifepristone 4 days ago and took misoprostol 3 days ago returns today because of very heavy vaginal bleeding. They state they have soaked 5 maxi-pads in the last 3 hours.
 - What should you assess first?
 - What diagnostic work-up would you initiate?
 - What management options would you offer this patient?
 - What are indications for a uterine aspiration after medication abortion?

CHAPTER 4 TEACHING POINTS: MEDICATION ABORTION

The following exercises refer to mifepristone and misoprostol regimens unless stated otherwise.

EXERCISE 4.1

1. I live 4 hours away from the clinic. Can I still get the abortion pill? Can it be delivered to me?

- Yes. Patients can have a MAB and have the medications delivered to them if allowed in that state.
- Studies have demonstrated safety, effectiveness, efficiency, and acceptability of direct-to-patient telemedicine provision without any in-person visits ([Raymond 2019](#)) with medications delivered to the patient's requested address
- The follow up appointment may be done via telemedicine (with or without follow up urine hCG or serial blood hCGs drawn at a location in close proximity to the patient).
- Consider legality of telemedicine MAB depending on the state of practice ([KFF 2022](#)).

2. What are my chances of needing an aspiration abortion after medication abortion?

- MAB is >95% effective in most settings. Continuing pregnancy rate is rare ($\leq 1\%$ to 3% , as above) regardless of pregnancy dating when using the recommended mifepristone with misoprostol regimens. Redosing misoprostol alone (or mifepristone and misoprostol) is an option that can be discussed but has limited evidence. For >63 days LMP, the total incidence of aspiration after MAB is 2-9%, with the range decreasing to <1% to 3% when a second dose of misoprostol is used ([NAF CPG 2022](#)).
- Uterine aspiration may be needed for excessive bleeding/cramping, or by patient request.
- For persistent gestational sac without evidence of development, a 2nd dose misoprostol can be offered, or patient can be followed for several more weeks if stable.
- For asymptomatic patient (minimal bleeding or cramping) with echogenic material and thickened endometrial stripe on US, no further treatment is necessary.

3. How will I know if I'm bleeding too much?

- After misoprostol, bleeding usually starts within 1 to 10 hours (average 4 hours).
- Bleeding can be heavier than a normal period and accompanied by cramps and/or clots. Bleeding usually slows substantially after passing the pregnancy.
- If the bleeding soaks more than 2 maxi-pads per hour for greater than 2 consecutive hours, that is more than normal; have patient call if they are concerned.
- Hypovolemia symptoms warrant immediate evaluation (history, orthostatic vital signs, pelvic exam) and often urgent uterine aspiration.
- Hemoglobin or hematocrit can guide the need for iron or blood transfusion.
- Blood transfusion is rarely needed (<0.2% of cases).
- There is scant data regarding the optimal treatment for moderate bleeding. The efficacy of commonly used agents (such as a second dose of misoprostol, methylergonovine, or a tapered regimen of high-dose oral contraceptives) is unknown.

4. What will I see when the pregnancy passes?

- Below 63 days LMP, blood and clots are normally visible, and it is unlikely a patient would identify an embryo.
- At > 63 days LMP, the fetus may be identifiable; counsel patients accordingly.
- Consider showing a drawing and counsel with information such as: "At X weeks of

pregnancy, this is what the pregnancy / fetus looks like. Would you like more information or do you want to go ahead with the medication abortion?" If they are not comfortable, they may prefer an aspiration abortion.

5. My partner wants me to keep this pregnancy. Will they know that I had an abortion?

- The symptoms of an abortion with pills and a miscarriage (spontaneous abortion) are identical. Miscarriage happens in 15-20% of all pregnancies

6. I got a judicial bypass and my parents don't know I'm pregnant and having an abortion. Is this the right method for me?

- Discuss the individual circumstance with the patient, to help them decide whether a medication or an aspiration abortion might be preferable.
- Explore options for a safe location where the young person might be able to use the misoprostol; e.g. a supportive relative's house, a friend's house.

7. I took abortion medications that I ordered online from a website. Does my doctor have to report it?

- Self-managed abortions by any method are criminalized in some states in the U.S. and people can face prosecution. Health care providers do not have to report it if you disclose it to them. Please refer to <https://www.reprolegalhelpline.org/> for more details.
- There is no blood test to find out if you took the abortion medications. However, patients in restrictive areas may want to avoid vaginal misoprostol, as fragments may be found on vaginal exam.

8. I had a positive pregnancy test - a surprise because I am on testosterone (which I'm taking as a transgender male). I am unsure of my LMP due to irregular spotting. I am interested in abortion pills being delivered to my home.

• Do I qualify for a telemedicine medication abortion?

No, due to unknown LMP and irregular spotting, we are unable to date the pregnancy or confirm intrauterine pregnancy. Additionally, provision via telemedicine must be allowed in your state (currently in 31 states; [KFF 2022](#)).

• What additional workup do I need?

The patient therefore needs an US prior to visit or in the office.

• I received the medications in-person after an ultrasound showed a 6 wk pregnancy. I get telemedicine follow up in 1 week. In addition to confirming abortion completion, what else will I need?

Even in amenorrheic patients, testosterone therapy does not necessarily stop ovulation, and is not effective as contraception ([Bonnington 2019](#)). Discuss birth control options during the initial appointment or during follow up if patient desires.

EXERCISE 4.2

1. I took the misoprostol 2 hours ago. Now my temperature is 100.5° F and I feel like I have the flu. Should I be concerned?

- No. Common side effects of misoprostol are temperature elevation, and flu-like symptoms. These are usually self-limited, and the body temperature should return to normal within a few hours. Have the patient recheck temperature again in 2-3 hours.

2. I took the misoprostol 30 hours ago and passed the pregnancy 24 hours ago, but now my temperature is 101.5 ° F.

- Persistent elevated temperature (>100.4° F) for several hours or > 24 hours after misoprostol warrants an office visit to evaluate for infection. Work-up should include:
 - Evaluation for other etiologies of symptoms
 - Questions about pelvic pain, bleeding pattern, or odorous discharge
 - Review of systems to rule out other sources of fever
 - Pelvic exam for tenderness, pus, GC/CT if not done prior
 - CBC to evaluate for leukocytosis
 - Ultrasound to evaluate for retained tissue
- Significant pelvic or cervical motion tenderness with fever suggests post-abortal endometritis, and appropriate antibiotics should be initiated. If US shows significant intrauterine material, uterine aspiration is also indicated.
- If additional concerns arise for atypical infection, further evaluation may be warranted. In very rare cases, patients have presented with low-grade fever and nonspecific complaints (abdominal or pelvic pain, nausea, diarrhea, malaise) along with dramatic leukocytosis and hemoconcentration (Fjerstad 2011, Meites 2010) In patients with this presentation, a high index of suspicion is needed for *Clostridium*-mediated toxic shock syndrome as it may progress rapidly to fulminant sepsis and death. If atypical infection is suspected, refer for inpatient sepsis management with infection disease consultation.

3. I used the medication vaginally, but I think one of those pills just fell into the toilet (or vomited if using buccal, sublingual, oral misoprostol). What should I do?

- If the misoprostol pills are vomited (or fall out if taken vaginally) less than 30 minutes after placed, the patient may need a second misoprostol dose. If >30 minutes has elapsed, there is no need to redose as the active ingredient will have had adequate time to be absorbed, even if the pill appears undissolved. They may choose to wait to see if appropriate bleeding begins, and re-dose if no bleeding occurs within 4 hours. Discuss taking antiemetics prior to redosing misoprostol if the patient vomited.

4. I took mifepristone in the clinic yesterday and started to bleed (like a period) this morning. I have not taken the misoprostol yet. What should I do?

- Mifepristone alone may cause bleeding but is often inadequate for successful abortion; misoprostol significantly increases efficacy - and therefore the safety of the regimen.
- Advise the patient to take misoprostol now.

5. I vomited three hours after using the mifepristone, what should I do?

- Nothing. There is no need to redose the mifepristone if ingested for >30 minutes .

6. I am having new really heavy vaginal bleeding. It has been 4 weeks since my medication abortion. What should I do?

- Assess the amount of bleeding, symptoms of hypovolemia to ensure no hemorrhage.
- Review records for confirmation of MAB completion (symptom check with negative home urine pregnancy test, adequately down-trending serum hCG, or US).
- If there has been little to no interim symptoms of prolonged bleeding and cramping, this new onset heavy bleeding may represent onset of menses.
- If prolonged bleeding and cramping have been ongoing, consider evaluation and management with uterine aspiration as appropriate.

EXERCISE 4.3

1. A 29 year-old G3P1 patient requests medication abortion and is 6 weeks by LMP. Serum hCG level is 782 IU/L. Following mifepristone and misoprostol, the patient has moderate bleeding and cramping. When the patient returns on Day 4, serum hCG level is 5530 IU/L.

- This patient's rapidly rising hCG level suggests continuing viable pregnancy, despite a history of bleeding after misoprostol. Ectopic pregnancy should also be excluded.
- Consider US, if available and the patient is able to follow up in the office.
- If ectopic can be firmly ruled out with an US, treatment options include aspiration, repeat misoprostol alone (second dose is about 30% effective), or repeat mifepristone with misoprostol (may be a patient-centered option, but no evidence base for efficacy).
- If no intrauterine pregnancy is identified despite rising hCG, the patient must be evaluated and treated for presumed ectopic pregnancy.

2. A 25 year-old G2P1 patient returns for follow-up after taking mifepristone and misoprostol. They report moderate bleeding and cramping a few hours after taking misoprostol, and have had no complaints since then. On a follow-up ultrasound in 2 weeks, there is a moderate amount of heterogeneous debris in the endometrial cavity.

- What management would you suggest for heterogeneous uterine material?
 - If US is performed at the follow-up visit, the sole purpose is to determine if the patient is still pregnant ([SFP 2014](#)).
 - Endometrial thickness should not be used to guide management after MAB. The post-abortion uterus will normally contain sonographically hyperechoic tissue that consists of blood, blood clots, and decidua ([Reeves 2009, 2008](#)). In the absence of heavy bleeding or cramping, avoid unnecessary intervention for US findings ([NAF CPG 2022](#)).
 - Providers can monitor such patients based on symptoms ([SFP 2014](#)).
- How would you manage this patient differently if they were symptomatic with ongoing moderate vaginal bleeding and/or cramping?
 - An aspiration may be warranted for hemodynamic instability or for patient preference ([SFP Clinical Guidelines 2014](#)).
 - Clinicians providing MAB may wish to be trained in uterine evacuation procedures; alternatively, they may establish referral relationships with other providers trained in aspiration.

3. A 19 year-old G4P0 patient took mifepristone 4 days ago and took misoprostol 3 days ago returns today because of very heavy vaginal bleeding. They state they have soaked 5 maxi-pads in the last 3 hours.

- What should you assess first?
 - Hemodynamic status (orthostasis or orthostatic vital signs)
 - Exam to assess active bleeding and uterine boggy
- What diagnostic work-up may be of assistance?
 - Hemoglobin/hematocrit
 - Ultrasound (if available)
- What management options would you offer this patient?
 - Urgent uterine aspiration is indicated
 - Intravenous access is likely indicated
 - Uterotonics may be indicated
 - Initiate iron supplementation as needed
 - Blood transfusion is rarely needed but may be necessary.
- What are indications for a uterine aspiration after medication abortion?
 - Bleeding in hemodynamically unstable patient (emergent)
 - Continuing pregnancy: Persistent growth, cardiac activity, or persistent increase in hCG. Can offer:
 - Uterine aspiration
 - A second dose of misoprostol (completes expulsion in 35% patients with ongoing pregnancy <63 days; [Reeves 2008](#)), or
 - Repeat misoprostol and mifepristone (patient-centered but not evidence based approach, lacking data on efficacy), or
 - Symptomatic problematic bleeding / cramping unresponsive to medical treatment
 - Patient preference if declines repeat misoprostol and has retained pregnancy or tissue

5. PAIN MANAGEMENT AND OTHER MEDICATIONS

*Updated March 2022, by Hannah Rosenfield MD, Deyang Nyandak MD,
and Hannah Biederman, MD*

This chapter describes methods of pain management as well as medications used before, during, and after uterine aspiration, including medications indicated for clinical emergencies.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

- Describe the role of antibiotic prophylaxis and cervical ripening in uterine aspiration
- List when to use Rh-D immunoglobulin in the prevention of isoimmunization
- List pain control options for uterine aspiration, effectiveness, and considerations for patients who use opioids
- Perform techniques and describe precautions for paracervical block
- Understand options for patient-centered individualized care for pain control
- Identify appropriate responses to and medications for clinical emergencies

VIDEOS

- Pain with Uterine Aspiration Abortion (IERH): <https://vimeo.com/129470439>

READINGS / RESOURCES

- [Paul et al \(eds\)](#). Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care, Chapter 8 (Wiley-Blackwell, 2009)
- NAF: [Managing Pain for Patients using Medication-Assisted Treatment for Opioid Use](#)
- SFP: [Clinical Recommendations for Pain Control](#)

SUMMARY POINTS

SKILLS

- Pain perception includes both physical and psychosocial elements, and is best managed with both non-pharmacological and pharmacological techniques.
- Studies show racial disparities in pain care, maternal morbidity and mortality, as well as disparities in pain management for people with substance use disorder, raising important opportunities for clinicians to pause and evaluate their own biases.
- Non-pharmacological methods of pain management offer multi-modal options for pain control that allow for individualized care at low-risk.
- Paracervical block helps reduce pain, and there are many variations on technique.
- Oral NSAIDs, anxiolytics, or opioids may be given individually or together prior to uterine aspiration, although the latter may cause nausea with limited benefit.
- Intravenous pain management may be chosen if monitoring and staffing are available; patients may require provision of respiratory support.
- Individuals who regularly use opioids or have opioid use disorder on medication assisted therapy should continue their medications prior to a procedure, and may require higher doses of pain medications. Substance use should not impact a clinician's usual assessment of capacity for informed consent.

SAFETY

- Universal pre-procedure antibiotic prophylaxis for uterine aspiration is well supported by the available evidence.
- Attention to allergies, concurrent medications, conditions that compromise respiratory status, recommended dose limits, and reversal agents will improve safety.
- Emergency management simulations and supplies should be regularly reviewed.

ROLE

- Participation in decisions around the procedure, gentle procedural technique, deep-breathing techniques, distraction through conversation, the support of a partner, friend, doula, or medical assistant, and a reassuring tone of voice will all be helpful in addition to pain medication.

PRE-PROCEDURE MEDICATIONS

PROPHYLACTIC ANTIBIOTICS

There is strong evidence for the use of routine antibiotic prophylaxis in people undergoing uterine aspiration for abortion. People who received antibiotics were 0.59 times as likely to experience post-abortion infection compared to those who received placebo in a Cochrane review of 15 randomized controlled trials (Low 2012). This protective effect was evident in people with and without risk factors (history of PID, positive CT, or pre-procedural BV). Limited evidence suggests that routine antibiotics are optional for asymptomatic people undergoing uterine aspiration for early pregnancy loss (Goranitis 2019).

Evidence supports pre-procedure dosing of prophylactic antibiotics for maximal effect, and the shortest possible course to give the lowest risk of adverse reactions and antibiotic resistance (Achilles 2011). Effective regimens include metronidazole, tetracyclines (e.g. doxycycline) or azithromycin. There is little data to support post-procedure antibiotics (Achilles 2011).

CERVICAL PREPARATION FOR FIRST TRIMESTER PROCEDURES

Misoprostol and other methods of cervical ripening for uterine aspiration have been well researched. While cervical preparation with misoprostol is generally safe and may decrease procedure time, it is not routinely recommended for uterine aspiration under 12 weeks gestation. This is due to increased waiting time, bleeding, cramping, other side effects, and minimal demonstrated benefit for ease of dilation or pain (Ipas 2021, Kapp 2010, Allen 2007). It is recommended to consider cervical preparation in adolescents (especially > 12 weeks), when an initial dilatation attempt has been challenging (SFP 2015). Misoprostol can be administered vaginally, sublingually, and buccally. Evidence-based recommendations when using misoprostol include 400 mcg sublingually 1-2 hours prior to the procedure, or 400mcg buccally or vaginally 2-3 hours prior to the anticipated procedure (NAF 2022, Meirik 2012, Saav 2015). An alternative regimen using 600 mcg misoprostol 1.5 hours prior to the procedure was found to be non-inferior with improved patient acceptability in the late first trimester (Dean 2017). One non-misoprostol regimen to consider is mifepristone 200 mg orally 24-48 hours prior to the anticipated procedure (NAF 2022).

RH-D IMMUNOGLOBULIN

Rh alloimmunization may jeopardize the health of a subsequent pregnancy. While past guidelines recommended all Rh-negative abortion patients be tested and receive anti-D immunoglobulin, new evidence has called this practice into question. Flow cytometry studies show first trimester fetal red blood cell exposure remains below the calculated threshold for maternal Rh sensitization until after 12 weeks of pregnancy (Chan 2021, Horvath 2020, Hollenbach 2019, Weibe 2019).

- Rh testing must be offered to people with unknown Rh status > 12 weeks LMP and anti-D IG offered to patients > 12 weeks who are Rh negative.
- For patients < 12 weeks by LMP, may forego Rh testing and Rh-D IG for aspiration or medication abortion (NAF 2022, WHO 2022).

Additionally:

- A person > 12 weeks LMP declining Rh testing or anti-D IG should sign an informed waiver, including a patient who desires no future children.
- Documentation may be by onsite testing, outside source, or self-report.
- Document discussion and waiver for Rh testing as appropriate.
- When Anti-D IG indicated, use 50 mcg at < 13 wks, or 300 mcg at > 13 wks.

- Second injection indicated only if last > than 3 weeks earlier (Bichler 2003).
- Anti-D antibodies may be present if a patient had anti-D IG injection within the last 3 months or was sensitized from a prior pregnancy.
- For sensitized individuals, an additional anti-D IG injection is not indicated.

PAIN MANAGEMENT

Pain perception during uterine aspiration is a complex phenomenon influenced by both physical and psychosocial elements, and can vary considerably between individuals. The table below summarizes the research on factors associated with pain during uterine aspiration. In the multivariable analyses, no single factor predicts procedure-associated pain (Singh 2008) and every person deserves a discussion of pain control options.

Additionally, racial biases have been shown to contribute to provider perception of a person’s pain and subsequent treatment decisions regarding pain management (Mende-Siedlecki 2019; Sabin 2020). A meta-analysis on pain management including 20 years of data found that Black patients were 22% less likely to receive pain management than white patients, and the size of the difference was sufficiently large to raise not only normative but quality and safety concerns (Meghani 2012). To improve patient care and equity, providers should work to identify and minimize their own biases, which may include unlearning of prior practices.

FACTORS ASSOCIATED WITH PAIN DURING UTERINE ASPIRATION

Increased Pain	Decreased Pain	Conflicting Results	Not Strongly Associated
Anxiety/depression Ambivalence Expectation of pain Younger patient age Dysmenorrhea Fewer pregnancies	Previous vaginal delivery Older patient age More pregnancies Shorter operative time Participation in the choice of anesthesia	Gestational age Max cervical dilation Comfort w/ decision Provider experience	Prior pelvic exam Prior uterine aspiration Prior cesarean section Manual vs. electric uterine aspiration

NON-PHARMACOLOGIC PAIN MANAGEMENT

Many people have anxiety about anticipated pain. Supportive verbal communication, including distraction and so-called “vocal local” or “verbicaine,” can play a role in reducing anxiety and pain. Providers can acknowledge the possibility of pain while offering strategies to manage it. Offering elements of positive suggestion may help to allay concerns. For example:

“It is normal to be worried, and often people are surprised that the procedure is faster and more tolerable than expected. Pain can vary, but slow deep breathing helps, and I’ll give you some numbing medicine and be as gentle as possible.”

Guiding patients to take slow, deep, regular breaths can assist in reducing anxiety, avoiding hyperventilation, and also give an increased sense of control. Encourage patients to release their hips into the table instead of pulling away and tightening.

Guided imagery can also decrease anxiety and analgesic requirements for surgical patients (Gonzales 2010). Consider encouraging patients to recall a favorite place, activity, or color, during the procedure. Relaxing images or mobiles above the exam table have also been used to decrease pain and anxiety during gynecologic procedures (Carwile 2014). Playing music in the room may be helpful with anxiety and satisfaction, but does not decrease pain (Wu 2012, Guerrero 2012, Cepeda 2006). A heating pad or hot water bottle may be helpful during the procedure, in recovery or at home. A support person of the patient’s choice can also improve their abortion experience (Altshuler 2021). For additional considerations, see the RHAP Contraceptive Pearl (Ti 2022).

CHOICE OF PAIN MANAGEMENT METHODS

Discussion of pain management options should be reviewed as part of the informed consent process, including the range of possible experiences, available options for pain management, as well as their risks and benefits. If someone has a strong preference for an option your facility does not offer, an appropriate referral can be given.

Premedication with NSAIDs has been shown to decrease pain during and after the procedure, and has few contraindications or side effects (Ipas 2021). Some people choose this option to be more alert, have shorter recovery, or to drive themselves home.

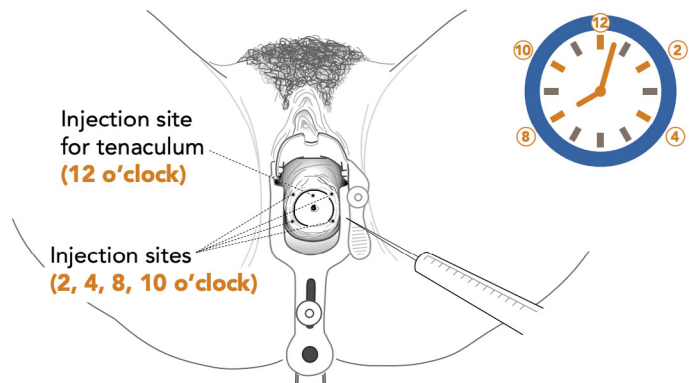
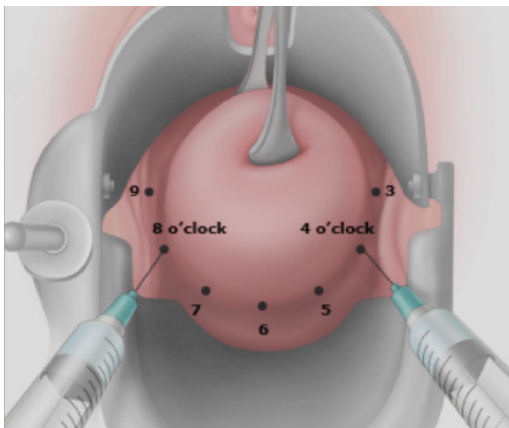
Other patients may choose more sedating options to reduce pain and anxiety, to induce some degree of amnesia, or to manage a later procedure. Oral opiate analgesics have shown minimal effect on pain compared to placebo and cause more side effects including nausea (Micks 2012). IV sedation may be offered in some settings for people who request more analgesia, although some medical conditions, monitoring, or facility limitations preclude moderate or deep sedation. Deep sedation can be used, but is not routinely recommended (Ipas 2021).

PROVIDING EFFECTIVE LOCAL ANESTHESIA

Local anesthesia options include paracervical block (PCB) and vaginal lidocaine.

Below are techniques and pitfalls of paracervical block, preparations, and injection.

- Paracervical block (PCB) is effective at reducing pain, although injection can be painful (Renner 2012). Injection locations and techniques vary by provider.
- A four-site PCB appeared to be superior to a two-site PCB (Renner 2016).
- Reported pain scores during dilation and aspiration are improved with 20mL buffered lidocaine and deep injections (1.5 to 3 cm) (Renner 2010, Moayedi 2018).
- Slower injection (30 sec vs. 120 sec), smaller needle diameter (e.g. 25 gauge), or injecting ahead of the needle may decrease pain.
- Some use cough technique during injection, but data is limited (Lambert 2020).
- Local anesthetics block nerve impulses, and volume causes tissue distention, separating nerve endings, providing some analgesic effect.
- Saline has less effect than lidocaine (Chanrachakul 2001).
- Ketorolac in block decreased dilation pain, but not overall pain (Cansino 2009).
- No evidence suggests one anesthetic is superior; options are reviewed below.
- No study demonstrates complete pain prevention with local anesthesia, some providers test with light stimulation, adding additional anesthesia if needed and safe.



One approach is to inject 1-2 mL at 12 o'clock for the tenaculum, and then inject at 4 and 8 o'clock as depicted above to target paracervical innervation. Other approaches are to inject at 2 and 10 o'clock, or 3 and 9 o'clock. Images: VIDAeff 2016 & Ipas.

Self-administered vaginal lidocaine gel is noninferior to PCB in first trimester procedural abortions, and may be considered as an alternative, noninvasive approach to pain control (Conti 2016, Liu 2021).

TIPS TO MINIMIZE SYSTEMIC ABSORPTION

The most studied maximum dose of lidocaine in pregnancy is 200 mg [achieved for example, by giving 20 ml of 1% lidocaine (10 mg/ml)]. A study of paracervical block combined with intrauterine lidocaine in pregnancy found a dose of 300 mg was safe, but with more systemic side effects (Edelman 2006). A maximum dose of 300 mg of lidocaine is typically recommended for any local anesthetic use. With IV injection, people may experience peri-oral tingling, dizziness, tinnitus, metallic taste or irregular/slow pulse. At higher concentrations, they may have muscular twitching, seizure, cardiac arrhythmias, unconsciousness, and even death (Paul 2009).

- Minimize direct intravascular injection and excessive anesthetic dosing.
- Use a combination of superficial (1 cm) and deep injections (3 cm).
- Move the needle while injecting (superficial to deep) and/or aspirate before injecting.
- Use a dilute concentration (using 0.5% lidocaine or diluting with saline).
- Use a vasoconstrictor mixed with the anesthetic to slow systemic absorption.

Generic (Trade)	Potency	Onset	Duration	Max Dose (mg) without epi
Bupivacaine (Marcaine)	Strong	Medium (to 20 min)	Long (3-6 h)	175 mg
Lidocaine (Xylocaine)	Medium	Fast (4-7 min)	Medium (1-2 h; 3 h w/ epi)	300 mg
Mepivacaine (Carbocaine)	Medium	Fast (4-7 min)	Medium (3 h)	400 mg
Chloroprocaine (Nesacaine)	Weaker	Fastest	Short (30 min)	800 mg

UNIVERSAL PRECAUTIONS

To prevent transmission of blood-borne pathogens, universal precautions include:

- Glove and use protective eye wear when working with body fluids (i.e. injection, procedure, handling of tissue or contaminated instruments).
- Avoid recapping contaminated needles, and place sharps immediately in a puncture-resistant container for disposal.
- For blood exposure, inform your supervisor, and consult National Clinicians' [Post-Exposure Prophylaxis Hotline](#).

CONTINUUM OF SEDATION LEVEL

Various approaches to pain management may be offered, depending on the clinical situation and resources. Below is a short summary of the levels of sedation, examples of medications used, and the associated risks.

Level of Sedation	Example	Responsiveness	Airway	Spontaneous Ventilation	Cardiovascular Function
Minimal (Anxiolysis)	Oral lorazepam and/or hydrocodone	Normal response to verbal stimulation	Unaffected	Unaffected	Unaffected
Moderate “Conscious Sedation”	Fentanyl +/- Midazolam	Purposeful response to verbal or tactile stimulation	No intervention required	Adequate	Usually maintained
Deep	Add propofol or higher doses of meds used for moderate sedation	Purposeful response following repeated or painful stimulation	Intervention may be required	May be inadequate	Usually maintained
General Anesthesia	Propofol or other medications	Unarousable even with painful stimuli	Intervention often required	Frequently inadequate	May be impaired

Adapted from Continuum of Depth of Sedation: Definition of GA and levels of Sedation / Anesthesia, [ASA 2019](#).

MONITORING GUIDELINES

- During moderate sedation, a person trained to monitor cardiorespiratory and level of consciousness must be present, other than the provider.
- Moderate sedation may lead to deep sedation with hypoventilation, so providers must be prepared to provide respiratory support ([ASA 2019](#)).
 - Pulse oximetry should be used to enhance monitoring.
 - IV access should be maintained.
 - Verbal responsiveness should be checked frequently.
 - For patients with severe systemic disease, a higher level of care should be considered
- When moderate sedation is used, monitoring must be of a degree that can be expected to detect the respiratory effects of the drugs being used.
- The practitioner administering deep sedation or general anesthesia must be certified according to applicable local, hospital, and state requirements.

CONSENT CONSIDERATIONS PRIOR TO SEDATION

Obtaining informed consent should occur prior to initiation of sedating medications. If a patient is drowsy or unable to answer orienting questions, consider having them rest awhile and reevaluate for consent. Substance use disorder history, and use of MAT medications does not alter the informed consent process; in fact withdrawal symptoms may impede proper consent.

It is also important to use verbal consent throughout the procedure as is recommended with trauma informed care.

Techniques for evaluating if patients are able to consent for a procedure include asking orientation questions and having patients repeat information back after reviewing it, with the following key considerations of medical decision making capacity. Patients must be able to:

- demonstrate an understanding of risks, benefits and alternative options
- demonstrate an appreciation of those benefits and risks
- shows reasoning in making a decision
- communicate their choice

PAIN CONTROL CONSIDERATIONS FOR PEOPLE WHO USE OPIOIDS

Incidence of opioid use and opioid use disorder is increasing in the U.S. ([CDC 2021](#)). People who use opioids regularly may develop tolerance to opioid medications and / or may be on medication assisted therapy (MAT).

Common Medication Assisted Therapy (MAT) for Opioid Use Disorder		
Methadone	Full opioid agonist	People on methadone and buprenorphine should continue their medications as prescribed to prevent withdrawal and reduce the risk of return to use.
Buprenorphine +/- Naloxone (Suboxone, Subutex)	Partial opioid agonist +/- antagonist	
Naltrexone	Opioid antagonist	People on oral naltrexone should hold their medication for 72 hours if possible to allow opioids to work. An abortion should not be delayed to allow IM naltrexone to wear off.

There is no difference in the goal of pain management for people with opioid tolerance (or opioid use disorder) compared to those who do not use opioids regularly. Here are general principles ([Snyder, NAF 2018](#), [SAMHSA 2021](#), [ASAM 2020](#), [Huxtable 2011](#)):

- People who use opioids or are on MAT may need higher opioid doses to achieve adequate analgesia, particularly to overcome the opioid receptor blocking effects of buprenorphine and IM naltrexone.
- MAT for opioid use disorder will not contribute to the analgesia provided.
- Short acting, high affinity opioids like fentanyl or hydromorphone (Dilaudid) are effective and safe to use.
- Benzodiazepines may be more sedating for people on buprenorphine and methadone.
- Determine dosing by monitoring reported pain, alertness, and respiratory rate.
- Ensure reversal agent (naloxone) is available, and start with a low dose if needed to reduce withdrawal risks.
- Reassure that you will provide adequate pain control. Be aware that people with opioid use disorder, particularly people of color, may have experienced medical discrimination and inadequate pain control in the past.
- Don't forget to additionally utilize other pain control methods such as NSAIDs, local anesthetic, breathing and visualization techniques, and a support person.
- Trauma informed care is for everyone. Rates of physical, emotional, and sexual trauma are higher in this population. Acknowledge that using opioids for pain management may be triggering for some people.
- The expected duration of pain from uterine aspiration is the same as with people not on MAT, and post-procedural pain management should not differ.
- MAT prescribers can often provide guidance for acute pain control, and can help provide close follow up after the patient received opioids. Communicate with the prescribing clinic or physician if possible, or offer a note documenting the opioids received under your care.
- For additional considerations, see the [RHAP Contraceptive Pearl](#) on "Special Considerations for People with Substance Use Disorder" (Attaie 2022).

PAIN MANAGEMENT OPTIONS FOR PEOPLE WITH OPIOID USE DISORDER

Aspiration Abortion	Management Options	
Managing MAT prior to procedure	Buprenorphine: Continue home dose. Methadone: continue dose on day of procedure. Naltrexone (po): hold for 72 hours prior to procedure Naltrexone (IM): avoid procedural delay as opioids may be ineffective if <30days since last injection.	
Oral pain medication pre-procedure	Give NSAID (e.g., ibuprofen or ketorolac) if used. Any opioid may be given**. May give twice the standard dose. Opioids are less effective if the patient is on naltrexone. Lorazepam 1-2 mg (avoid if also using IV midazolam during procedure). Consider gabapentin 300 -600 mg (may cause sleepiness after procedure).	
Moderate Sedation	For patients on Methadone or Buprenorphine	For patients on Naltrexone (po < 72 hours, IM < 30 days)
	Cervical block Fentanyl 200 mcg IV (higher initial doses are often needed). Midazolam 2 mg IV (may repeat 1-2 mg q 2-5 minutes). Can take 3-6 minutes before full effect. Consider ketamine 0.3-1.0 mg/kg (25- 50 mg, slow push IV. Consider dexmedetomidine 25 mcg slow push IV (repeat q5-10 min as needed).	Cervical block Fentanyl ineffective at office-based doses. Midazolam 2 mg IV (may repeat 1-2 mg q 2-5 minutes). Can take 3-6 minutes before full effect. Consider ketamine 0.3-1.0 mg/kg (25- 50 mg, slow push IV. Consider dexmedetomidine 25 mcg slow push IV (repeat q5-10 min as needed).
Deep sedation	Cervical block Propofol per facility protocol Careful escalation of fentanyl with monitoring.	
Post-procedure pain management for home use	Give NSAIDs (e.g., ibuprofen) Give acetaminophen (maximum daily dose < 4000 mg) Avoid opioids or mixed narcotic analgesics (e.g., Tylenol with codeine)	
Medication Abortion		
Home pain management	Continue regular dose of medication-assisted treatment Give NSAIDs (e.g., ibuprofen) Give acetaminophen (maximum daily dose < 4000mg) Avoid opioids or mixed narcotic analgesics (e.g., Tylenol with codeine)	

Snyder, NAF 2018

**While data show oral opioids may increase nausea without improving pain, there are situations in which they are used, and may require higher doses in opioid use disorder.

BASIC MEDICATION OPTIONS

Drug (Class)	Dose Range	Comment
Local Anesthesia and Additives		
Lidocaine (Xylocaine) (0.5% – 1%)	Most common 100- 200 mg (20 mL 1% or 40 mL 0.5%), maximum dose 300 mg	Most common in U.S. Lower concentration as effective but more expensive
Bacteriostatic Saline	20 mL	Less effective than lidocaine
Bicarbonate Buffer	1mL / each 10mL of lidocaine	Less injection pain and faster absorption; only for use with lidocaine
Vasopressin (Vasostrict)	3-5 units mixed with anesthetic	Decreases bleeding & slows systemic absorption; do not recommend more than 5 units total
Oral and IV Pain Medications		
Ibuprofen (Motrin; Advil)	600 – 800 mg PO	More effective at least 30 minutes before procedure
Naproxen (Naprosyn; Aleve)	250 – 500 mg PO	More effective at least 30 minutes before procedure
Acetaminophen	500 – 1000 mg PO	Can be added to PO regimen (limited evidence based data)
Hydrocodone or Codeine	1-2 tablets of 5mg hydrocodone or or 30 mg codeine PO	Equivalent medications can also be used or those combined with acetaminophen
Fentanyl (Sublimaze)	50 – 100 µg IV	Give over 30-60 seconds. Antidote is naloxone
Anxiolytics		
Lorazepam (Ativan)	0.5–2mg mg SL or 1-2 mg PO	Shorter acting benzodiazepine. Antidote is flumazenil
Diazepam (Valium)	5 –10 mg PO	Longer acting benzodiazepine. Antidote is flumazenil
Midazolam (Versed)	1 – 2 mg IV	Give over 30-60 seconds. Antidote is flumazenil
Uterotonics for Post-Aspiration Hemorrhage		
Methylergonovine (Methergine)	0.2 mg PO/IM or intracervical	Use with caution in hypertensive patients
Misoprostol (Cytotec)	800mcg SL or 800-1000mcg PR	Given a rapid time to peak concentration, SL or buccal may be preferable to PR if possible (Kerns 2013)
Carboprost (Hemabate)*	0.25 mg IM, may repeat at 15-90 minute intervals to max of 2mg	Use with caution in asthmatic patients * Not available for use outside inpatient medical facilities
Oxytocin (Pitocin)	10 u IM, or 10-40 u IV in crystalloid, or 10 u IVP	More uterine oxytocin receptors > 20 weeks
Tranexamic acid (TXA)	1 g / 100mL NS IV over 10 min	May repeat 1 g dose in 30min for total of 2 g
Emergency Medications		
Atropine Sulfate (Atropen)	0.2 mg (0.5 mL) IV push or 0.4 mg (1 mL) IM, each 3-5 min to max dose of 2 mg	For prolonged symptomatic bradycardia with vasovagal Some use in paracervical block to prevent vasovagal
Diphenhydramine (Benadryl)	25 – 50 mg IM/IV/PO	For allergic reaction Use PO for mild symptoms and IM/IV for anaphylaxis
Epinephrine 1:1000 (Adrenalin)	0.3 – 0.5 mg (1 mg/mL) SQ/IM Repeat in 5-15 min as needed	For anaphylaxis. Preferable to inject in mid-anterolateral thigh
Naloxone (Narcan)	0.1 mg – 0.2 mg (0.25-0.50 mL) IV / IM each 2-3 min Max dose 0.4 mg OR 2- 4 mg Intranasal	Opiate antidote
Flumazenil (Romazicon)	0.2 mg (2 mL) IV each min Max dose of 1 mg	Benzodiazepine antidote

Alternative or supplemental options for pain management can include ketamine IV, dexmedetomidine IV, gabapentin ([Gray 2019](#)), and nitrous oxide ([Singh 2017](#)). However limited data on pain improvement with use.

MANAGING EMERGENCIES

MAINTAIN CLIENT SAFETY • CALL FOR HELP • ASSESS CLIENT CONDITION						
Symptoms/ context	Recent exposure Hives Coughing/ sneezing Low pulse Flushed/ agitated More severe: SOB	High pulse Cool, clammy skin Low BP Perioral cyanosis Onset over minutes or hours Rare syncope	Low pulse Low BP Pale, sweaty Cool, clammy skin Nausea, vomiting May lose consciousness Sudden onset	Unresponsive No pulse Absent respirations	Rhythmic limbs, jaw movements Pulse >60 Possible incontinence	Anxious Rapid, shallow breathing Normal pulse Numbness Carpal-pedal spasm
Most likely diagnosis	Anaphylaxis	Hypovolemic Shock	Vasovagal Reaction (Neurogenic Shock)	Cardio- Pulmonary Arrest	Seizure	Hyper- ventilation
Management	Call 911 Epinephrine 1:1000 0.2–0.5 SQ/IV in 10 mL NS, slow push Benadryl 50 mg IM Oxygen	Call 911 Elevate legs Place large bore IV, infuse NS rapidly	Keep supine Elevate legs Isometric muscle contractions Cool cloth/ice pack Ammonia capsule Oxygen	Call 911 & for AED Start CPR (30:2) Attach AED; defibrillate if indicated	Prevent injury Lateral position to protect airway Let seizure run its course Oxygen	Reassure patient Slow-count breathing Place paper bag over mouth to re-breathe CO ₂
Important considerations	If low BP: Start IV LR or NS	Evaluate source and manage (6Ts) Start 2nd IV line	If persistent symptomatic bradycardia: Give Atropine 0.2 or 0.4mg IM / IV If no recovery call 911	Every 2 minutes check pulse, rhythm, and switch compressors until EMS arrives	If continues >2min, call 911 Give Diazepam (Valium) 5 mg IV or Midazolam 5-10 mg IM	Assure patient is stable before leaving the clinic

- Clinics should have written protocols for the management of medical emergencies, including bleeding, perforation, respiratory depression/arrest, anaphylaxis, and emergency transfer.
- Clinics should have hospital transfer agreements outlining the means of communication and transport and the protocol for emergent transfer of care. (NAF CPGs 2022)
- Emergency scenarios are available for role-plays, debrief, and teaching at <https://www.teachtraining.org/training-tools/simulation-workshops/medical-emergency-drills/>

• **CHAPTER 5 EXERCISES:**
MEDICATIONS AND PAIN MANAGEMENT

EXERCISE 5.1

Purpose: To review management of side effects and complications from medications used to control pain and anxiety. How would you manage the following case scenarios of people undergoing uterine aspiration?

1. A patient states that last year they had an allergic reaction to the local anesthetic that the dentist used.

2. A patient chooses to have IV sedation for pain management. You administer midazolam 1 mg and fentanyl 100 mcg. As you dilate the cervix, the patient falls asleep and is not arousable to repeated stimulation. The oxygen saturation falls from 99% to 88%.

3. A patient who is 5 weeks by LMP has a history of alcohol and heroin use, and states that they last used heroin yesterday. The patient requests IV sedation. Venous access is limited, but you are able to insert an IV and administer midazolam 1 mg and fentanyl 100 mcg. You insert the speculum, and the patient pulls away stating *"I can feel everything."*
 - a. How would you treat this person's pain?
 - a. How would this change if the patient were on buprenorphine (Suboxone)?
 - b. How would this change if the patient disclosed using heroin today?

4. Consider the consent process for each of the following people. What factors contribute to informed consent? What questions would you ask/what information would help you to make a decision in each case?
 - a. An 18-year old patient at 5 weeks GA who appears nervous. When you enter the room you can smell marijuana.
 - b. A 35 year old patient at 12 weeks GA is on methadone for opioid use disorder. They have been on the same dose for 8 years, and last took their medication this morning.

CHAPTER 5 TEACHING POINTS: MEDICATIONS AND PAIN MANAGEMENT

EXERCISE 5.1

Purpose: To review management of side effects and complications from medications used to control pain and anxiety. How would you manage the following case scenarios of patients undergoing uterine aspiration?

1. A patient states that last year they had an allergic reaction to the local anesthetic that the dentist used.

- It is important to distinguish between allergic reaction, side effect, and toxicity.
- There are two classes of anesthetics, esters (e.g. lidocaine) and amides (e.g. chloroprocaine). Allergy to one class does not infer an allergy to the other.
- Allergic reactions to -caines are extremely rare, and mostly occur from the preservative or epinephrine. Allergic reactions include itching, hives, bronchospasm, and progression to anaphylaxis.
- If the reaction appears to have been a true allergy, the safest alternative may be to avoid local anesthetic. If the type of anesthetic is known, the alternative class can be used. Or if unknown, may use saline (plain or bacteriostatic), which is less effective than lidocaine (Chanrachakul 2001).

2. A patient chooses to have IV sedation for pain management. You administer midazolam 1 mg and fentanyl 100 mcg. As you dilate the cervix, the patient falls asleep and is not arousable to repeated stimulation. The oxygen saturation falls from 99% to 88%.

Both medications cause sedation and respiratory depression. Individuals react differently due to interaction with other agents (e.g. alcohol) or genetic differences in metabolism.

Prevention can be aided by using a stepwise approach to pain management.

- Smaller doses for low weight patients.
- Serial doses until adequate pain control is achieved.
- Reversal using antagonists, in a stepwise and titrated fashion.

O ₂ Saturation	Management
95 –100%	Continue monitoring
90 - 94%	Check monitor lead placement Advise deep breathing Head tilt – chin lift to protect airway
89% or less	Provide titrated reversal agents if no improvement Head tilt – chin lift to protect airway Initiate oxygen PPV if inadequate spontaneous breathing Transfer if persistent

- Hypoxic patients who have received both an opioid and a benzodiazepine should generally receive naloxone before flumazenil. Naloxone reverses both opioid sedation and respiratory depression. Flumazenil has not been shown to reliably reverse respiratory depression, and also carries seizure risk if the patient has benzodiazepine tolerance or a seizure disorder.
- Monitoring is recommended for two hours after use of reversal agents, because the sedative may last longer than the antagonist (ASA 2002).

3. A patient who is 5 weeks by LMP has a history of alcohol and heroin use, and states that they last used heroin yesterday. The patient requests IV sedation. Venous access is limited, but you are able to insert an IV, and administer midazolam 1 mg and fentanyl 100 mcg. You insert the speculum, and the patient pulls away stating “I can feel everything.”

a. How would you treat this pain?

- Patients with regular opioid use have likely developed tolerance and often require higher doses of opioid medication to achieve pain control. A reasonable starting place for someone with significant tolerance would be to double the starting dose of fentanyl.
- Rapid reversal of opiates or benzodiazepines in patients who chronically use these medications can also provoke withdrawal or seizures respectively.
- Remember to utilize non-opioid forms of pain control and anxiolysis (as with all patients). Consider topical lidocaine (e.g. 4% lidocaine gel or cream in the lower 1/3 of the vagina for improved pain control with speculum placement).

b. How would this change if the patient were on buprenorphine (Suboxone)?

- Be aware that individuals on MAT or on chronic opioid pain medications often have higher tolerance of opioids.
- Additionally, buprenorphine has a high affinity for the mu opioid receptor, thus higher doses of a similarly high affinity opioid (fentanyl or hydromorphone) are needed to overcome this effect.
- Those who are prescribed MAT or chronic opioids should continue taking their medications as prescribed. MAT does not contribute to analgesia.
- If possible, communicate with their prescriber to plan for the procedure and follow-up or provide a note for the patient regarding medications used.
- Increase opioid dose as needed, guided by monitoring, reported pain, alertness, and vital signs.
- Encourage the patient to have close follow-up with their prescribing physician.

c. How would this change if the patient disclosed using heroin today?

- Substance use (when chronic) on the day of the procedure should not impact decision making around pain management other than awareness of possible drug interactions.
- Ability to complete a consent form is based on standard protocols for consent. Most individuals with active substance use are able to consent to a procedure regardless of prior use that day. Someone with withdrawal may in fact be less capable of providing consent depending on their symptoms.
- Increase opioid dose as needed, guided by monitoring, reported pain, alertness and vital signs.

4. A Consider the consent process for each of the following people. What factors contribute to informed consent? What questions would you ask/what information would help you to make a decision in each case?

Consider the following key elements of medical decision making capacity:

- Patients are able to demonstrate an understanding of the benefits and risks of a procedure/treatment as well as alternative options.
- Patients are able to demonstrate an appreciation of those benefits and risks.
- The patient shows reasoning in making a decision.
- The patient can clearly communicate their choice.

a. An 18 year old patient at 5 weeks GA who appears nervous. When you enter the room you can smell marijuana.

- Substance use including marijuana in most cases does not interfere with informed consent.
- Techniques for evaluating if patients are able to consent include asking orientation questions and having patients repeat information back after reviewing it together.
- If a patient is drowsy or not able to answer orienting questions, consider allowing the patient to rest awhile and then reevaluate for consent.

b. A 35 year old patient at 12 weeks GA is on methadone for opioid use disorder. They have been on the same dose for 8 years, and last took their medication this morning.

- Substance use disorder history, and use of MAT medications does not alter the informed consent process.
- Using methadone on procedure day is recommended and in fact a state of withdrawal can more greatly interfere with informed consent.

EXERCISE 5.2

Purpose: To become familiar with other medications used with uterine aspiration.

Please answer the following questions.

1. In which of the following situations is administration of Rh-D immunoglobulin (Rhogam) suggested in a patient over 12-weeks gestation?

a. Patient has positive anti-D antibody titer.

- The patient may already be sensitized (in which case RhoGam will not help).
- Or the patient recently received RhoGam and still has those anti-D antibodies in their blood (t 1/2 is 24 days).
- In either case, don't give RhoGam unless there is a new indication and 3 weeks have elapsed since the last dose.

b. Rh-negative patient received RhoGam 4 weeks ago during evaluation for threatened abortion.

- RhoGam may be present for up to 9-12 weeks after full-dose administration ([Bichler 2003](#)), but the manufacturer advises that it be given if three or more weeks have elapsed since the initial injection in term pregnancies.
- Until further data delineates therapeutic levels after mini-dose RhoGam, re-dosing after 3 elapsed weeks may be prudent.

c. Rh-negative patient is 4 days post-abortion and did not receive RhoGam at the uterine aspiration visit.

- RhoGam should ideally be administered within 72 hours.
- Beyond 72 hours, some recommend anti-D still be given as soon as possible, for up to 28 days (Fung Kee Fung 2003).
- For medication abortion, RhoGam is ideally given at the time of mifepristone, but many give it up to 72 hours afterwards.

2. While completing an early uterine aspiration procedure using local cervical anesthesia and ibuprofen only, the patient complains of nausea and “feeling faint”. The patient is pale and sweating. The blood pressure is 90/50 with a pulse of 48.

a. What is the differential diagnosis?

- This appears to be a classic vasovagal reaction, with low pulse, hypotension, and sweating. Vasovagal reflex is caused by stimulation of the parasympathetic nervous system, and occurs often with cervical dilation, fear and other emotions. A patient who is overheated, dehydrated, hypoglycemic, or over-medicated may also be predisposed to syncope.
- Differential Diagnosis: Vasovagal, hemorrhage, low blood sugar, or an inadvertent intravascular –caine injection.

Vasovagal Reflex	Hemorrhage	Low Blood Sugar	Intravascular -caine
Slow pulse (< 50) Low BP Pallor Cool clammy skin +/- N/V +/- Abdominal Cramps	Rapid Pulse Late low BP Pallor, Cool clammy skin +/- N/V +/- Uterine cramps	Normal / late rapid Late low BP Pallor, Cool clammy skin +/- N/V +/- Abdominal Cramps	Slow pulse (<50) Tinnitus Perioral tingling Metallic taste Irregular pulse
Rare: Syncope, Seizure-like activity	Rare: Syncope	Rare: Syncope, Seizures	Rare: seizure, ventricular arrhythmias, cardiac arrest
Not orthostatic	Becomes orthostatic	Not orthostatic	Not orthostatic

b. How might you prevent this reaction?

- To help prevent vasovagal reactions, emphasize hydration, keeping cool (i.e. be careful about being overheated from walking to the clinic in hot temperatures), and staying calm. Isometric extremity contractions may also help prevent vasovagal (see below).

c. How would you manage this patient?

- Vasovagal Management
 - Airway / Positioning: supine or Trendelenburg, head to side if vomiting
 - Cool cloth on head or neck
 - Sniffing ammonia capsule may help
 - Vasovagal reflex may be aborted prior to syncope by isometric contractions of the extremities (gripping the arm, hand, leg and foot muscles) (Cason 2014). These maneuvers activate the skeletal-muscle pump to augment venous return and abort the reflex.
 - Prolonged vasovagal, consider:
 - Atropine
 - IV Fluids, oxygen
 - Evaluation for other potential causes (hemorrhage, etc)
 - Record events, and transfer as needed.

6. UTERINE ASPIRATION PROCEDURE

Updated June 2022 by Lara Crystal-Ornelas MD, Vanessa Ramirez MD, Aisha Wagner MD

This chapter contains information on first-trimester uterine aspiration with manual and electric suction, used for both abortion and early pregnancy loss (EPL) management. It will review use of trauma-informed care, aspiration equipment, steps in the uterine aspiration procedure, and tissue evaluation. Management of complex cases and complications will also be discussed.

CHAPTER LEARNING OBJECTIVES

Following chapter completion and hands-on experience, you should be able to:

- Approach communication, exams, and abortion care with a trauma-informed lens
- Consistently use “no-touch technique” while performing uterine aspiration
- List the steps of uterine aspiration and tips for cervical dilation
- Correctly use equipment for manual and electric uterine aspiration
- Evaluate products of conception for presence of appropriate gestational tissue
- Assess and manage challenges and complications related to uterine aspiration

VIDEOS / SIMULATIONS

- First-Trimester Aspiration Abortion Video (IERH): <https://bit.ly/3KF4F51>
- Animated Uterine Aspiration Simulation Workshop (IERH): <https://bit.ly/3ffRCaz>
- Procedural simulation papaya workshops:
 - TEACH: <http://goo.gl/AtuHF5>
 - RHAP: <http://goo.gl/zvOxyn>
- Managing complications
 - IERH Complications of Procedural Abortion & Prevention Strategies: <https://bit.ly/3pWJFPy>
 - IERH Managing Complications of Procedural Abortion: <https://bit.ly/3MUgxIZ>
 - TEACH Managing Hemorrhage Simulation Workshop: <https://goo.gl/rErXOm>
 - TEACH Simulation Practice Scenarios: <http://goo.gl/QzGHrF>

READINGS / RESOURCES

- Paul et al (eds). Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care (Wiley-Blackwell, 2009)
 - Chapter 10: First Trimester Aspiration Abortion
 - Chapter 13: The Challenging Abortion
 - Chapter 15: Surgical Complications: Prevention and Management
- World Health Organization 2022 Abortion Care Guidelines: <https://bit.ly/3sOpXas>

SUMMARY POINTS

SKILL

- Learn the art of trauma-informed pelvic care, including establishing rapport, choosing sensitive language, and affirming the patient's control to help put patients at ease.
- Learn hand-eye coordination, tactile feedback, internal landmarks, position and angle of the uterus and cervical canal that are critical to the safety of dilation. With experience, you will develop appreciation for the variability of cervical length and curvature, as well as the amount of pressure needed during dilation.
- Differentiate products of conception (POC; including gestational sac, membranes, villi, and fetal parts) from decidua (mucous membrane lining the uterus, shed during menses or aspiration).

SAFETY

- The risk of abortion complications is minimal, with <0.5% of patients experiencing a major complication requiring hospitalization (NASEM 2018, Upadhyay 2015, White 2015). Overall abortion is low risk, although the rate of complications increases with gestational age. Once a person decides to undergo an abortion, it is important to proceed without delay (Upadhyay 2015).
- Mortality associated with childbirth is 14 times that of abortion (Raymond 2012).
- The prevalence of complications is similar across clinic contexts. TRAP laws requiring facilities to meet ambulatory surgical center standards or hospital admitting privileges do not improve abortion safety in office settings (White 2015).
- If cervical dilation is particularly challenging, there are various strategies to try, but it is important to know when to stop.
- Routine post-abortion tissue examination by a pathology lab confers no incremental clinical benefit (Paul 2002).
- Routine sharp curettage should be avoided due to increased procedure time, bleeding, pain, and scarring risk (Asherman's Syndrome) (Gilman 2014, Tunçalp 2010).
- Early abortion safety, efficacy and acceptability are found to be equivalent between physicians and advanced practice clinicians (Barnard 2015, Weitz 2013).

ROLE

- Considering risk factors for a challenging procedure ahead of time allows providers to customize care and minimize complications.
- It is optimal to provide care with a support person and trained assistant during uterine aspiration. Your leadership will ensure a respectful, supportive environment for all.

TRAUMA-INFORMED CARE DURING PROCEDURES

Adapted from RHAP Contraceptive Pearl: [Trauma Informed Pelvic Exams 2015](#)

- If the patient has never experienced a pelvic exam, take extra time and care to explain what will happen, what a speculum is, how it is inserted, and how to best position their body. Take their age and size into consideration. If appropriate and available, use a pediatric or narrow speculum. Explain that future pap tests will only involve speculum placement so they do not anticipate the additional experiences of an abortion during their next speculum exam.
- It is important to routinely perform a trauma-informed exam, and not just with those who disclose a history of trauma. A pelvic exam can trigger a response related to past trauma ([Gorfinkel 2021](#)), and many people will not report or disclose previous trauma to their healthcare providers.

TRY TO	
Establish rapport	Introduce yourself and take a seat to demonstrate respect and ease anxiety.
Invest in patient's experience	Prioritize the patient's experience. This includes observing the patient's reactions, taking breaks as requested, and adjusting instruments/position for comfort.
Allow a support person	Allow a support person such as a partner, friend, family member, or trained doula. Those receiving doula support are less likely to require additional clinic support resources, although pain and satisfaction are unchanged (Chor 2015).
Support the patient's comfort	Keep the patient's body covered, uncovering only areas being examined. Use a smaller speculum, use lubricant. Say "footrests" instead of "stirrups" and offer frog leg position without footrests. Say "bed" instead of "table". Minimize touching; some recommend against touching a patient's thigh with a "warning touch."
Review relaxation techniques	Discuss distraction and breathing techniques (see Chapter 5 page 90), before starting the consent process.
Invite the patient to take control	Ask what would make the exam more comfortable. Assure they have control over the pace and can stop a procedure if uncomfortable. Ask for permission to place or advance the speculum, or offer the patient to insert the speculum themselves.
Keep the patient informed	Check in about patient preferences. Some like to know about each step right before it happens. Some prefer less detail. It can be helpful to say, "We're about two-thirds through" or "This part takes about one minute."
Use your intuition	Assess what will be most helpful and follow the patient's lead: sometimes quiet, sometimes humor, and sometimes talking about work, kids, school or goals will resonate well with a patient. Sometimes patients like to listen to music or pray.
Go at the patient's pace	If the patient asks to stop, then stop (if safe), adding "Do you need a break now? Let's try taking some deep breaths. Let me know when you're ready to proceed."
Check in	Check in about whether they want physical and/or emotional support during the procedure, offering an assistant's reassurance or hand to squeeze.
Use supportive statements	Say "The procedure is progressing smoothly" or "You are doing a good job focusing on your breath"

QUICK GUIDE: COMMUNICATION DURING THE PROCEDURE

If the provider does not do the abortion counseling or consent

Depending on how your services are set up, a counselor may conduct pre-abortion counseling instead of the provider. This can make establishing rapport even more important, and can be assisted by sitting at the patient's eye level, using an accepting tone, and starting with open-ended questions. You might check in with the patient, such as *"I know you have spoken to the counselor. I wanted to see what questions you may still have for me."* Look for emotional cues, and try to create a safe space for them to express their emotions, perhaps saying *"all your emotions are welcome here."*

Approach to Communication

The use of gentle, neutral language and avoidance of words associated with pain has been shown in some but not all studies to decrease pain perception during procedures such as administration of local anesthesia (Dalton 2014, Ott 2012), but has not specifically been studied in uterine aspiration. Many providers prefer to use language describing what they are doing next rather than what the patient may feel. Others describe symptoms the patient may experience but avoid descriptions of pain or sexual references. For example, *"You may feel a cramp,"* as opposed to *"You are going to feel a poke/prick/stick"*. Below are some tips. Consider asking about terms people use for their body parts and mirror their language by using those terms (Wesp 2016).

Approach to Communication	Instead of
Introduction sitting at patient's eye level	Introduction looking down at patient
<i>Your pregnancy is 8 weeks along.</i>	<i>Your baby is 8 weeks old.</i>
<i>Place your feet in the footrests.</i>	<i>Place your feet in the stirrups.</i>
<i>There is room for you to move down further on the exam table.</i>	<i>Move your bottom down the bed until you feel like you're going to fall off.</i>
<i>Allow your knees to fall to the sides like an open book or butterfly stretch.</i>	<i>Open or spread your legs.</i>
<i>Your cervix looks healthy and normal.</i>	<i>Your cervix / uterus looks/feels good.</i>
<i>You may feel some cool wet cotton</i>	<i>I am cleaning your cervix (implying it is dirty).</i>
<i>This is the numbing medicine. You may feel numbness or a cramp.</i>	<i>You are going to feel a poke/prick/stick with the injection.</i>
<i>We're over halfway through.</i>	<i>It will be a few more minutes.</i>
<i>I will place the IUD or implant.</i>	<i>I will insert the IUD or implant.</i>

When is it appropriate to defer an abortion?

Some patients feel a new sense of uncertainty immediately before the procedure begins. This may be another way a patient communicates heightened anxiety, or it may be that the reality of being in the procedure room is making the patient reconsider their decision.

It is usually not appropriate to try to facilitate a decision-making process while the patient is sitting, undressed, on the table. Trust your instincts in deciding how to proceed. The patient can be offered supportive counseling and more time to think. It is ok to pause prior to initiating the procedure and ask for a clear statement of the patient's intent before proceeding. For example:

"It's not clear that you are ready to go on with the procedure today. If you are not sure, it is OK to postpone. Do you need some more time?" or "Are you feeling as sure as you can be that you'd like to proceed?"

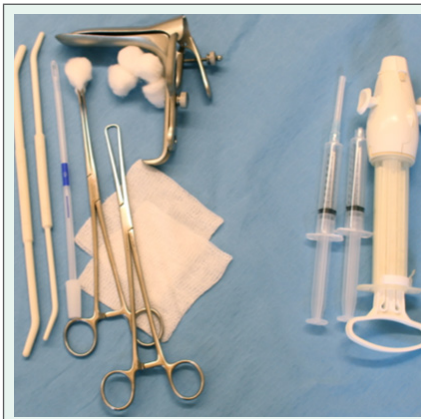
For many patients, this last moment is what they need; when faced with the possibility of not going forward, they see this option is less appealing, and know they want to proceed. For others, it gives them a chance to think more about what they truly want.

NO-TOUCH TECHNIQUE

Preventing infection after uterine aspiration is an important goal. Measures to accomplish this include properly sterilizing instruments, administering prophylactic antibiotics as indicated, minimizing bacterial entry into the sterile uterine cavity, and meticulously using the "no touch" technique to assure that the portions of instruments entering the uterus remain sterile (Paul 2009). To follow no-touch technique:

- Maintain sterility of procedure tray, separating non-sterile instruments.
- Place contaminated instruments in a separate designated "non-sterile" area of tray.
- Avoid contamination by gathering needed materials before placing speculum.
- Hold only the center of dilators, not the tips that will enter the uterus. If needed, can use sterile gauze to hold the end of the dilators while maintaining sterility of the dilator.
- Attach sterile cannula to vacuum source without touching the cannula tip.
- Avoid vaginal contamination of uterine instruments.
- Change out instruments that will enter the uterus if inadvertently contaminated.

Even with antiseptic use, it is impossible to "sterilize" the vagina. In fact, randomized studies showed that preoperative antiseptic vaginal cleansing had no effect on post-abortion infection rates (Varli 2006, Achilles 2011), and may decrease healthy vaginal flora without significantly decreasing endocervical bacteria. Use of non-sterile gloves for uterine aspiration is acceptable if the no-touch technique is maintained



Typical tray set-up Instruments shown: Sterile side on left, non-sterile on right (except needle)

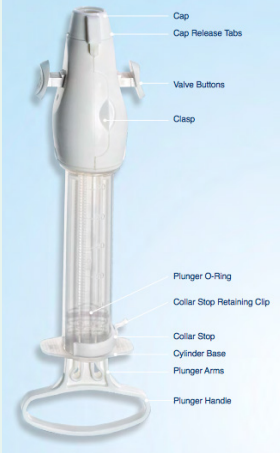


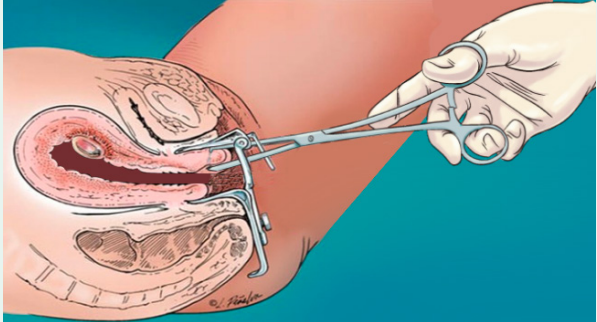
- Appropriate sizes of dilators (Denniston shown)
- Cannula (on sterile field vs. in sterile package)
- Ring forceps with cotton
- Single-tooth tenaculum
- Speculum
- Gauze
- Anesthetic 10ml syringe (not sterile)
- 25mm gauge needles (sterile)
- MVA Plus (not sterile)

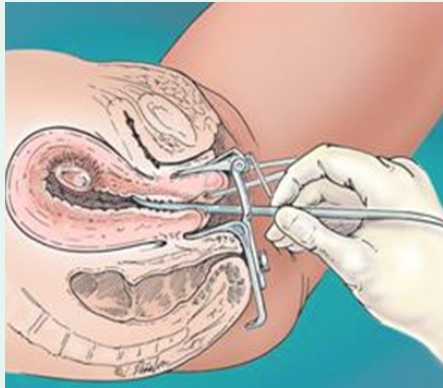

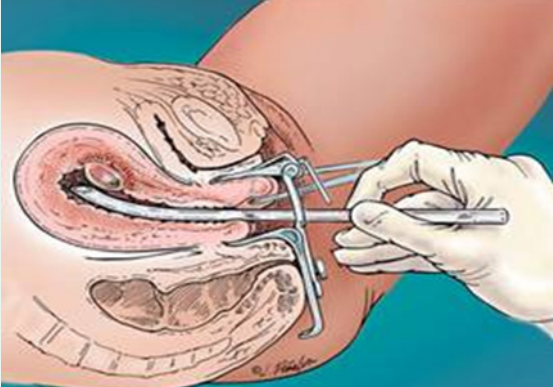
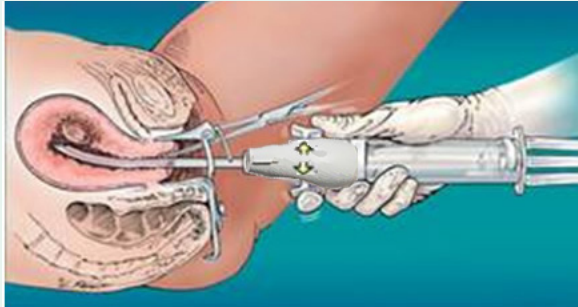
STEPS FOR UTERINE ASPIRATION

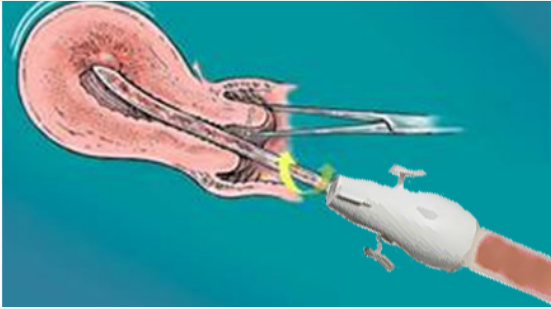
1. Review patient history, gestational age, & consents (procedure, sedation, contraception)
2. Introduce yourself (and trainee or trainer), establish rapport, elicit and answer patient's questions: "What questions do you have for me?" Provide reassurance and details to extent the patient desires.
3. Assess vitals, perform time-out, and administer IV medications.
4. Don gloves, mask, and protective eyewear (+/- gown, shoe covers). Prepare equipment tray and all items for procedure (cannula, block, etc.); adjust table and light.
5. Perform bimanual exam (BME) to confirm uterine position & size. May not need if using US guidance.
6. Insert the speculum, evaluate, and collect samples as needed for screening / testing (STI, pap).
7. If using, apply antiseptic solution to cervix.
8. Administer paracervical block. Assess patient's pain level throughout procedure.
9. Place tenaculum at 12 or 6 o'clock (depending on position of uterus); close slowly. Exert gradual traction to straighten cervical canal.
10. Dilate cervix to size of cannula you will be using [gestational age in weeks (+/- 1-2 mm)]
 - a. With traction on the tenaculum, gently explore canal, holding dilator loosely and allowing it to rotate within canal (should have a snug smooth, mucosal feel).
 - You may feel the internal os "give way" to gentle, steady pressure
 - b. If unable to pass through the internal os, try the following:
 - Gently apply traction on tenaculum to straighten canal.
 - Change angle of dilator, dropping wrist, or switch to flexible plastic sound or os finder.
 - Reposition patient with hips further off table or on rolled towel to create more hip flexion.
 - Change tenaculum location (placing on posterior lip for a retroflexed uterus).
 - Use transabdominal US guidance.
 - Repeat pelvic exam.
 - Consider shorter, wider (or Klopfer) speculum if available. Try widening blades.
 - Provide [misoprostol](#) (sublingual/vaginal/buccal) and reattempt dilation in 1.5 - 3 hours.
11. Advance cannula to just inside internal os using gentle firm traction on the tenaculum.
12. Connect aspirator (MVA or EVA) to cannula, and empty uterus until signs that it is empty (see below).
13. After confirming products of conception (POC) are complete, place IUD or implant if desired by patient.
14. Remove tenaculum, assure minimal bleeding, and remove speculum.
15. Check POC for adequacy, if not already done. Inform patient of complete procedure & recovery process

USING MVA AND EVA EQUIPMENT

Images adapted from MVA, a presentation by PRH and ARHP, 2000; 2012, 2022

	<h3>Manual Vacuum Aspirator Plus</h3> <ul style="list-style-type: none">• Cap• Cap release• Valve buttons• Clasp• Plunger O-ring• Collar stop Retaining Clip• Collar stop• Cylinder base• Plunger arms• Plunger handle
	<h3>Prepare the aspirator</h3> <ul style="list-style-type: none">• Begin with valve buttons open and plunger pushed fully into the barrel.• Close valve by pushing the buttons down and forward until locked in place.
	<h3>Create the vacuum</h3> <ul style="list-style-type: none">• Pull the plunger back until its arms snap outward over the rim at the end of the barrel.• Make sure plunger arms are positioned over wide edges of the barrel rim.
	<h3>Attach the tenaculum</h3> <ul style="list-style-type: none">• Gently attach the tenaculum to the cervix (either anterior lip, as shown here) or posterior lip (for a retroverted uterus), closing slowly 1-2 clicks.• Exert gradual traction to straighten cervical canal.

	<p>Gently dilate the cervix after paracervical block</p> <ul style="list-style-type: none"> • Use dilators of increasing size to accommodate cannula size chosen based on gestational weeks. • Dilator: <ul style="list-style-type: none"> • Denniston – dilate to cannula size (e.g. size 7 for 7 mm cannula) • Pratt – dilate to cannula size x 3 (e.g. 21 French for 7mm cannula)
	<p>Choose a cannula</p> <ul style="list-style-type: none"> • Flexible: longer with two openings at tip • Rigid: larger single opening at tip • No significant difference safety or efficacy (Kulier 2001) • Larger cannula: faster aspiration, more intact tissue • Smaller cannula: less dilation and less resistance <p>Last NAF Provider's survey (O'Connell 2009):</p> <ul style="list-style-type: none"> • 54% used size (in mm) = weeks gestation • 37% used 1-2 mm < weeks gestation • 9% used 1-3 mm > weeks gestation
	<p>Insert the cannula</p> <ul style="list-style-type: none"> • Apply traction to tenaculum to straighten uterus. While holding cannula with fingertips, gently insert through cervix with rotating motion. • Attach aspirator to cannula. • Do not grasp aspirator by plunger arms.
	<p>Release the valve buttons</p> <ul style="list-style-type: none"> • When the pinch valve is released, the vacuum is transferred through the cannula into the uterus. • Blood, tissue, and bubbles will flow through the cannula into the aspirator.



Evacuate the uterus

- Rotate the cannula and move it gently from fundus to the internal os, applying a back and forth motion as clinically indicated until:
 - Grittiness is felt through cannula
 - Uterus contracts and grips cannula
 - There is increased cramping, and / or
 - No more blood passes through cannula.



Choice of Vacuum for Aspiration

- Availability / preference determine use
- Some use > 1 MVA to facilitate emptying, or switch to EVA > 9 weeks
- Minimal differences in pain, anxiety, bleeding, or acceptability (Dean 2003)
- EVA sound may be audible to patients; silent, in-wall suction is available.

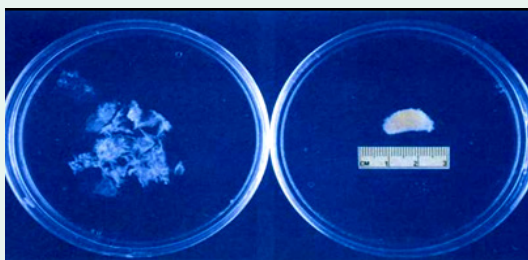
EVA use:

- Turn on and check suction gauge, turn dial to adjust
- Attach cannula
- Open thumb valve, keep open while placing cannula in uterus
- Once at fundus, close thumb valve to initiate suction
- Release suction by opening thumb valve when passing out of the cervical canal.



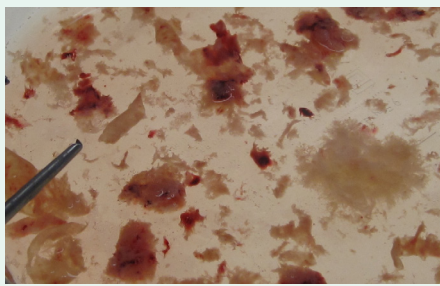
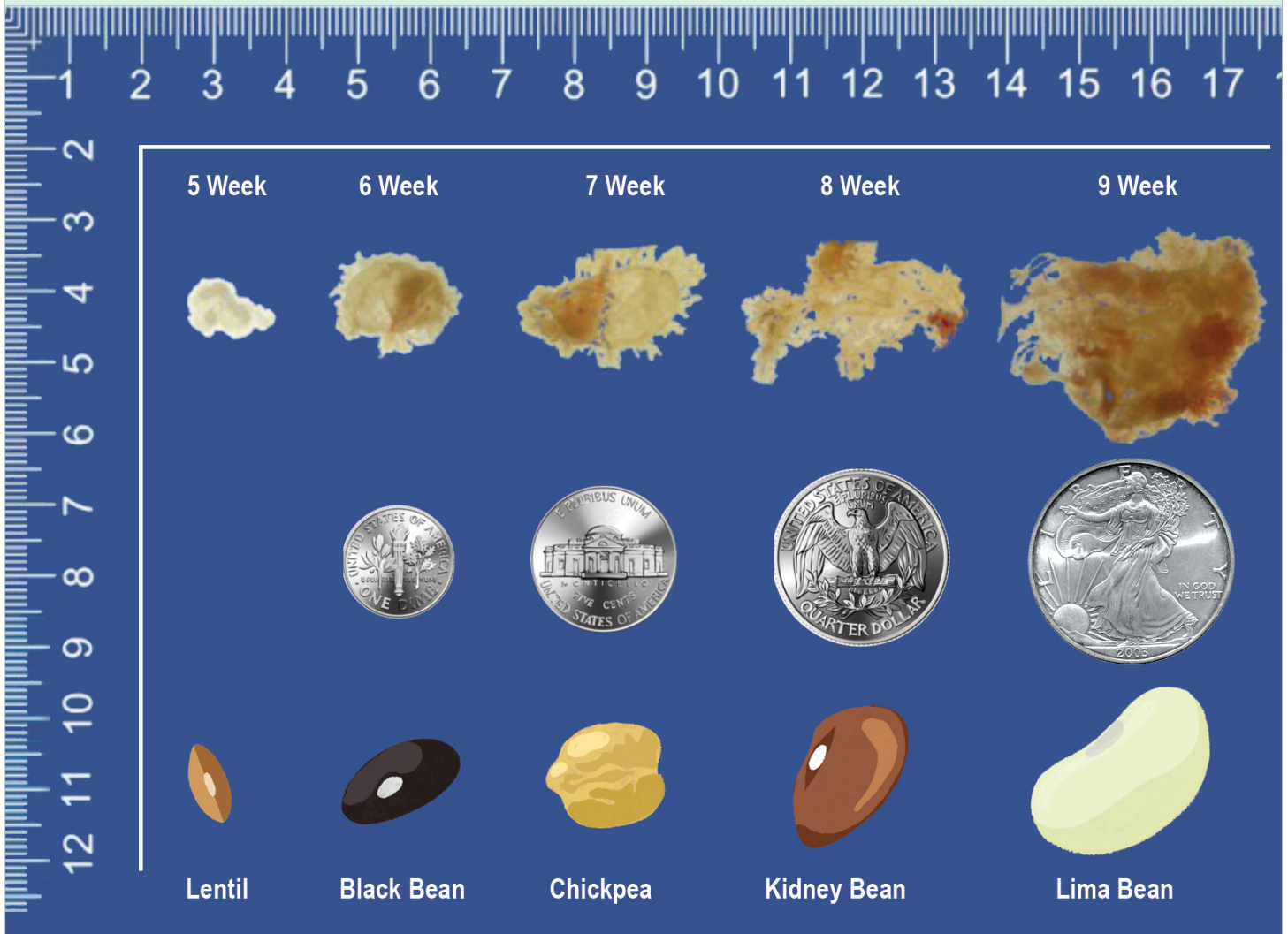
Inspect the tissue

- Rinse and strain the tissue
- Place tissue in a clear container
- Backlight is recommended to inspect tissue if gross visual inspection is non-diagnostic.



Gestational sac at 6 weeks

- Shredded (on left) vs. intact
- To minimize shredding, consider using MVA and/or a slightly larger cannula.

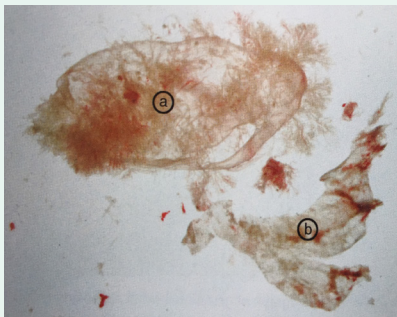


Membranes and Villi (POC)

Frond-like villi
 Clumps held by membrane
 Transparent like plastic wrap
 Luminescent; light refractory
 Turns white if vinegar added
 More stretchy
 Floats more in liquid media

Decidua (not POC)

No fronds
 No villi or thin membrane
 Opaque like wax paper
 Less light refractory
 Minimal color change
 More breakable
 Sinks more in liquid media
 Quantity variable



Decidua capsularis

Caution not to confuse
 a) gestational sac (8 wk) with
 b) decidua capsularis, a portion of the decidua which grows proportionally to gestational sac but is thicker and tougher (Paul 2009).

Fetal part development

Parts may be seen earlier.
 ≥ 10W look for 4 extremities, spine, calvarium and gestational sac.
 ≥12W must find all fetal parts + placenta.

MANAGING COMPLICATIONS

IMMEDIATE COMPLICATIONS	CLINICAL PRESENTATION	MANAGEMENT OPTIONS	OCCURENCE RATE*
Vasovagal Episode	Presentation may include: <ul style="list-style-type: none"> • Pale, clammy, dizzy, nauseated or with emesis • Pulse < 60 • Rare syncope • During or after procedure • Usually resolves quickly and spontaneously Etiology: <ul style="list-style-type: none"> • Parasympathetic nerve stimulation and painful stimuli 	Pause procedure: <ul style="list-style-type: none"> • Apply cool compresses • Trendelenburg position or elevate the legs above the chest • Sniffing ammonium may help • Isometric extremity contractions For persistent symptomatic bradycardia: <ul style="list-style-type: none"> • Atropine 0.2 mg IV or 0.4 mg IM, May repeat in 3-5 minutes (max dose of 2 mg) 	Not reported Cason 2019
Excessive Bleeding/ Hemorrhage	EBL > 150 cc = excessive to 10 wks EBL ≥ 500 cc = hemorrhage Remember 4T's of etiology: (ALSO 2020) <ol style="list-style-type: none"> 1. Tissue (not completely evacuated) 2. Tone (inadequate uterine tone) 3. Trauma (perforation or cervical lac) 4. Thrombin (rare underlying bleeding disorder) Hemorrhage risk groups: (Kerns 2013) <ol style="list-style-type: none"> 1. Low risk: no prior c/s, <2 prior c/s and no previa/accreta, no bleeding disorder, no history of obstetric hemorrhage 2. Moderate risk: ≥ 2 c/s, prior c/s and previa, bleeding disorder, history of obstetric hemorrhage not needing transfusion, increasing maternal age, GA>20 weeks, fibroids, obesity 3. High risk: accreta/concern for accreta, history of obstetric hemorrhage needing transfusion, +/- others from moderate category 	6T's (Goodman 2015) Tissue: Assure uterus is empty <ul style="list-style-type: none"> • Estimate EBL • Reaspirate (US guidance; EVA for rapid evacuation); check POC Tone: Uterotonics <ul style="list-style-type: none"> • Uterine massage • Medications: Methergine 0.2 mg IM/IC, Misoprostol 600-1000 mcg SL/BU/PR, and/or Vasopressin 4-8 units (in 5-10 cc NS) IC, after 1st tri: Oxytocin 10 units IM, or 20-40 units in 1L NS IV, TXA 1000mg (in 100cc NS) run over 10 mins Trauma: Assess source <ul style="list-style-type: none"> • Cannula test** • Clamp bleeding site at cervix with ring forceps Thrombin <ul style="list-style-type: none"> • Review bleeding history • Additional tests as indicated (coags, repeat CBC, clot test***) Treatment <ul style="list-style-type: none"> • IV fluid bolus • For uterine / cervical injury, inflate Foley catheter to tamponade Transfer <ul style="list-style-type: none"> • Vitals every 5 minutes • Initiate transfer 	0.07 – 0.4 % NASEM 2018 Upadhyay 2015 Weitz 2013
Perforation	Instruments pass deeper than expected by EGA and pelvic exam Patient may feel sudden sharp pain; may be painless Risk factors: <ul style="list-style-type: none"> • Inadequate dilation • Increased gestational age • Uterine flexion • Previous cesarean section • Operator inexperience • Uterine anomaly 	Stop procedure: <ul style="list-style-type: none"> • Turn off suction • Assess patient: VS, pain, bleeding, abdominal exam • Check contents of aspirate for omentum or bowel, and for POC If stable: <ul style="list-style-type: none"> • Evaluate with US • Experienced providers have safely explored uterus and completed procedure under US guidance • Observe for 1.5-2 hours • Consider uterotonics to contract uterus and control bleeding • Consider antibiotics If unstable or perf with suction, transfer	0.02 – 0.07% NASEM 2018 Upadhyay 2015 Weitz 2013

DELAYED COMPLICATIONS	CLINICAL PRESENTATION	MANAGEMENT OPTIONS	OCCURENCE RATE*
Incomplete Abortion (Residual non-viable fetal tissue)	<p>At time of aspiration:</p> <ul style="list-style-type: none"> Inadequate POC or <p>Days to weeks after:</p> <ul style="list-style-type: none"> Pelvic pain, fever Abnormal bleeding Pregnancy symptoms Enlarged or boggy uterus <p>US shows persistent IUP or debris [latter is non-specific; may be normal (Russo 2012; Paul 2009, pg. 228)]</p>	<p>Offer misoprostol, reaspiration to empty uterus, or expectant management</p> <p>Reaspiration preferred if:</p> <ul style="list-style-type: none"> Signs of infection Hemorrhage Severe pain Significant anemia 	0.2 – 4.4% Upadhyay 2015 Weitz 2013
Continuing Pregnancy	<p>Presentation:</p> <ul style="list-style-type: none"> Ongoing pregnancy symptoms Enlarging uterus <p>Risk factors:</p> <ul style="list-style-type: none"> Early gestational age Uterine anomalies/fibroids Missed multiple gestation Operator inexperience 	<p>If inadequate POCs suspected at time of procedure, consider:</p> <ul style="list-style-type: none"> US Serial hCGs Ectopic precautions as needed <p>Counsel patient; reaspirate as appropriate</p>	0.4 – 2.3% Upadhyay 2015 Kerns 2013 Weitz 2013
Hematometra (Accumulation of blood in uterus following procedure)	<p>Immediate:</p> <ul style="list-style-type: none"> Minutes to hours post-ab Severe lower abdominal or pelvic pain Rectal pressure Minimal to no post-procedural bleeding +/- hypotension, vasovagal US: large amount uterine clot Uterine exam: enlarged, firm <p>Delayed:</p> <ul style="list-style-type: none"> Days to weeks post-ab Pelvic pressure or cramping +/- low grade fever 	<p>Prompt uterine aspiration of blood offers immediate relief</p> <p>Uterotonic medications post aspiration:</p> <ul style="list-style-type: none"> Methergine 0.2 mg IM / IC Misoprostol 800 mcg PR or buccal 	1.1 – 2.2 % Weitz 2013 Yonke 2013 Bennett 2009
Postabortal endometritis	<p>Presentation:</p> <ul style="list-style-type: none"> Lower abdominal / pelvic pain Fever, malaise Tenderness Purulent discharge Elevated WBC 	<p>Diagnose:</p> <ul style="list-style-type: none"> US for retained POC / clot Consider reaspiration Wet mount Test for GC/CT <p>Treat:</p> <ul style="list-style-type: none"> Antibiotics (CDC PID regimen) Reaspiration if indicated 	0.09-2.6% Upadhyay 2015 Weitz 2013 Yonke 2013
Missed Ectopic Pregnancy	<p>Suspect if inadequate POC at time of aspiration</p> <p>Possible late signs/symptoms:</p> <ul style="list-style-type: none"> Pelvic pain or shoulder pain Syncope or shock 	<p>Referral for appropriate care if:</p> <ul style="list-style-type: none"> Ectopic is suspected (for diagnosis and/or treatment) Immediate hospital care if: <ul style="list-style-type: none"> Concern for rupture Clinically unstable <p>Methotrexate vs. surgical management</p>	0.0 – 0.3% (Scant data) Bennett 2009

*Summary occurrence rates from Taylor, 2010: Standardizing early aspiration abortion complication definitions and tracking.

** Cannula test: Watch blood return as you slowly withdraw cannula from fundus to cervix, to identify bleeding zone.

***Clot test: Fill plain glass tube with whole blood; leave 10 minutes. Complete clotting at 10 minutes rules out DIC at that time.

CHAPTER 6 EXERCISES: ASPIRATION ABORTION PROCEDURE

EXERCISE 6.1

Purpose: To practice management of challenging situations that can arise at the time of aspiration abortion procedures.

1. You are performing an abortion for a 20-year-old G1P0 patient at six weeks gestation. You complete the cervical block and have the tenaculum in place. As you attempt to introduce the smallest dilator, you are unable to advance the dilator through the internal os. After readjusting the speculum and the tenaculum, you again find that there is severe resistance as you attempt to advance the dilator into the cervical canal; it feels dry, gritty, and tight, and does not have the “normal” feel of the dilator tip advancing through the cervical canal.
 - a. What is the differential diagnosis?
 - b. What would you do next?
 - c. How might you respond to the patient’s request for a break due to pain?
2. You have just completed an aspiration abortion for a 19-year-old patient at six weeks gestation. Their pre-procedure ultrasound shows a 5 mm fluid collection, but no yolk sac or embryonic pole. Their pregnancy test was positive. Dilation was not difficult and you were able to use a 6 mm flexible cannula. The tissue specimen is very scant and you are not certain whether you see sac or villi.
 - a. What is the differential diagnosis?
 - b. What would you do next?
3. You are performing an abortion on a nulliparous 16-year-old patient at seven weeks gestation. You notice that their cervix is very small and it is hard to choose a site for the tenaculum. As you put traction on the tenaculum and try to insert the dilator, the tenaculum pulls off, tearing the cervix. There is minimal bleeding, so you reapply the tenaculum at a slightly different site, although it is difficult because the cervix is small. This time, the cervix tears after inserting the third dilator, with substantial bleeding.
 - a. What should you do now?
4. You are inserting the cannula for a procedure on a patient at 9 weeks gestation with a retroflexed uterus. Although the dilation was easy, you feel the cannula slide in easily but at a different angle and much further than you sounded with one of the dilators. You don’t feel any “stopping point.” The patient feels something sharp.
 - a. What is the differential diagnosis?
 - b. What should you do now?
 - c. How might you have anticipated and prevented this problem?

5. A G3P2 patient at 8w5d presents for termination, with a history of one previous cesarean and a postpartum hemorrhage not requiring transfusion. The aspirator quickly fills with blood when suction is applied. You empty it, recharge, and it again fills with blood. You have seen some tissue come through. You ask your assistant to prepare another MVA but it promptly fills with blood when attached to the cannula.
 - a. Given the patient's risk factors, what additional preparations would you consider beyond normal precautions? (Review in Managing Immediate Complications Table [page 115](#)).
 - b. What do you suspect?
 - c. What can you do now?

EXERCISE 6.2

Purpose: To practice managing challenges that may occur after uterine aspiration.

1. The nurse consults with you about a possible problem phone call regarding a patient who had an abortion at the clinic five days ago. The patient complains of severe cramping and rectal pressure, has had minimal bleeding, and has a mild fever.
 - a. What is the differential diagnosis?
 - b. Which exam and ultrasound findings would support your diagnosis?
 - c. What are your management recommendations?
 - d. If these symptoms developed immediately after an abortion, what would you do?
2. A 21-year-old patient comes to your office for follow-up after an 8-week abortion two weeks ago at another facility, and still has some symptoms of pregnancy including breast tenderness and abdominal bloating. Medications include birth control pills. The patient has had intercourse regularly for the past six days. The patient is afebrile, with normal vital signs. Pelvic exam is normal except for an 8-week size uterus. A high sensitivity urine pregnancy test is positive.
 - a. What is the differential diagnosis?
 - b. How can you rule in or out any of your diagnoses?
 - c. How might your approach differ if the ultrasound shows moderate amount of heterogeneous contents?
 - d. If the patient is not pregnant, how can you explain their positive urine pregnancy test and breast tenderness?

CHAPTER 6 TEACHING POINTS: ASPIRATION ABORTION PROCEDURE

EXERCISE 6.1

Purpose: To practice management of challenging situations that can arise at the time of aspiration abortion procedures.

1. You are performing an abortion for a 20-year old G1P0 patient at six weeks gestation. You complete the cervical block and have the tenaculum in place. As you attempt to introduce the smallest dilator, you are unable to advance the dilator through the internal os. After readjusting the speculum and the tenaculum, you again find that there is severe resistance as you attempt to advance the dilator into the cervical canal; it feels dry, gritty, and tight, and does not have the “normal” feel of the dilator tip advancing through the cervical canal.

a. What is the differential diagnosis?

- Acute flexion or tortuosity of the cervix
- Congenital or acquired uterine abnormalities:
 - Abdominal scarring due to prior (especially multiple) cesarean sections, which often limit adequate traction.
 - Cervical stenosis
 - Müllerian anomaly
 - Fibroid in the lower uterine segment (unlikely in this age group)
- Error in assessment of uterine position (e.g possible sharply anteverted uterus with high cervix that may appear retroverted by visual exam without a thorough bimanual).
- False passage of the dilator due to any of the above
- Cervical scarring from prior procedures (colpo, LEEP unlikely in this age group)

b. What would you do next?

- See dilation tips from Steps for Uterine Aspiration of this chapter [page 110](#).
- Ask for ultrasound guidance.
- Consider having a more experienced provider assist with dilation or finish the procedure—(may require returning another day) —or convert to medical abortion.

c. How might you respond to the patient’s request for a break due to pain?

- As much as possible, give the patient control and keep them informed.
- If the patient asks to stop, then stop.
- Check in about whether they want additional pain management.
- Ask if they want physical or emotional support during the procedure.
- Consider adding “Let me know when you are ready to proceed.”
- Keep them informed if you need to consider additional steps for safety, including a discussion of risks if procedure can not be completed today.

2. You have just completed an aspiration abortion for a 19-year-old patient at six weeks gestation. Their pre-procedure ultrasound shows a 5 mm fluid collection, but no yolk sac or embryonic pole. Their pregnancy test was positive. Dilation was not difficult and you were able to use a 6 mm flexible cannula. The tissue specimen is very scant and you are not certain whether you see sac or villi.

a. What is the differential diagnosis?

- Failed or incomplete aspiration abortion
- Completed aspiration abortion with POC too small to visualize
- Ectopic pregnancy

b. What do you do next?

- Recheck POC, MVA, EVA bottles, tubing, cannula, and strainer (if used).
- Use a magnifier and backlighting if available.
- Repeat US.
- Reaspirate if tissue is still visible, with US guidance as indicated.
- Consider using a different cannula, such as rigid, curved cannula to follow flexion.
- Rule out an ectopic pregnancy in any case without definitive POC:
 - Draw serial hCGs and give ectopic precautions.
 - An hCG decrease of 50% within 48 hours suggests successful abortion (and is more reliable than US or pathology).
- If free-floating villi are seen without any membranes present, consider the possibility of retained gestational sac, and repeat US.
- If you see no villi, you may send the specimen to pathology. “Villi” on a pathology report confirms a pregnancy but not completion. Provider examination of POC reduces the risk of failed or incomplete abortion. Routine histologic exam by a pathologist confers no incremental clinical benefit, and adds cost (Paul 2002).

3. You are performing an abortion on a nulliparous 16-year old patient at seven weeks gestation. You notice that their cervix is very small and it is hard to choose a site for the tenaculum. As you put traction on the tenaculum and try to insert the dilator, the tenaculum pulls off, tearing the cervix. There is minimal bleeding, so you reapply the tenaculum at a slightly different site, although it is difficult because the cervix is small. This time, the cervix tears after inserting the third dilator, with substantial bleeding.

a. What should you do now?

Try the following:

- Before applying tenaculum to a small or flat cervix, inject several mLs of anesthetic to add bulk and facilitate placement (deeper in cervix, not in bleb).
- Try a second tenaculum elsewhere on the cervix to provide a broader base of support, an atraumatic tenaculum (pictured in Chapter 5 Paracervical Block image [page 91](#)); then re-attempt dilation.
- If bleeding, apply cervical pressure (direct pressure or clamp cervix with ring forceps). Inject dilute vasopressin (4-6 units in 5-10 cc sterile saline intra-cervically), Monsel’s solution, or silver nitrate may also be used; sutures are rarely required.

- Offer medication abortion, if eligible.
- Consider misoprostol in adolescents or those with a prior difficult dilation.
- If unsuccessful, consider additional analgesia, misoprostol for 2–4 hours, delaying the procedure for a week to allow for more cervical ripening

4. You are inserting the cannula for a procedure on a patient at 9 weeks gestation with a retroflexed uterus. Although the dilation was easy, you feel the cannula slide in easily but at a different angle and much further than you sounded with one of the dilators. You don't feel any "stopping point." The patient feels something sharp.

a. What is the differential diagnosis?

- A probable uterine perforation vs. a creation of false passage.

b. What should you do now?

- Immediately stop suction and gently remove cannula.
- Evaluate for sharp or localized pain, vital signs, and bleeding.
- US may assess fluid collection in the cul-de-sac, but in first trimester it is rare to be able to identify abdominal contents in the uterus, or uterine contents in the abdomen.
- If the uterine cavity can be re-identified, an experienced provider may choose to finish the procedure under US guidance.
- If vacuum has been applied, look for evidence of intra-abdominal contents (i.e. omental fat) in the aspirate. If seen, this confirms perforation. Any evidence of intra-abdominal contents necessitates transfer to higher level of care.
- If patient remains asymptomatic for pain or bleeding, consider observation for two hours, antibiotic coverage (Paul 2009; p. 241), and precautions before discharge.
- Consider uterotonics if bleeding is significant.
- Hospitalization is indicated if:
 - The patient is hemodynamically unstable. Place IVs and initiate IV fluid.
 - The patient has significant pain.
 - There is evidence of large perforation, laceration, expanding hematoma, fetal parts in abdomen, or any viscera / omentum in uterus or aspirate.

a. How might you have anticipated and prevented this problem?

- Use gentle steady pressure during dilation until beyond the internal os.
- Traction on the tenaculum helps straighten uterine flexion. Consider posterior placement for a retroflexed uterus to help straighten the angle.
- Passage of a flexible uterine sound or os finder may help to find the correct path, although use caution as a smaller instrument may increase perforation risk.
- If your dilator passes easily but the cannula does not, consider using a smaller cannula or dilating one size higher.
- Do not hesitate to re-check your pelvic exam.
- Use US guidance, if available.
- Consider a rigid curved cannula to maneuver the angle better.
- Cervical ripening with misoprostol can be helpful.

5. A G3P2 patient at 8w5d presents for an abortion, with a history of a previous cesarean and a postpartum hemorrhage not requiring transfusion. The aspirator quickly fills with blood when suction is applied. You empty it, recharge, and it again fills with blood. You have seen some tissue come through. You ask your assistant to prepare another MVA but it promptly fills with blood when attached to the cannula.

a. Given the patient's risk factors, what additional preparations would you consider beyond normal precautions?

This patient is in the moderate risk category for hemorrhage (Kerns 2013). In addition to what you would do for a low risk patient (see Managing Immediate Complications Table page 115), the following should also be considered:

- Consider obtaining consent for transfusion.
- Have uterotonic medications readily accessible.
- Consider ultrasound guidance.
- With additional risk factors, if possible, you might also consider referring to a center with transfusion capability, anesthesia, and interventional radiology.

b. What do you suspect?

- The patient has already bled about 200 cc, and is at risk for hemorrhage (defined as 500 cc EBL).
- Consider some causes of hemorrhage with 4T's mnemonic: tissue (incomplete aspiration), tone (atony), trauma (cervical laceration or perforation), or thrombin (a rare underlying bleeding disorder). Also consider ectopic pregnancy.

c. What can you do now?

As a memory tool, practice 2 primary steps for each of the 6T mnemonic of management:

- Tissue: Assure uterus is empty
 - Estimate EBL
 - Reaspiration (with US guidance) EVA for rapid evacuation; check POC is adequate. US may assist and identify the rare cervical or cesarean ectopic.
- Tone:
 - Uterine massage
 - Medications (methergine, misoprostol, dilute vasopressin, tranexamic acid)
- Trauma: Assess source
 - "Cannula test" (watching return as you slowly withdraw cannula from fundus to external os, to identify bleeding zone)
 - Walk or clamp cervix with ring forceps
- Thrombin:
 - Review bleeding history
 - Consider additional tests as indicated (clot test, coagulation tests, CBC)
- Treatment
 - IV fluid bolus
 - Uterine tamponade with Foley catheter or Bakri balloon (inflate bulb)
- Transfer
 - Vitals every 5 minutes
 - Initiate transfer

EXERCISE 6.2

Purpose: To practice managing challenges that may occur after uterine aspiration.

1. The nurse consults with you about a possible problem phone call regarding a patient who had an abortion at the clinic five days ago. The patient complains of severe cramping and rectal pressure, has had minimal bleeding, and has a mild fever.

a. What is the differential diagnosis?

- This patient may have developed a hematometra, or accumulation of blood in the uterus following the procedure.
- Undetected perforation with possible bowel injury

b. Which exam and ultrasound findings would support your diagnosis?

- Physical examination reveals a large, tense, and tender uterus.
- US shows an expanded uterine cavity with heterogeneous echo complex, consistent with clots in the uterus.

c. What are your management recommendations?

- While small collections of clot may pass spontaneously or with uterotonics if the patient's pain is tolerable, aspiration is usually required for larger clots, with or without intraoperative uterotonics.

d. If these symptoms developed immediately after abortion, what would you do?

- Aspiration is usually required with or without uterotonics, and may save an ED visit.

2. A 21-year-old patient comes to your office for follow-up after an 8-week abortion two weeks ago at another facility, and still has some symptoms of pregnancy including breast tenderness and abdominal bloating. Medications include birth control pills. The patient has had intercourse regularly for the past six days. The patient is afebrile, with normal vital signs. Pelvic exam is normal except for an 8-week size uterus. A high sensitivity urine pregnancy test is positive.

a. What is the differential diagnosis?

- A completed abortion in a patient with hormonal contraceptive side effects
- A failed attempted abortion with an ongoing pregnancy
- Retained POC / asymptomatic hematometra
- Uterine fibroids causing enlarged uterine size
- Ectopic pregnancy or heterotopic pregnancy with continuing ectopic
- Hydatidiform mole

b. How can you rule in or out any of your diagnoses?

- Home pregnancy tests are high sensitivity pregnancy tests (HSPT; positive at 20-25 mIU/mL) and can remain positive 4 – 6 weeks after abortion so a positive HSPT two weeks later may be positive for any of the differential diagnoses in this example.
- Assess whether POC, post-abortion US, or an hCG were checked after the abortion, but a quantitative hCG is an important baseline for further testing.
- Is serial serum hCG rising or falling, and at what rate? See Chapter 3 [page 56](#).
US can help identify an ongoing pregnancy, remaining clots, or an ectopic pregnancy. However, a negative US is inconclusive and cannot definitively rule out an ectopic.
- Exam may be helpful to evaluate uterine size, bogginess, or adnexal masses.
- Re-aspiration determines uterine contents: presence of POC or pathologic changes.
- Breast tenderness could be from hormonal contraceptives.
- 8-week size could be due to fibroids, retained clots, or inter-examiner variability.

c. How might your approach differ if the ultrasound showed a moderate amount of heterogeneous contents?

- This suggests retained tissue, decidua and/or clotted blood. Uterine re-aspiration may show evidence of chorionic villi, membranes, or fetal parts.

d. If the patient is not pregnant, how can you explain their positive urine pregnancy test and breast tenderness?

- A high sensitivity pregnancy test may still be positive for up to 4 – 6 weeks following an abortion.
- Breast tenderness may be secondary to the initiation of hormonal contraceptives.

7. CONTRACEPTION AND ABORTION AFTERCARE

Updated June 2022 by Mayra Hernandez Schulte MD, Chelsea Faso MD,
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This chapter will help you to learn the art of patient-centered contraceptive care by establishing rapport with each patient, eliciting their preferences, utilizing the latest evidence to determine eligibility, and providing access for patients to start and stop the full range of methods. It will also help you provide routine aftercare with clear instruction for home care following uterine aspiration.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you will be able to:

- Describe options, indications, contraindications, side effects and common myths for specific contraceptive methods
- Facilitate informed, patient-centered choice in contraceptive care
- Provide post-procedure counseling, including instructions about home care, warning signs for complications, medications (if indicated), and emergency contact information

VIDEOS

- Shared Decision Making Using a DecisionAid (IERH): <https://bit.ly/3KMoWWv>
- Contraception 101 (IERH): <https://bit.ly/3teDMPB>
- Global Contraception (IERH): <https://vimeo.com/129470448>

RESOURCES

- Medical Eligibility Criteria for Contraceptive Use (MEC; apps available):
 - [US MEC](#)
 - [WHO MEC](#)
- Selected Practice Recommendations for Contraceptive Use (SPR; apps available):
 - [CDC SPR 2021](#)
 - [WHO SPR](#)
- Bedsider Providers Page: providers.bedsider.org
- UCSF Bixby Beyond the Pill: beyondthepill.ucsf.edu
- Reproductive Health Access Project: <https://www.reproductiveaccess.org/contraception/>
- Family Planning National Training Center: <https://rhntc.org/>

SUMMARY POINTS

SKILL

- Establish rapport with each patient, use open-ended questions, ask patients what matters most to them about a method, and provide access to the range of methods.
- Invest in the patient's experience, rather than in a particular contraceptive method or outcome. You will learn from patients and colleagues as you proceed through training.
- Consider the quality of your counseling from the patient's point of view. Data shows patients are more likely to be satisfied with counseling and to continue using their selected method if they felt their provider:
 - Respected them as a person,
 - Listened to their values about their method,
 - Centered their values and preferences,
 - And gave them enough information to make a decision (Dehlendorf 2018).
- Improve access by minimizing unnecessary tests and visits to obtain contraception.
- Ensure patients have the right to prompt IUD or implant removal for any reason, without judgment or resistance from their provider.

SAFETY

- Understand the medical eligibility, risks and side effects associated with both contraception and pregnancy to accurately inform patients.

ROLE

- Ensure that you offer all methods as part of routine contraceptive counseling for all interested patients, including for adolescents, transgender and gender diverse patients. Offer all patients condoms to reduce STI risk and emergency contraception, regardless of the contraceptive method chosen.
- Respect a person's autonomy to decide the right time to discuss contraception for them, as people seeking abortion services may not desire contraceptive counseling on the day of abortion. Be mindful of the history of contraceptive coercion that has particularly impacted communities of color, and continues to this day.
- Provide patients with instructions for home care, medications, contraception, warning signs, and emergency contact information to help minimize patient stress, phone calls, and need for a follow-up appointment following routine aspiration

CONTRACEPTIVE COUNSELING

The world health community has affirmed the “basic right of individuals to decide freely and responsibly the number, spacing and timing of their children” (UN 1994). The gap between need for and access to contraception varies, but exists in all countries (Guttmacher 2016).

Reproductive Justice see Chapter 1, page 3 (RJ) includes the human right to maintain personal bodily autonomy, have children, not have children, and parent children in safe and sustainable communities; RJ principles recognize the limited choices marginalized communities face in reproductive health services, as intersecting systems of oppression impact access to care (SisterSong).

Contraception is primary health care. All patients with reproductive potential should be counseled regarding their reproductive preferences and offered contraception if desired as a part of routine primary and abortion care (CDC QFP 2017). Optimal contraceptive counseling supports patients to make fully-informed decisions by providing unbiased information about the full range of options (Senderowicz 2020). Given the social and historical context in which some communities’ reproduction has been devalued, counseling should be responsive to each patient’s priorities and concerns rather than direct patients towards using contraception, or towards the selection of any specific method or method type (Dehlendorf 2014) and include information on the risks, benefits, and side effects of methods that meet their preferences. Quality and effectiveness of counseling has been validated by a person-centered contraceptive counseling measure (Dehlendorf 2018). Patients are more likely to be satisfied with their counseling, continue use, and like a selected method 6 months later if they responded that they felt as if their provider:

- Respected them as a person
- Listened to their values about their method
- Centered their values and preferences
- Gave them enough information to make a decision

Core principles / steps in quality contraceptive counseling include:

1. Establishing and maintaining rapport with the patient
2. Assessing the patient’s needs and personalizing discussions accordingly
 - If the patient has a strong interest in one method, asking permission before providing information on others.
 - Considering methods that align with patient priorities, such as:
 - Changes to menstrual bleeding
 - Route, ease of use, or remembering, and cost
 - Privacy from a partner or parents
 - Effectiveness
 - Hormonal or non-hormonal
 - Impact on sex and / or pleasure
3. Working with the patient interactively to establish a plan
 - Anticipate & address barriers to accurate/consistent use for chosen method
4. Simplifying the decision process (i.e. appropriate language and visual aids)
5. Confirming patient understanding
 - Using active learning strategies such as teach back (CDC QFP 2017)

Addressing bias and reproductive coercion in family planning

Many marginalized communities including people of color, low-income or uninsured people, indigenous people, immigrants, and people with disabilities have been aggressively targeted by providers for long acting reversible contraception (LARC) as an effort to limit family size, and have also been subjugated to a long history of sterilization abuse (NWHN/SisterSong 2021). This history demands that providers recognize their own implicit biases and ensure people are provided information about a full range of contraceptive options.

Understanding and addressing one's own biases is a life-long process and requires that providers acknowledge and challenge their assumptions about certain individuals and / or communities. Providers should invest in the patient's experience and preferences, rather than in a particular method or outcome. (See related content in Chapter 2 [page 25](#))

Addressing contraception as a part of abortion care services is an important part of ensuring people's long-term reproductive health needs are met. However, people may not want to talk about contraception on the day of their abortion consultation or in the setting of abortion (Brandi 2018). Patients may feel they are not ready to decide, or they may be overwhelmed by the information they are receiving. It is also common for people undergoing abortions to criticize themselves for their use or non-use of contraception, and to blame themselves when their method fails. Because of abortion stigma and self-blame, patients may feel pressured to choose and start a contraceptive method that day, even though they may not want to.

During abortion care, the provider should help to diminish any self-blame and shame by normalizing abortion services and encouraging the patient to set their own contraceptive priorities. Setting their own contraceptive priorities in an abortion consultation may mean that they are open to hearing about options, or that they don't want to talk about or consider contraception at that time, and that is okay, too.

Improving access

- To avoid delays, send scripts to the pharmacy, mail, or pre-pack for pick up.
- Provide virtual or telehealth visits for counseling and initiation for some methods.
- Initiate bridging method as needed, pending a follow-up visit for IUD, implant, sterilization, or DMPA (consider SQ self-administration):
 - Video: SubQ DMPA: <https://bit.ly/2CEha3b>
 - Depo-subq-user-guide: <https://bit.ly/2BdHnoO>
- Use evidence-based extended use (Ti 2020, Ali 2017), if patient desires.
- Provide both contraceptive initiation & LARC removal as essential services.
- In the absence of medical issues, contraception may often be refilled without a visit.
- Dispensing 12 months is safe, effective, and improves continuation (Foster 2006).

Evidence-Based Extended Use		
Method	FDA-approved duration	Evidence-based duration
CuT IUD (Paragard®)	10 years	12 years
LNG 52 mg IUD (Liletta®)	8 years	8 years (Creinin 2021)
LNG 52 mg IUD (Mirena®)	8 years	8 years
LNG 19.5 mg IUD (Kyleena®)	5 years	
LNG 13.5 mg IUD (Skyla®)	3 years	
Implant (Nexplanon®)	3 years	5 years

Counseling for Side Effects and Common Concerns

Many patients have used various contraceptive methods and may have strong opinions about a method based on their personal/peer experience. Investing in a patient's experience requires authentically listening to, and identifying, a patient's preferences.

- Empathize with the patient: *"That sounds really difficult."*
- Normalize their experience: *"I hear that from a lot of patients"*.
- Reassure the patient: *"I can remove your IUD for you today"*.
- Offer options that honor the patient's preferences: *"We can remove your IUD today. Would you be interested in hearing about potential options to help manage the bleeding?"*

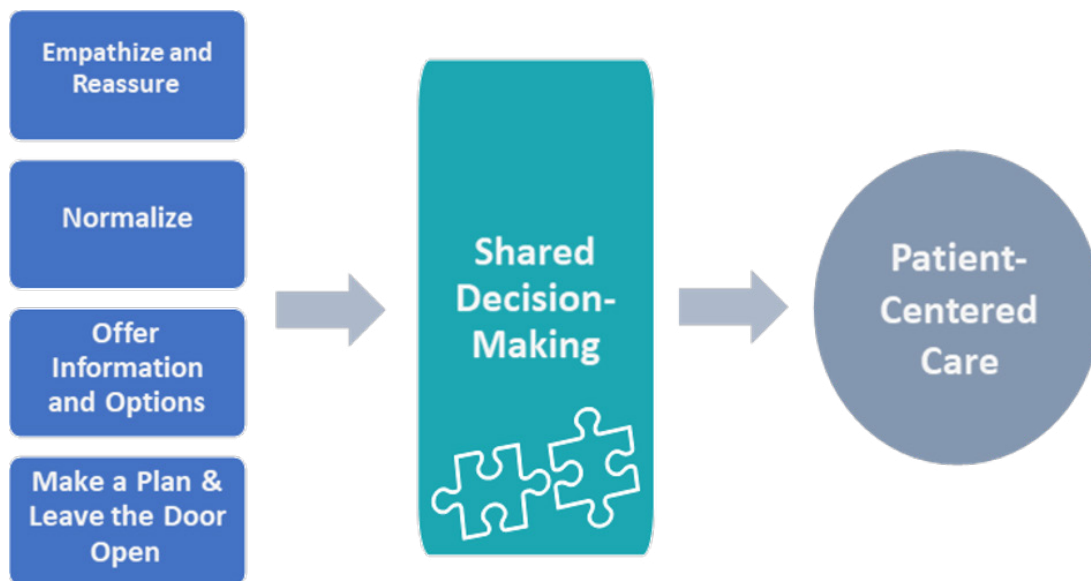


IMAGE UCSF BTP

EVIDENCE-BASED CONTRACEPTIVE GUIDANCE

The rapidly growing body of evidence surrounding contraception is tremendously helpful to our patients. This chapter provides a brief update, with links to more in-depth resources. Keep in mind that the goal is to remove barriers to access for those patients desiring contraception, rather than to have every patient leave the abortion visit with a contraceptive method ([Matulich 2015](#), [Brandt 2018](#)).

Visual Aids for Counseling

It helps to use visual aids so patients can explore their options. It is important to acknowledge the priorities inherent in the chart being used, and focus on methods that match the patient's priorities. Some examples of visual aids:

- [Your Birth Control Choices Factsheet \(RHAP\)](#)
- [Birth Control Method Options \(FPNTC\)](#)
- [Birth Control \(Bedsider\)](#)

Simplified Screening ([CDC SPR 2016](#))

Most methods can be safely initiated with few additional requirements. Prior to initiating a new method, the provider should:

- Review medical history to identify potential contraindications
- Consult the MEC. If patient desires MEC category 3 method:
 - use shared-decision making to discuss risks
- Consider required exam components for specific methods:
 - BP (self-report adequate): combined hormonal methods
 - Pelvic exam: IUD and some diaphragms
 - STI screening: IUD (same visit; **only** if risks & not yet screened; [Sufrin 2015](#))
- Not required to initiate contraception:
 - Heart, lung, breast or well-person exam, pap test, hemoglobin or “routine” labs

Quick Start – Initiation of Contraception ([CDC QFP 2017](#))

- If desired, initiate method on day of patient’s visit in any part of the patient’s cycle (including same-day IUD / implant when feasible and desired by the patient)
- If unable, provide bridge method until the patient returns to start their desired method
- [Quick Start Algorithms \(RHAP\)](#)

Post Abortion Initiation of Contraception

- Post aspiration, all methods can be started on day of procedure if desired
- Post medication abortion or miscarriage:
 - Implant and DMPA can be placed or given day of mifepristone ([Raymond 2016](#))
Same day DMPA associated with increased ongoing pregnancy rate compared to initiation at follow-up (3.6% vs. 0.9%),but patient satisfaction is higher
 - Pills, patch, and ring can be started after misoprostol administration
 - IUD at follow-up visit and offer bridging method if unable to schedule follow-up within 7 days ([CDC SPR 2021](#))

Evidence-based IUD and Implant Eligibility

- No association of IUD with increased infertility risk ([Hubacher 2001](#))
- PID risk with IUD no greater than any other non-barrier contraceptive method
- No restriction for multiple partners
- Contraindications: pregnancy, cervicitis or PID, significant uterine cavity distortion
- LNG-IUD 52 mg minimizes blood loss with menorrhagia, endometriosis, fibroids
- IUD and implant are safe, effective, & have high satisfaction and continuation rates
- 3-year continuation ~ 70% LARCs vs. ~ 30% short-acting methods ([Diedrich 2015](#))
- Assure removal upon request, for any reason, as part of informed consent process

IUD Selection for Individual Preferences

Cu-T IUD (Paragard®)	LNG 52 mcg IUD (Mirena® / Liletta®)	LNG 13.5 – 19.5 mcg IUD (Skyla®/ Kyleena®)
Wants regular menses	Wants light menstrual flow (Amenorrhea 30%) Wants non-contraceptive benefits (for painful periods or uterine protection)	Wants less menstrual flow Amenorrhea 6-12%
Doesn't want hormones	Interested in benefits of hormones	Interested in benefits of hormones: low dose
Wants EC	Wants EC	Needs/wants smaller IUD

IUD & Implant Insertion Tips; Insertion and Removal Videos:

- IUD: place any time in cycle if reasonably sure patient is not pregnant (CDC SPR 2021)
- Consider IUD start with negative urine pregnancy test (UPT) at any time in the cycle
Research shows no pregnancies occurred with unprotected intercourse (UPI) episode 6-14 days before IUD placement, or with multiple UPI episodes (BakenRa 2021)
- Routine antibiotic prophylaxis unnecessary for IUD placement (CDC SPR 2021)
- Routine misoprostol is not evidence based (Pergialiotis, 2014)
- After an unsuccessful attempt, misoprostol 400 mcg vaginally or buccally 2 hrs prior improves subsequent placement (Bahamondes 2015)
- Routine IUD string checks not supported by evidence (Davies 2014)
- Back-up method is no longer required after 52 mg LNG-IUD placement (Fay 2021)
- Managing IUD insertion pain video (IERH): <https://bit.ly/3KLuck2>
 - Most patients tolerate with PO Ibuprofen
 - Paracervical block should be offered (if available), especially if there is history of painful insertion or nulliparous (Mody 2018)
- IUD Insertion Videos (IERH): <https://bit.ly/3O6gF1T>
 - Cu-T using no touch technique: <https://bit.ly/3zQq09O>
 - Implant insertion video (IERH): <https://bit.ly/3HCeFMi>
 - Pop out removal technique video: <https://bit.ly/3GtSBCY>

Ensuring IUD / Implant Removal

- Patients have a right to prompt LARC removal, without provider resistance
- Clinicians often prefer to await symptom resolution (Amico 2018)
- Resisting removal may jeopardize satisfaction & clinical relationship (Raifman 2018)
- Patients are more likely to consider IUD if aware of self-removal option (Foster 2014)
- Self-removal is safe; among those who try, 1 in 5 successful (Foster 2014)
 - (RHAP): [IUD Self-Removal Fact Sheet](#)

Progesterone-only Methods (Implant, LNG-IUDs, DMPA, POP):

- Safe for most patients with estrogen contraindications (e.g. migraines with aura)
- Generally decrease bleeding & pain; possible amenorrhea (DMPA, LNG-IUD, Implant)
- Decreased risk of endometrial and ovarian cancer (DMPA, 52mg LNG-IUD)
- For metrorrhagia / menorrhagia & no contraindications, can add back estrogen
- DMPA-subcutaneous can be safely self-injected by patients (Burlando 2021)
- New POP (Slynd®) has a 24 hour missed-pill window, as compared to other POPs that must be taken within a 3 hour daily window

Combined Hormonal Contraceptives (COC, Patches, Rings):

- Decreased dysmenorrhea, PMS & menstrual migraines, improved acne
- Decreased gyn cancers, ovarian cysts, PID, benign breast tumors, osteoporosis
- Rare adverse health outcomes: VTE, heart attack, stroke, for some risk categories
- Annovera Ring is FDA approved for 13 cycles as compared to NuvaRing / EluRing 1 month (may be used for 3 weeks/1 cycle, then replaced by a new ring a week later)
- Twirla® Patch is a slightly larger patch that is comparable to a low dose oral contraceptive, as opposed to Xulane Patch which has a higher dose than an OCP. Twirla is contraindicated with BMI >30 (increased VTE risk and less effective)

Peri-coital Methods (used at or around time of intercourse)

- Contraceptive gel (**Phexxi®**): acidifying vaginal gel that is hostile to sperm, placed into vagina up to 1 hour prior to intercourse
- Diaphragms (**Caya®**, **Milex®**)
- External / internal condoms, can protect against HIV and STIs

Extended / Continuous Contraception to Reduce / Eliminate Withdrawal Bleeding

- Safe, acceptable, and as efficacious as monthly cyclic regimens
- Fewer scheduled bleeds; less estrogen-withdrawal symptoms (**Edelman 2014**)
- Various monophasic OCP and vaginal ring (**Annovera®** or **NuvaRing®**) can be used
- Unscheduled bleeding decreases over time with these regimens

Contraceptive Care across the Gender Spectrum

- Transgender & gender diverse (TGD) patients (whose gender identity or expression is different from that assigned at birth) can be offered full range of contraceptive options
- Testosterone does not serve as a contraceptive; its use is not a contraindication to hormonal contraception, though some prefer to avoid estrogens (**Krempasky 2020**, **Bonnington 2020**, **ACOG 2021**)
- TGD patients may want non-contraceptive menstrual suppression (**Boudreau 2019**)
- Include a discussion of future fertility goals with TGD patients when discussing contraception options
- See Birth Control across the Gender Spectrum (RHAP): <https://bit.ly/3iczORk>

Emergency contraception (EC):

- LNG EC pills (ECP) via US pharmacies / online without Rx for all ages / genders
- EC effectiveness:
 - CuT or LNG 52 mg IUD equivalent; ~ 100% effective at any BMI or repeat intercourse; provides ongoing contraception (**Turok 2021**, **Wu 2010**)
 - Offer IUD if increased risk ECP failure (**Turok 2021**, **Glasier 2011**, **Shen 2017**)
 - UPA more effective than LNG ECP at any BMI. UPA less effective with BMI > 30, LNG ECP less effective with BMI > 25
 - After Ulipristal (UPA) EC pills, consider delaying Implant or DMPA until 5 days after UPA (**ASEC 2016**); theoretical decrease in efficacy, weighed again difficulty initiating method

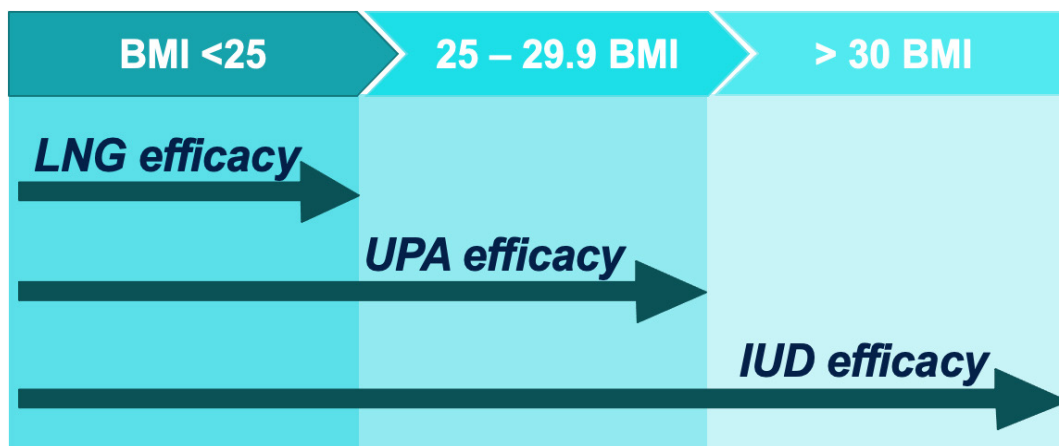


Image UCSF BtP

Evidence that IUD and EC Pills (ECPs) are not abortifacients

- Neither IUDs nor ECPs will disrupt an implanted pregnancy or cause an abortion
- Post-IUD tubal flush studies find no fertilized eggs ([Ortiz 2007](#))
- Post-IUD transient hCG elevations not found ([Turok 2022](#))
- LNG ECPs prevent ovulation by blocking LH surge, inhibiting follicular development and egg release. UPA delays ovulation, including after LH surge started. This extended activity likely explains UPA's greater efficacy ([Turok 2022](#))
- Neither LNG or UPA EC taken after ovulation affect implantation and LNG results in similar conception rates compared to placebo at that point. No evidence LNG exposure affects fetal development, miscarriage, stillbirth, or subsequent menses ([Endler 2022](#))

MEDICAL ELIGIBILITY FOR INITIATING CONTRACEPTION

Condition	Qualifier for condition	Estrogen/ progestin: pill, patch, ring	Progestin- only: pill	Progestin- only: injection	Progestin- only: implant	Hormonal IUD	Copper IUD
Age	<18	1	1	2	1	1	1
	18-40	1	1	1	1	1	1
	40-45	2	1	1	1	1	1
	> 45	2	1	2	1	1	1
Anemia	Thalassemia	1	1	1	1	1	2
	Sickle cell disease	2	1	1	1	1	2
	Iron-deficiency anemia	1	1	1	1	1	2
Bariatric surgery	Stomach restrictive procedures, including lap band	1	1	1	1	1	1
	Malabsorptive procedures, including gastric bypass	Pill: 3 Patch or ring: 1	3	1	1	1	1
Breast cancer	Family history of cancer	1	1	1	1	1	1
	Current	4	4	4	4	4	1
	In past, no evidence of disease for > 5 years	3	3	3	3	3	1
Breast problems, benign	Undiagnosed mass	2	2	2	2	2	1
	Benign breast disease	1	1	1	1	1	1
Cervical cancer and pre-cancerous changes	Cervical intraepithelial neoplasia	2	1	2	2	2	1
	Cancer, awaiting treatment	2	1	2	2	4	4
Depression		1	1	1	1	1	1
Diabetes mellitus (DM)	Gestational DM in past	1	1	1	1	1	1
	DM without vascular disease	2	2	2	2	2	1
	DM with end-organ damage or > 20 years duration	3	2	3	2	2	1
Drug interactions	Antiretrovirals	All antiretroviral medications (except fosamprenavir) are either 1 or 2 for every contraceptive method.					
	Anticonvulsants: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine	3 Must select a pill with ≥ 30 mcg of estrogen to maximize efficacy	3	1	2	1	1
	Lamotrigine alone (Lamotrigine/valproate combo does not interact with hormones)	3	1	1	1	1	1
	Rifampin/rifabutin	3	3	1	2	1	1
	ALL OTHER antibiotics, antiparasitics, & antifungals	1	1	1	1	1	1
Endometrial cancer		1	1	1	1	4	4
Endometriosis		1	1	1	1	1	2
Gallbladder disease	Asymptomatic gallstones or s/p cholecystectomy	2	2	2	2	2	1
	Symptomatic gallstones, without cholecystectomy	3	2	2	2	2	1
	Pregnancy-related cholestasis in past	2	1	1	1	1	1
	Hormone-related cholestasis in past	3	2	2	2	2	1
Headaches	Non-migranous	1	1	1	1	1	1
	Headaches: migraines	2	1	1	1	1	1
HIV infection	With aura	4	1	1	1	1	1
	High risk for HIV infection	1	1	1	1	2	2
Hypertension	HIV infection (without drug interactions)	1	1	1	1	1 if well/2 if ill	1 if well/2 if ill
	During prior pregnancy only – now resolved	2	1	1	1	1	1
	Systolic < 159 & diastolic < 99	3	1	2	1	1	1
	Systolic ≥ 160, diastolic ≥ 100, and/or with vascular disease	4	2	3	2	2	1

click the chart to go to the source on the web

Condition	Qualifier for condition	Estrogen/ progestin: pill, patch, ring	Progestin- only: pill	Progestin- only: injection	Progestin- only: implant	Hormonal IUD	Copper IUD
Inflammatory bowel disease	Ulcerative colitis, Crohn's disease	2	2	2	1	1	1
Ischemic heart disease	Past or current	4	2	3	2	2	1
	Multiple risk factors (such as smoking, diabetes, hypertension, hyperlipidemia, or older age)	4	2	3	2	1	1
Liver Disease	Viral hepatitis-carrier	1	1	1	1	1	1
	Viral hepatitis-active	4	1	1	1	1	1
	Cirrhosis-mild	1	1	1	1	1	1
	Cirrhosis-severe	4	3	3	3	3	1
	Tumors-focal nodular hyperplasia	2	2	2	2	2	1
	Hepatocellular adenoma	4	3	3	3	3	1
	Tumors-malignant	4	3	3	3	3	1
Obesity	BMI > 30 kg/meter squared	2	1	1	1	1	1
Ovarian cancer		1	1	1	1	1	1
Ovarian cysts	& benign tumors	1	1	1	1	1	1
Pelvic inflammatory disease	Past, with subsequent pregnancy	1	1	1	1	1	1
	Past, without subsequent pregnancy	1	1	1	1	2	2
	Current	1	1	1	1	4	4
Postpartum, not breastfeeding	< 3 weeks postpartum	4	1	1	1	See Postpartum IUDs	
	3-6 weeks, increased risk DVT	3	1	1	1		
	3-6 weeks, normal risk DVT	2	1	1	1		
	> 6 weeks postpartum	1	1	1	1	1	1
Postpartum, & breastfeeding	< 3 weeks postpartum	4	2	2	2	See Postpartum IUDs	
	3-4 weeks postpartum	3	2	2	2		
	4-6 weeks, increased risk DVT	3	1	1	1		
	4-6 weeks, normal risk DVT	2	1	1	1		
	> 6 weeks postpartum	2	1	1	1	1	1
Postpartum IUDs	< 10 minutes post-placenta delivery- Breastfeeding					2	1
	< 10 minutes post-placenta delivery- not breastfeeding					1	1
	10 minutes post-placenta delivery to 4 weeks					2	2
	> 4 weeks					1	1
Post-abortion	First trimester	1	1	1	1	1	1
	Second trimester	1	1	1	1	2	2
	Immediately after septic abortion	1	1	1	1	4	4
Rheumatoid arthritis	On immunosuppressive therapy	2	1	2	1	2	2
	Not on immunosuppressive therapy	2	1	2	1	1	1
Sexually Transmitted Infections (STI)	Vaginitis / Increased risk of STI	1	1	1	1	2	2
	High risk of STI	1	1	1	1	2	2
	Current GC/Chlamydia/ Purulent cervicitis	1	1	1	1	4	4
Smoking	Age < 35	2	1	1	1	1	1
	Age > 35, < 15 cigarettes/day	3	1	1	1	1	1
	Age > 35, > 15 cigarettes/day	4	1	1	1	1	1
Seizure disorder	Without drug interactions	1	1	1	1	1	1
Stroke	Past or current	4	2	3	2	2	1
Surgery	Minor	1	1	1	1	1	1
	Major, without prolonged immobilization	2	1	1	1	1	1
	Major, with prolonged immobilization	4	2	2	2	2	1
Systemic lupus erythematosus	Antiphospholipid Ab +	4	3	3	3	3	1
	Severe thrombocytopenia	2	2	3	2	2	3
	Immunosuppressive treatment	2	2	2	2	2	2
	None of the above	2	2	2	2	2	1
Thyroid disorders	Simple goiter, hyperthyroidism, hypothyroidism	1	1	1	1	1	1
Uterine fibroids	IUDs ok unless fibroids block insertion	1	1	1	1	2	2
Valvular heart disease	Uncomplicated	2	1	1	1	1	1
	Complicated	4	1	1	1	1	1
Varicose veins		1	1	1	1	1	1
Venous thrombosis	Family history (first-degree relatives)	2	1	1	1	1	1
	Superficial thrombophlebitis	3	1	1	1	1	1
	Past DVT, high risk of DVT, or known thrombophilia	4	2	2	2	2	1
	Current DVT	4	2	2	2	2	2

ABORTION AFTERCARE

Care of patients following uterine aspiration is usually straightforward, and can occur in a recovery area or procedure room. Care may vary slightly with gestational age of the pregnancy, type of anesthesia, and any complicating factors. Post-aspiration care includes discharge education, observation and support related to analgesia administered, surveillance for immediate and delayed complications, and review of any instructions or referrals for any contraceptive method chosen by the patient.

Recovery and Monitoring

Provider or staff should assess the following parameters prior to discharge:

- Adequate pain control
- Controlled stable vaginal bleeding
- Normal stable vital signs
- Normal oxygen saturation if sedation is used
- Ability to ambulate independently
- Alertness (i.e. Aldrete score) if IV sedation used

The following discharge medications may be given or reviewed for home use:

- NSAID and / or any additional pain medications
- Preferred contraceptive method, if applicable, including offering condoms and EC

Most patients require only 15-30 minutes of recovery time, including those receiving local anesthesia, NSAIDs, oral opioids / anxiolytics, or short-acting IV sedation. A patient should not drive after sedating medications. Sedation may still be provided with or without an escort as long as the patient does not drive themselves.

Discharge education should include guidance for deciphering normal symptoms from warning signs, and instructions should such symptoms occur (see below). Review instructions prior to sedation or after it has worn off, and have written materials for the patient to take with them.

While some patients may have specific indications for a follow-up visit, data does not support routine visits after uterine aspiration ([Grossman 2004](#)). Most patients can be given aftercare instructions and a phone number to call with concerns in lieu of a routine follow-up visit, but specific indications for a follow-up visit include:

- Suspected incomplete abortion, ongoing pregnancy or ectopic pregnancy
- Need for re-evaluation or follow-up (e.g. serial hCGs)
- Need for follow-up contraceptive visit (e.g. unable to place IUD on day of procedure, BP check for elevated blood pressure)
- Medical, social, or emotional needs identified during their abortion care.

Offer to be available, but also give reliable referral information to respectful providers and facilitate care, including to:

- Support hotlines
- Primary and specialty medical care, including prenatal or fertility services.
- Mental health, behavioral health, intimate partner violence, or substance use counseling
- Social needs such as food, housing, etc.

ABORTION PROCEDURE AFTERCARE

Adapted from RHAP & RRWC MVA AFTER-CARE INSTRUCTIONS

Today you had an abortion procedure. You will most likely feel fine when you go home. You can return to your normal activities as soon as you want. You can take a shower and wash your hair as soon as you want. You can eat normally, but you may still feel nauseated for a couple days.

Many providers advise not putting anything in the vagina for 1 week (e.g. tampons, menstrual cup) however there is no evidence this is beneficial. Douching is never recommended. You may or may not feel like being intimate or having vaginal intercourse during this time. It is good to trust your body and resume intercourse when you feel ready.

WHAT TO EXPECT

Vaginal Bleeding: You can expect to have bleeding for up to 2 weeks. It is common for the bleeding to stop and start for a few weeks after the abortion. Some people have no bleeding for 2 or 3 days and then begin to have bleeding like a period. Other people have only spotting for a few days and then no bleeding at all. You may notice that the bleeding increases when you exercise; this is not dangerous.

Cramping: You may have cramps off and on during the week following an abortion. You can use pain medication like Tylenol, Ibuprofen (Motrin or Advil), or Naproxen (Aleve or Naprosyn). You can also use a heating pad or drink some warm tea.

Mood changes: You may feel relieved when the abortion is over. You may also feel sad or moody. These feelings may be due to hormonal changes, now that you are no longer pregnant and are normal.

When will your period come back? You can expect a period in 4 to 8 weeks. This varies.

YOU SHOULD CALL US IF:

- Your bleeding soaks through more than 2 pads per hour for more than 2 consecutive hours.
- Your cramps are getting stronger and are not helped by pain medication.
- Your temperature is higher than 100.4 degrees Fahrenheit (38 degrees Celsius).

TO REACH US - CALL OUR 24-HOUR CONTACT NUMBER:

If you have any questions or think something is going wrong, please call this number and someone will call you back. It may take 10-15 minutes to return your call. No question is too small. Please feel free to call us.

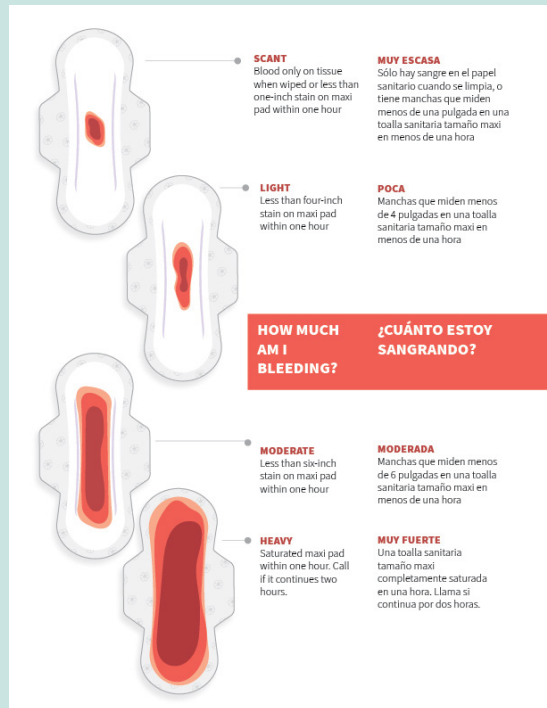
Follow-up visit: (as requested/needed): You have an appointment on _____ at _____ am/pm.

Birth Control (as requested)

If you want to use birth control pills, the patch, or the ring, I have given you a prescription. You should start these on _____, even if you are still bleeding.

ADDITIONAL SUPPORT

Most patients feel better in the month following an abortion or miscarriage. If you are in need of additional support, call us, or consider contacting one of the following hotlines, which help answer questions and provide you with additional support: www.exhaleprovoice.org or 866-4EXHALE, www.alloptions.org or 888-493-0092, or www.connectandbreathe.org or 866.647.1764.



CHAPTER 7 EXERCISES: CONTRACEPTION AND AFTERCARE

EXERCISE 7.1

Purpose: To role-play different aspects of contraceptive counseling and understand recent evidence-based contraceptive developments and medical criteria for use.

1. How would you respond to these common patient concerns about contraception?
 - I don't like the idea of having something inside of my body.

 - I don't want any hormones.

 - Won't an IUD (or EC pills) cause an abortion?

 - I want to have this (IUD / implant) removed (a few months after placement).

2. A 17-year-old G0 patient who is sexually active and currently using withdrawal and condoms comes to the clinic. Role-play how you might initiate a conversation about their contraceptive priorities and options based on preferences of privacy of contraceptive use (from parents) and avoiding STIs.

3. A 28-year-old G3P3 patient presents to the clinic seeking to switch to a new method of contraception. They are currently using DMPA, which has been causing weight gain, and want something non-hormonal. A friend mentioned having pain with an IUD, so your patient is hesitant to consider that option. Role-play being the healthcare provider and / or patient whose priority is avoiding weight gain and other hormonal side effects.
 - Using the person-centered contraceptive counseling measure, what did you do as a provider to ensure that the patient felt respected, listened to, had their preferences identified and received information?

 - As the patient, is there more the provider could have done to establish rapport, identify priorities and share information?

4. What would you discuss with the following patients regarding their desire for contraception? (Consult MEC as a reference)
 - A 36-year-old smoker with BMI > 30 who wants the patch.

 - A 29-year-old with migraine headaches with aura who wants the pill.

- A 20-year-old nulliparous patient with a history of chlamydia at age 15 and who wants an IUD.
- A 28-year-old patient who has BMI > 30, has vaginitis, and wants emergency contraception as well as ongoing contraception. Pt had unprotected intercourse 3 and 5 days ago.
- A 25-year-old with a history of deep vein thrombosis (DVT) 2 years ago (6 weeks postpartum). They are interested in the vaginal ring.
- A 25-year-old transgender man who became amenorrheic on testosterone, wants to prevent pregnancy with a partner that makes sperm.
- A 31-year-old who takes anti-seizure medications and wants the pill.
- A 27-year-old who wants a combined hormonal method but doesn't want a monthly period.

EXERCISE 7.2

Purpose: To review routine follow-up after uterine aspiration, please answer these questions.

1. A patient has had nausea and vomiting throughout pregnancy. How long will it take for them to feel better after the abortion?
2. Providers typically advise patients to call the office if they have certain “warning signs” following uterine aspiration. What “warning signs” would you include and why?
3. After an aspiration, how long would you advise your patient to wait before resuming exercise, heavy lifting, and vaginal intercourse? What is the rationale for your recommendations?

CHAPTER 7 TEACHING POINTS: CONTRACEPTION AND ABORTION AFTERCARE

EXERCISE 7.1

Purpose: To role-play different aspects of contraceptive counseling and to understand recent evidence-based contraceptive developments and medical criteria for use.

1. How would you respond to these common patient concerns about contraception?

- When talking about side effects or common patient concerns, try to empathize, reassure and normalize the patient's feelings. Avoid saying things that might invalidate a person's concerns.
- Avoid confrontational language. You are not trying to change the patient's mind, but instead, elicit the patient's priorities, and understand their goals.
- Uses phrases like:
 - "Tell me more about that."
 - "I hear that concern from a lot of patients."
 - "What worries you the most about that?"
- Ask for permission to share information: For example, "*Can I share some information with you about contraception and abortion?*" If the patients give permission, then go on to share facts to help their understanding.

a. I don't like the idea of having something inside of my body.

- Thank you for sharing that with me. I have heard that concern from others. It's normal to be anxious about having something placed inside you;
- There are methods that don't have something inside of the body. Would you like to discuss those?

b. I don't want any hormones.

- I understand. A lot of people feel that way.
- What is it about a hormonal method that concerns you?
- Ok, there are several non-hormonal options we can discuss.

c. Won't IUDs (or EC pills) cause an abortion?

- *For an abortion to happen, someone has to first be pregnant, and IUDs prevent pregnancy in the first place (by preventing fertilization of an egg, or in the case of hormonal IUDs, by sometimes also preventing the release of an egg.)*
- See evidence that IUD and EC Pills (ECPs) are not abortifacients in this chapter [page 133](#).
- If the patient is still concerned, consider other options.

d. I want to have this (IUD / implant) removed (a few months after placement).

- You can absolutely have your method removed today. I am also curious to know more about what is making you want to have the method removed - as there are often things we can do to help manage symptoms, if you like.

2. A 17-year-old G0 old patient comes to the clinic who is sexually active and currently using withdrawal and condoms. Role-play how you might initiate a conversation about their contraceptive priorities, and options based on a preference of privacy of contraceptive use (from parents) and avoiding STIs?

- Ask if satisfied with method or wants to discuss others addressing preferences.
- Discuss effectiveness of withdrawal, and most important cycle times to use condoms.
- Discuss how and where storage will work to keep condoms, patches, pills or rings.
- Discuss common changes in menstruation with methods, which can be a signal of a change: DMPA, IUDs, & implants can change heaviness and frequency of periods.
- Screen for safety at home and in intimate relationship(s) and discuss what they might do for contraceptive failures (i.e. EC, abortion access, etc.)
- Tell patient that insurance explanation of benefits (EOBs) may be sent to home
- Know privacy laws in your state or country regarding reproductive health services, STI testing, and parental notification. ([Guttmacher 2022](#))

3. A 28-year-old G3P3 patient presents to the clinic seeking to switch to a new method of contraception. They are currently on DMPA, which has been causing weight gain, and want something non-hormonal. A friend mentioned having pain with an IUD, so your patient is hesitant to consider that option. Role-play being the healthcare provider and/or patient whose priority is avoiding weight gain and other hormonal side effects.

- Using the person-centered contraceptive counseling measure, what did you do as a provider to ensure the patient felt respected, listened to, had their preferences identified and received information?
- As the patient, is there more the provider could have done to establish rapport, identify priorities and share information?

Consider the following principles and steps:

- Establish and maintain rapport with the patient
- Assess the patient's needs and personalize discussions accordingly
 - If the patient has a strong interest in one method, ask permission before providing information on others
 - Consider methods that align with patient priorities (e.g. bleeding changes, frequency of use, privacy, effectiveness, or modality of administration)
- Work with the patient interactively to establish a plan
 - Anticipate and address barriers to accurate and consistent use of chosen method
- Provide information that can be understood and retained by the patient
 - Simplify the decision process using visual aids
- Confirm understanding
 - Use active learning strategies such as teach back

There are many online tools, curriculum and videos to assist learners with contraceptive counseling. Bedsider has excellent videos discussing contraception from the patients' perspective: <https://www.bedsider.org/methods>. Watching a few of the videos can help learners appreciate the impact of counseling on patients.

4. What would you discuss with the following patients regarding their desire for contraception? (Consult MEC as a reference)

Classification of Categories for Medical Eligibility Criteria (MEC)

1. A condition for which there is no restriction for the use of the contraceptive method.
2. The advantages of using generally outweigh the theoretical or proven risks.
3. The theoretical or proven risks outweigh the advantages of using the method.
4. The condition represents an unacceptable health risk if the contraceptive is used.

- MEC Category 1 and 2 are both considered safe and OK to proceed with use.
- MEC Category 3: Discuss risks and use shared decision-making with patient. Consult as needed. Document risk-benefit discussions.
- MEC Category 4 is considered an absolute contraindication without acceptable use of the method with the specific health condition.

a. A 36-year-old smoker with BMI > 30 who wants the patch.

There are two issues to consider:

- Tobacco users who smoke >15 cigarettes/day and are >35 years old should not use estrogen-containing methods due to increased stroke and M.I. risk (MEC 4).
- BMI > 30 is not considered a contraindication for any birth control (Lopez 2016).
- This patient could safely use any progestin-only or barrier method.

b. A 29-year-old with migraine headaches with aura who wants the pill.

Avoid estrogen-containing contraceptives in patients with migraines with aura due to increased stroke risk. Use caution with patients with migraines without aura, and consider additional prothrombotic risks (e.g. smoking). These patients are best served with a progestin-only or barrier method. Additional MEC categories include:

- Migraine with aura or focal neurological symptoms any age (MEC 4).
- ≥35 years old and migraine without aura (MEC 3).
- <35 years old and migraine without aura (MEC 2).
- Non-migraine headaches at any age (MEC 1).

Migraine with focal neurological symptoms is equivalent to migraine syndrome with aura (or classic migraine), and consists of one or more of the following that usually precedes and sometimes accompanies the headache:

- Visual disturbances, scintillating scotoma, aura
- Paresthesias (numbness and tingling)
- Hemiparesis (weakness or partial paralysis in an extremity)
- Dysphasia (slurred speech or inability to speak)

c. A 20-year-old nulliparous patient with a history of Chlamydia at age 15 and who wants an IUD.

- IUDs are safe and well accepted among nulliparous patients (MEC 2).
- Prior concerns about infertility with IUD no longer pertain with modern IUD designs (using monofilament IUD strings). Tubal infertility is linked to presence of Chlamydia antibodies, not to history of IUD use (Hubacher 2001).
- Return to baseline fertility is almost immediate following IUD removal.
- Although past studies suggested nulliparous patients have a slightly increased risk of IUD expulsion, a prospective study found no difference in rates of expulsions by parity among CuT users, and lower expulsion rates in nulliparous users of the LNG 52 mcg IUD compared with parous users (Birgisson 2015).

d. A 28-year-old patient who has BMI > 30, has vaginitis, and wants emergency contraception as well as ongoing contraception. Pt had unprotected intercourse 3 and 5 days ago.

- CuT IUD & LNG IUD EC are nearly 100% effective, including with BMI > 30. Both provide ongoing contraception, if desired (Turok 2021, Wu 2010).
- Vaginitis (MEC 2), vs. purulent cervicitis or PID (both MEC 4 for IUD).
- Vaginitis should not preclude IUD placement; simply initiate treatment today.
- Patients receiving IUDs for EC were half as likely to become pregnant in the following year compared to oral EC (Turok 2014).
- Alternatively, consider UPA EC with ongoing contraception as desired.

e. A 25-year-old with a history of deep vein thrombosis (DVT) 2 years ago, which occurred 6 weeks after a vaginal delivery. They are interested in the vaginal ring.

Any patient with a history of a DVT is no longer considered a candidate for estrogen containing birth control, including the vaginal ring. It is important to find out more about the patient's disease.

- A postpartum DVT would be considered a pregnancy-associated DVT which is an absolute contraindication (MEC 4).
- Family history (1st degree relative) is not a contraindication (MEC 2), but someone you should consider testing for thrombophilic conditions.

f. A 25-year-old transgender man who became amenorrheic on testosterone, wants to prevent pregnancy with a partner that makes sperm.

If a patient has a uterus and ovaries, they are capable of becoming pregnant, including TGD people who are taking testosterone and no longer having periods. People taking testosterone can use any method of contraception. Testosterone does not reliably work as contraception, and does not interact with hormones in birth control, although some patients prefer to avoid exogenous estrogen. Some people choose a method to minimize or stop bleeding. As with all patients it is important to discuss the person's preferences and assess whether there are any contraindications to specific methods.

See Birth Control across the Gender Spectrum: <https://bit.ly/3iczORk>

g. A 31-year-old who takes anti-seizure medications and wants the pill.

- Certain anti-seizure medications, antibiotics, and antifungals activate the liver’s p450 enzyme system, resulting in faster metabolism of hormones, and decreased efficacy of combination and progestin-only pills and implants (all MEC category 3 while taking these medications; use shared decision-making; see table below).
- CHCs may also reduce bioavailability of lamotrigine (Lamictal).
- Some of these medications may also be used to treat certain psychiatric illnesses, headaches, chronic pain and other conditions.
- IUDs or DMPA are the safest options (MEC 1 and 2 respectively).

Drugs known to increase liver enzyme metabolism / reduce contraceptive effectiveness	Drugs with questionable effects	Drugs known not to effect liver enzyme metabolism or contraceptive effectiveness
<ul style="list-style-type: none"> • Carbamazepine (Tegretol, Equetro, Carbetrol) • Oxcarbazepine (Trileptal) • Phenobarbital • Phenytoin (Dilantin) • Primidone (Mysoline) • Topiramate (Topamax) mild ↓ • Rifampin • Rifampicin • Rifamate • Griseofulvin • St John’s Wort 	<ul style="list-style-type: none"> • Troglitazone (Rezulin) • Felbamate (Felbatol) 	<ul style="list-style-type: none"> • Lamotrigine (Lamictal) • Gabapentin (Neurontin) • Tiagabine (Gabitril) • Levetiracetam (Keppra) • Valproic Acid (Depakote) • Zonisamide (Zonegran) • Vigabatrin (Sabril) • Ethosuximide (Zarontin) • Benzodiazepines • INH (not in combination with Rifampin) • Ketoconazole (anti-fungal) • Fluconazole (anti-fungal)

h. A 27-year-old who wants a combined hormonal method but doesn’t want a monthly period.

- Extended contraception is safe, acceptable, and as efficacious as monthly cyclic regimens ([Edelman 2014](#)).
- Increased ovarian suppression is noted in regimens that shorten or eliminate the hormone free interval, with the potential for increased effectiveness ([London 2016](#)).
- Regimens result in fewer scheduled bleeding episodes and fewer menstrual symptoms, particularly headache ([Edelman 2014](#)).
- Breakthrough bleeding is common in the first six months of continual use; however this side effect usually resolves within 4-6 months.
- Extended and continuous use formulations of mono-phasic COCs, and vaginal ring (Anovera or NuvaRing) may be used.
- Patch is not recommended due to concern over increased levels of estrogen.

EXERCISE 7.2

Purpose: To review routine follow-up after uterine aspiration, please answer these questions.

1. A patient has had nausea and vomiting throughout pregnancy. How long will it take for them to feel better after the abortion?

- Nausea is one of the first pregnancy symptoms to subside after an abortion, generally within 24 hours. Nausea may be induced by CHC use.
- If it persists beyond a week, rule out ongoing pregnancy or retained tissue.
- Breast tenderness subsides in 1-2 weeks, but may be influenced by CHCs.

2. Providers typically advise patients to call if they have certain “warning signs” following uterine aspiration. What “warning signs” would you include and why?

- Persistent severe pain or cramping:
 - May indicate hematometra, infection, uterine trauma, or ectopic.
- Pelvic / rectal pain with little or no bleeding:
 - Suggests hematometra.
- Heavy bleeding (saturating >2 pads per hour for >2 hours) or orthostatic symptoms:
 - Suggests the need for intervention.
- Peritoneal signs (pain with cough, palpation, or sudden movement):
 - May suggest perforation or infection and warrant reevaluation.
- Sustained fever (greater than 100.4°F / 38°C):
 - Raises concern about pelvic infection.

3. After an aspiration, how long would you advise your patient to wait before resuming exercise, heavy lifting, and vaginal intercourse? What is the rationale for your recommendations?

- Resuming exercise or heavy lifting
Many providers empirically discourage strenuous exercise and intercourse for 1-2 weeks after abortion, to prevent exacerbation of bleeding or cramping, or avoid infection, although there is no evidence that this makes any difference.

The patient may resume normal activity when they feel ready, this can be as soon as a few hours after their abortion, or more typically within 24 hours. Probably the best advice is to “listen to your body,” enjoy the activities that make them feel better, and avoid activities that make them worse.

- Resuming vaginal intercourse
No data suggest increased infection with intercourse after an abortion, so advice may be liberalized. Encourage them to trust their body and resume intercourse when they feel ready. As ovulation can occur within 7-10 days, encourage the patient to initiate their chosen method of contraception promptly after abortion if they do not want to become pregnant at this time.

8. EARLY PREGNANCY LOSS MANAGEMENT

Updated June 2022 by Chelsea Faso MD, Caitlin Weber, MD, MS
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This chapter will assist you in learning skills to support your patients through a common and often emotionally and physically difficult experience - the spontaneous loss of an early pregnancy. Management of early pregnancy loss commonly occurs in the primary care setting. The management options of expectant, medication, or aspiration management are recognized as being safe and effective.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be able to:

- Evaluate, diagnose, and counsel patients presenting with signs or symptoms of early pregnancy loss
- Evaluate for ectopic vs. early pregnancy loss, including hCG changes
- Answer questions about short- and long-term implications of early pregnancy loss including emotional effects and implications for fertility
- Present expectant, medication and aspiration management options
- Provide appropriate follow-up, including contraceptive counseling

VIDEOS

- [Early Pregnancy Loss Diagnoses and Counseling](#) (IERH)
- [Early Pregnancy Loss Management](#) (IERH)

READINGS / RESOURCES

- Websites:
 - [Managing Early Pregnancy Loss](#) (IERH)
 - [Miscarriage Resources](#) (RHAP)
 - [Training, Education and Advocacy in Miscarriage Management](#) (UW)
- Patient Resources:
 - <https://www.emptycradle.org>
 - <https://www.throughtheheart.org>
 - [Anita's Miscarriage Zine](#) (RHAP)
- MacNaughton, H, Nothnagle, M, Early, J. [Mifepristone and Misoprostol for Early Pregnancy Loss and Medication Abortion](#). Am Fam Physician 2021 Apr 15;103(8):473-480.
- Hendricks, E, MacNaughton, H, Mackenzie, M. [First Trimester Bleeding: Evaluation and Management](#). Am Fam Physician. 2019 Feb 1;99(3):166-174.
- Prine LW, MacNaughton H. [Office management of early pregnancy loss](#). Am Fam Physician. 2011 Jul 1;84(1):75-82.

SUMMARY POINTS

SKILL

- Open-ended questions and active listening are useful for counseling a patient with suspected early pregnancy loss (EPL).
- Eliciting desired pregnancy outcome can help patients cope with inherent uncertainties, and to identify their priorities and preferences for management.

SAFETY

- EPL can be managed safely and effectively with expectant care, medications, or uterine aspiration.
- Expectant management has a more unpredictable time course, with more bleeding and need for further interventions than aspiration. There is no increased risk for infection.
- EPL management with mifepristone and misoprostol is safe, effective, and avoids some procedural risks, but may take longer and may have medication side effects.
- Office-based uterine aspiration is safe, efficient, cost-effective, and usually more convenient than hospital-based procedures.
- Patients presenting with bleeding in early pregnancy may be experiencing early pregnancy loss or may have self-managed their abortion. Providers do not need to distinguish between the two - treatment strategies are the same for both situations ([Raifman 2021](#)).

ROLE

- Patients often have strong preferences for EPL management, and a shared decision-making approach is useful and patient-centered.
- Our role is to give patients as many treatment options as possible, and to maximize continuity, safety, and access to care.
- EPL management can be a great way to maintain continuity with a trusted provider for patients in the primary care setting. It can also be the first step to bringing other reproductive health services to the primary care setting, such as medication and aspiration abortion.

EARLY PREGNANCY LOSS (EPL)

EPL, often referred to as miscarriage or spontaneous abortion, includes all non-viable intrauterine pregnancies in the first trimester. EPL is common, occurring among 10-20% of clinically recognized pregnancies (ACOG 2015, Prine 2011, Blohm 2008). Nearly half of all EPLs are the result of random genetic errors (with the most common risk factors being age >35 years old and prior early pregnancy loss) while other factors such as environmental or other exposures, socioeconomic, and immunologic factors are also implicated (Lens 2021, ACOG 2015, Prine 2011). In most cases it's not possible to determine the cause of the pregnancy loss.

Patients with EPL often present with vaginal bleeding and/or abdominal cramping. A non-viable pregnancy can also be an incidental finding detected by routine US or absence of fetal heart tones on doppler in the absence of symptoms. EPL can be classified based on clinical exam and US findings as outlined in the table below.

Terminology	Clinical definition	Ultrasound findings
Anembryonic Gestation	Growth of a gestational sac without an associated embryo or yolk sac. Formerly called “blighted ovum”	Enlarged gestational sac without embryo (See criteria in Ch 3 page 53)
Embryonic or Fetal Demise	Loss of viability of a developing embryo or fetus	Embryonic or fetal pole ≥ 7 mm with no electronic cardiac activity (see Ch 3 page 53)
Missed Abortion	A non-viable intrauterine pregnancy, either <i>anembryonic</i> or an <i>embryonic demise</i> , often discovered by US. The patient may be asymptomatic or have a history of bleeding. The cervix is closed.	Anembryonic gestation or embryonic demise (see above)
Threatened Abortion	Uterine bleeding without passage of gestational tissue. The cervix is closed. The pregnancy is viable at time of presentation and prognosis remains uncertain.	Findings appropriate for stage of pregnancy, may or may not show subchorionic hemorrhage
Inevitable Abortion	Bleeding and/or uterine cramping. Cervix is dilated and passage of tissue is expected.	Findings may be appropriate for stage of pregnancy, +/- electronic cardiac activity.
Incomplete Abortion	The cervix is dilated and some, but not all, of the pregnancy tissue is expelled.	Heterogeneous or echogenic material, usually in the lower uterine cavity or in cervical canal
Complete Abortion	The pregnancy tissue has expelled completely	No pregnancy (sac/embryo or fetus) in intrauterine cavity, with possible endometrial thickening

Adapted from Prine, 2011.

Avoid terminology such as “pregnancy failure,” “spontaneous abortion,” and “blighted ovum”. Many patients prefer the term “miscarriage” or “early pregnancy loss” (Clement 2019). Consider that the term “miscarriage” may be received by some patients as an implication that they are somehow at fault (i.e. for not “carrying” the pregnancy correctly).

EPL is very rarely a medical emergency, thus management most commonly and appropriately occurs in the outpatient setting, which is safe, efficient, and cost-effective, while also providing more choices for patients. While some emergency departments (EDs) have worked to build capability to manage EPL, the goal of most has been to evaluate for possible ectopic pregnancy, manage patients with hemodynamic instability, and defer management of stable definitive or potential EPL to the outpatient setting (ACEP 2012).

With an increasingly restrictive legislative environment, abortion and pregnancy outcomes including pregnancy loss and stillbirth are increasingly at risk of being criminalized, with patients at risk of being reported to law enforcement for presenting to the ED for care. Risk of criminalization may be higher among individuals from historically marginalized communities. Additionally, patients and providers in some religiously affiliated institutions may face additional barriers to managing EPL, particularly for inevitable abortion where there is still electronic cardiac activity (Freedman 2008).

COUNSELING TIPS FOR EARLY PREGNANCY LOSS

Primary care and ED providers may be the first to evaluate patients with vaginal bleeding and abdominal cramping in early pregnancy. As the diagnosis often cannot be made definitively during the first visit, counseling presents a unique challenge, requiring heightened sensitivity to a patient's emotional needs.

- Have a conversation that acknowledges complex feelings. Not all people have similar pregnancy goals, intentions, sense of reproductive control, or supportive environments to safely parent ([Borrero 2015](#)), thus the conversation is often not a simple dichotomy (desired vs. undesired, planned vs. unplanned). Explore this with open ended questions like “*what does this pregnancy mean to you?*”
- While awaiting definitive results for a desired pregnancy, reassure that not all vaginal bleeding signifies pregnancy loss. Avoid guarantees that “*everything will be alright.*”
- Keep a patient informed throughout the diagnostic process regarding impressions and next steps. Provide results once a diagnosis is made, giving the patient time to process.
- Explore and address feelings of guilt or responsibility expressed regardless of the patient's desired pregnancy outcome. Respond to specific concerns, reassuring that nearly all cases of early pregnancy loss have no identifiable cause, and cannot be caused by common daily activities (e.g., from coitus, heavy lifting, stress, etc.).
- Describe that early pregnancy loss is common, occurring among 10-20% of clinically recognized pregnancies, and help to normalize the patient's emotions. Advise that no interventions are proven to prevent first trimester loss.
- Patients have strong preferences for choice of EPL treatment, and have greater satisfaction when treated according to their preference ([Wallace 2010](#), [Dalton 2006](#)). Since each option is safe and relatively effective in most clinical situations, the choice of management should align with a patient's treatment preferences.
- Underestimating the discomfort associated with any management option has been negatively associated with satisfaction ([Dalton 2006](#)).
- Assure that you or a colleague will be available throughout the process, answer questions as they arise, and encourage a support person to be at the visit.
- Counsel patients who are particularly bereaved regarding anniversary phenomena, as well as preparing themselves to discuss the loss with family and friends. Provide resources for counseling or phone support if desired by the patient.
- Prepare patients that well-meaning friends, family, and even partners may say the wrong thing as they try to support them, or may underestimate how long the emotional recovery time can be after an early pregnancy loss.
- Studies show some patients experience depressive symptoms following EPL, while most do not. Provide additional counseling resources as needed; although evidence is insufficient to demonstrate its effectiveness ([San Lazaro Campillo 2017](#)).
- ○ When a patient is ready, inquire and counsel about future fertility, providing immediate contraception or preconception care as needed. Inform and counsel about recurrent miscarriage risks (approximately baseline risk after one; 30% risk after two and increasing thereafter). Address any treatable risk factors, as appropriate, in a non-judgmental way. Consider initiating further work-up for patients who have had 3 EPLs, or for patients > 35 who have had 2 EPLs

EPL DIAGNOSTIC AND CLINICAL CONSIDERATIONS

There is no one classical presentation of EPL; it commonly occurs without symptoms or with one or more of the following:

- Vaginal bleeding (the most common sign)
- Abdominal cramping, pelvic or back pain
- Passing of tissue from the vagina
- Loss of pregnancy related symptoms (breast tenderness, nausea)
- Constitutional symptoms such as fever or malaise

Although vaginal bleeding is the most common sign, it does not always signify EPL:

- 30% of pregnancies that progress to term have vaginal bleeding.
- 50% ongoing pregnancy rate with isolated bleeding and closed cervix.
- 85% ongoing pregnancy rate with confirmation of fetal cardiac activity.

Evaluation should include a physical examination, US, and / or quantitative hCGs. Serial hCGs are most helpful when US is inconclusive (i.e. pregnancy of unknown location, chapter 3 [page 56](#)), and are unnecessary after US confirms an intrauterine EPL.

Physical exam assesses patient's status and offers diagnostic clues; it should include:

- Vital signs +/- labs (including orthostatics and H/H if symptoms of hypovolemia or anemia or with heavy bleeding)
- Abdominal examination (to rule out peritonitis or other causes for symptoms)
- Pelvic examination (for bleeding, cervical dilatation, tenderness)
- Tissue examination (for clot vs. pregnancy tissue)

EPL diagnosis is suggested by clinical history with rapidly declining hCGs in absence of IUP on US.

EPL diagnosis is confirmed by one of the following:

1. US confirmation of anembryonic gestation or embryonic/fetal demise in the uterus
2. Absence of previously seen IUP on US
3. Tissue exam confirming membranes and villi expelled or removed from uterus.

In all patients presenting with first trimester bleeding, ectopic pregnancy should be considered. Ectopic pregnancies often present with vaginal spotting, frequently occurring at 6-8 weeks gestation. Due to the implantation of an ectopic pregnancy at sites ill-equipped to support the nourishment of a growing pregnancy, levels of hCG can be insufficient to support the corpus luteum, eventually causing sloughing of the endometrial lining. In the interim, levels of hCG can rise or fall. In addition to vaginal bleeding, other signs and symptoms of ectopic pregnancy include abdominal pain and/or rebound tenderness, referred shoulder pain, and syncope.

Remember two critical aspects of evaluation in a patient with EPL signs or symptoms:

- Ensure hemodynamic stability, and manage or refer as appropriate
- Evaluate for ectopic pregnancy, and treat or refer as appropriate

COMPARING MANAGEMENT OPTIONS FOR EPL

Clinically stable patients can choose among the following management options to achieve completion of their EPL, or switch from one to another during the process:

- Expectant management (wait and watch)
- Medication management with misoprostol +/- mifepristone
- Aspiration in an outpatient or operating room setting.

Choosing from among these options is a preference-sensitive decision ([Wallace 2010](#)), as each option is safe and relatively effective, and patients report greater satisfaction when treated according to their preference.

Studies show a wide range of success rates for expectant and medication management, as success rates depend on type of EPL, clinical studies define success differently (based on US vs clinical endpoints), and there are inconsistencies as to when aspiration is offered to participants enrolled in expectant care. Studies suggest that expectant management has higher success rates when the process of expulsion has already begun, compared to other types of EPL. Providers should counsel patients about their chance of success with each method of management depending upon the type of pregnancy loss (see Comparison Table on page 153) and the amount of time the patient is willing to wait until completion.

EXPECTANT MANAGEMENT

Clinically stable patients may choose to await natural completion of EPL. “Watchful waiting” may avoid intervention and attendant side effects or complications (See Table below [page 154](#); [Nanda 2012](#)).

An EPL can take days to weeks to complete without intervention. Patients can be managed expectantly for 6 weeks if they remain stable and amenable. Clinicians may reassess patients every 1-2 weeks and provide phone access between visits and, to monitor progression and check in to see if the patient prefers to continue expectant management vs. another management option for faster resolution.

Given slightly increased rates of bleeding with expectant vs. aspiration management, patients with anemia (some providers use $hgb < 9$) or other bleeding risks may be best managed with aspiration ([Nanda 2012](#)).

MANAGEMENT WITH MEDICATIONS

Medication management offers patients a more predictable time to completion, avoidance of uterine aspiration, and an outpatient option available through their primary care provider. Overall though, medication management is more cost-effective than the other two options (less follow-up than expectant care and fewer overall costs than aspiration).

MIFEPRISTONE AND MISOPROSTOL

Treatment with 200mg oral mifepristone followed by misoprostol results in a higher likelihood of successful management of EPL (specifically missed abortion) than treatment with misoprostol alone (relative risk 1.25), with significantly less likelihood of uterine aspiration (relative risk 0.37), and a trend toward less bleeding ([Schreiber 2018](#), [Dzuba 2015](#)). The regimen may cost more than misoprostol alone, although fewer follow-up visits may be needed. Dosing and timing are similar to medication abortion with misoprostol dosed 24-48h after mifepristone. This regimen requires provider registration with a mifepristone manufacturer. (See Chapter 4 [page 67](#): Medication Abortion).

Mifepristone- Misoprostol Dosing for Miscarriage Management (Schreiber 2018)	
Missed abortion	Mifepristone 200mg orally (PO) followed by Misoprostol 800mcg vaginally (PV) in 7-48h* SL and buccal administration also likely to be effective

*highest success rates when misoprostol taken between 7-20h after mifepristone (Flynn 2021)

MISOPROSTOL ALONE

Misoprostol is effective and safe in treating EPL. Some studies show higher levels of bleeding and more follow-up with misoprostol compared to aspiration (Davis 2007, Zhang 2005), so patients with severe anemia (hgb <9) or risk factors for bleeding may be best managed with aspiration.

Misoprostol Only Dosing for Miscarriage Management (Ipas 2021)	
Incomplete abortion	600 mcg orally (PO) <u>or</u> 400 mcg sublingually (SL) or vaginally (PV) if no active vaginal bleeding
All other types of EPL	800 mcg vaginally (PV) or 600mcg sublingually (SL) repeated q3h until expulsion SL and buccal administration also likely to be effective

UTERINE ASPIRATION

Uterine aspiration offers the most definitive management of EPL and highest success rates. Patients may choose aspiration for rapid resolution, support through the entire process, or to avoid side effects of medication management. As with aspiration abortion, MVA for EPL can be performed safely for patients in most outpatient primary care settings and the ED. Costs and bleeding-related complications are greater in the operating room vs. office settings and may add unnecessary burdens to patients and families if options are available (Dalton 2006). If uterine aspiration is used to manage EPL, prophylactic antibiotics did not result in a significantly lower risk of pelvic infection, and are not recommended (Lissauer 2019, Prieto 2012). See Chapter 6 page 110 for MVA Steps.

COMPARISON OF MANAGEMENT OPTIONS FOR EPL

	Advantages	Disadvantages	Estimated Rates of Success
Expectant Management	<ul style="list-style-type: none"> • Non-invasive; body expels non-viable pregnancy • Perceived as natural by patients • Avoids anesthesia and surgery risks if successful 	<ul style="list-style-type: none"> • Process is unpredictable; can last days to weeks • Can have prolonged or heavy bleeding and cramping • Despite waiting, may still require uterine aspiration or other intervention 	<p>Incomplete EPL:</p> <ul style="list-style-type: none"> • Day 7: 50% • Day 14: 70-85% • Day 46: 90% <p>Other types of EPL:</p> <ul style="list-style-type: none"> • Day 7: 23-30% • Day 14: 35-60% • Day 46: 65-75% <p>(Nanda 2012, Casikar 2010, Kim 2017)</p>
Medical Management (Mifepristone 200 mg followed by Misoprostol 800mcg PV in 24-48h)	<ul style="list-style-type: none"> • Non-invasive • Safe • Highly effective • Avoids anesthesia and surgery risks if successful 	<ul style="list-style-type: none"> • May cause heavier or stronger cramping than aspiration • May cause short-term gastrointestinal & other side effects • May still need uterine aspiration 	<ul style="list-style-type: none"> • Complete expulsion: • Mife plus single dose misoprostol 84% vs. misoprostol alone 67% <p>(MacNaughton 2021, Schreiber 2018, Dzuba 2015)</p>
Medical Management (Misoprostol 600mcg oral or 400mcg SL for incomplete; 800mcg PV, repeat q3h until pregnancy expulsion for other)	<ul style="list-style-type: none"> • As above, may be less effective depending on the type of EPL and number of doses • Highly cost-effective 	<ul style="list-style-type: none"> • As above • SL and oral routes may have more GI and systemic SE than vaginal route • Increased side effects with more doses given 	<p>Incomplete EPL:</p> <ul style="list-style-type: none"> • Single Dose 96% <p>Other types of EPL:</p> <ul style="list-style-type: none"> • Single Dose 71% • Second Dose 84% • Every 3 hours x 2-3 doses: 88-92% <ul style="list-style-type: none"> • Higher efficacy when no embryo/fetus or cardiac motion detected on US <p>(Ipas 2021, Ngoc 2013, Neilson 2013, Zhang 2005, Kim 2017, Tang 2003)</p>
Office-based Aspiration	<ul style="list-style-type: none"> • Predictable • Offers fastest resolution • Less bleeding than expectant or medication • Low probability of further treatment need (<5%) • Pain control with local plus oral or IV meds • Compared to OR: <ul style="list-style-type: none"> - Cost & resource savings - Improved patient access, continuity and privacy - Less patient & staff time 	<ul style="list-style-type: none"> • Rare risks of invasive procedure • Less pain control options in some settings compared to an in-hospital procedure 	<ul style="list-style-type: none"> • 98-100% <p>(Nanda 2012)</p>
Operating Room Aspiration	<ul style="list-style-type: none"> • Can be asleep • Predictable, prompt resolution • Less time / bleeding than expectant or medication • Low probability of further treatment need (<5%) 	<ul style="list-style-type: none"> • More cost, time, exams than office-based procedures • Risks associated with invasive procedure; general anesthesia • May be more bleeding complications with general anesthesia vs. office procedure 	<ul style="list-style-type: none"> • 98-100% <p>(Nanda 2012)</p>

EPL OPTIONS COUNSELING

Consider a shared decision-making approach to counseling – after providing the relevant medical information, elicit the patient’s priorities for treatment through discussion, which can be easily identified from the Worksheet below. Next, review all management options, including advantages, disadvantages, and outcomes, as discussed in the Comparison Table above. Together you can agree on a management decision that honors the patient’s preferences and values for care.

Once the patient has chosen a management method, formulate a treatment and follow-up plan. For expectant or medication management, providers can follow a protocol such as outlined in the Step-by-Step Approach below.

Patient Treatment Priorities for Miscarriage

Having a miscarriage is extremely difficult for most patients. This worksheet is intended to help you and your provider choose a treatment that will make you the most comfortable.

Please circle any of the priorities below that you consider important in managing your miscarriage.

- Personal Priorities**
 - Treatment by your own provider
 - Recommendation of treatment from friend or family member
 - Provider recommendation of treatment
 - Lowest risk of need for other steps
 - Family responsibilities/needs
 - Most natural process
- Time and Cost Priorities**
 - Shortest time before miscarriage is complete
 - Shortest time in the clinic or hospital
 - Fastest return to fertility or normalcy
 - Fewest number of clinic visits
 - Lowest cost of treatment to you
- Medications and Procedure-related Factors**
 - Lowest risk of complications
 - Avoid invasive procedure
 - Avoid medications with side effects
 - Avoid going to sleep in case of a surgical procedure
 - Want to be asleep in case of a surgical procedure
 - Avoid seeing the pregnancy tissue
- Symptoms of Pain and Bleeding**
 - Least amount of pain possible
 - Experience symptoms of bleeding and cramping in private
 - Least amount of bleeding
- Past Abortion or Miscarriage (if applicable)**
 - Different treatment from previous
 - Similar treatment to previous



STEP BY STEP: EXPECTANT OR MEDICATION MANAGEMENT

First Visit			
<p>1. Assess desired pregnancy outcome and rule out contraindications</p> <ul style="list-style-type: none"> Suspected ectopic pregnancy Hemodynamic instability, pelvic infection Caution: anemia, bleeding disorder or anticoagulated If medication management: <ol style="list-style-type: none"> Allergy to medications used An IUD in place (remove) 	<p>2. Ultrasound if indications:</p> <ul style="list-style-type: none"> No definitive intrauterine EPL confirmed by previous US Bleeding since last US Assess US findings Ch. page 53 suspicious vs. diagnostic of EPL (Doubilet 2013) 	<p>3. Other diagnostic testing</p> <ul style="list-style-type: none"> Pregnancy test /serum hCG if needed (See algorithm) Consider Rh (chapter 3 page 49) Hgb if hx or current symptoms STI risk assessment / testing per CDC SPR Guidelines 	
<p>4. Counseling and consent</p> <ul style="list-style-type: none"> Consider patient access to emergency services & follow-up Evaluate patient's treatment priorities and discuss the risks, benefits, and alternatives Discuss expected symptoms and reasons to call for expectant and medication management Assess the patient's social support, coping strategies, and emotional state, and offer support as appropriate <p>If >9 week embryo, discuss possible recognizable fetal tissue</p>	<p>5. Management / Medications</p> <ul style="list-style-type: none"> Offer NSAID +/- a mild opioid Administer Rh IG if indicated (See Ch 5 page 89 Rh-D Immunoglobulin) <p>If patient elects medication mgmt:</p> <ul style="list-style-type: none"> Mifepristone + Misoprostol (or choose a medication regimen appropriate for the patient (see Table above) If patient elects aspiration: See Ch 6 "Steps For Uterine Aspiration" for additional guidance 	<p>6. Establish follow-up and instructions</p> <ul style="list-style-type: none"> Answer all questions, and provide 24-hour contact information for patient Review plans for the follow-up visit (via phone or in person) at 7-14 days Contraceptive counseling and initiation if patient is interested 	
Follow up visit(s) as needed			
	Findings consistent with completed expulsion		
<p>Assess for completion</p> <ul style="list-style-type: none"> History +/- physical Serial HCG levels (in all patients without a prior confirmed IUP) Serial hCG or US (in cases where Hx and physical are not consistent with a completed EPL) 	<p>History</p> <p>Cramping, bleeding with or without clots or tissue (POC) followed by:</p> <ul style="list-style-type: none"> Diminishing bleeding and resolving cramping Resolution of pregnancy symptoms <p>Physical exam if diagnosis remains unclear</p> <ul style="list-style-type: none"> Uterus firm, small, nonpregnant size VS +/- orthostatics as clinically appropriate 	<p>Serial hCG</p> <p>Decline >50% in 2 days suggests completed EPL</p>	<p>Ultrasound</p> <ul style="list-style-type: none"> Absence of previously identified gestational sac Note: A thickened endometrial stripe and/or heterogeneous intrauterine material are typical after successful management, and without ongoing or abnormal bleeding should not indicate the need for aspiration
If process is not yet complete		If process is completed	
<ul style="list-style-type: none"> Clinically stable patients may continue expectant management, consider 2nd dose of misoprostol and a 2nd follow-up, or opt for aspiration. Many providers dispense a 2nd misoprostol dose, to be taken after phone follow-up if no bleeding has occurred Uterine aspiration is recommended if there are signs of clinical instability or infection 		<ul style="list-style-type: none"> If pregnancy not desired, offer patient-centered contraceptive counseling, initiate method, and offer emergency contraception for future use if interested If pregnancy is desired, patient can try to get pregnant whenever they feel ready. Discuss future fertility plans and address concerns, as appropriate Offer support and referral for additional counseling if needed 	

3. A 24 yo G1P0 patient with vaginal spotting for 2 days. They are in a relationship with one partner and are interested in becoming pregnant. The last menstrual period was 6 weeks 2 days ago and the urine hCG is positive. They deny abdominal pain or passage of tissue. The patient is tearful and distraught.
- Does this patient need an ultrasound? How would you assess them without the use of ultrasound?
 - On examination, you find a closed cervical os, no gestational tissue, and a nontender uterus consistent with 6-week gestation in size without adnexal tenderness or enlargement. You are able to obtain a transvaginal US, which shows Mean sac diameter of 16mm with a yolk sac and no embryo. How do you interpret these results? What are the next steps in evaluation?
 - An hCG level drawn at the initial evaluation is 4000. The hCG done 48 hours later is 3200. What is the next step?
 - A repeat ultrasound was done 12 days after the initial ultrasound showed a mean sac diameter was 26mm with a yolk sac and no embryo. How do you interpret these results?
 - If EPL is confirmed and completed, what kind of patient support may be of use?
4. A 29 yo patient at 10 weeks by LMP calls in for a telehealth visit for vaginal bleeding. The patient had a visit 3 weeks ago confirming a viable intrauterine pregnancy, and intends to continue the pregnancy. Upon reviewing medical history, the patient discloses weekly cocaine use, and wants to know if they should go to the emergency room to see if this is an early pregnancy loss, but has fears about legal consequences of their substance use during this pregnancy. How would you manage and advise this patient?

CHAPTER 8 TEACHING POINTS: EARLY PREGNANCY LOSS MANAGEMENT

1. A 25-year-old patient you have been seeing for 5 years presents for an urgent visit. Their past history includes irregular periods, which you have managed with OCPs. They report not having had a period for 7 weeks, and now are having abdominal cramping and moderately heavy bleeding, up to a pad every hour. Urine hCG is positive.

a. How would you proceed with evaluation?

- Differential diagnosis: Threatened abortion with viable IUP, incomplete or inevitable abortion, resolving early pregnancy loss, and ectopic pregnancy.
- First consider and ensure hemodynamic stability.
- Then assess how the patient feels about the pregnancy, acknowledging and understanding that this can be dynamic and may need to be revisited throughout the workup and management.
- Proceed with speculum exam, bimanual exam, hCG and/or US, and Rh type as needed (see Ch 3 [page 49](#)).
- If the hCG is above the discriminatory zone, an US is important to determine the location of the pregnancy unless the patient has a previously diagnosed IUP or EPL. Alternatively, serial hCGs can be obtained.
- If initial value is below the discriminatory zone, serial hCGs can be obtained.
- If US is non-diagnostic, proceed with an hCG now. If initial value is above the discriminatory zone, proceed with a second hCG in 48-72 hours.
- If the pregnancy is undesired, the patient can choose to proceed directly to uterine aspiration (without waiting for hCG results) or medication abortion with ectopic precautions. This enables the patient to receive treatment without delay, and if opts for aspiration, may enable immediate confirmation of IUP vs. ectopic (if membranes and villi are confirmed).

b. How would you counsel while waiting for results?

- The uncertainty of waiting for results can be stressful if a pregnancy is desired.
- Keep them fully informed.
- Inform that in > 50% of first trimester bleeding, the pregnancy continues.
- Ask if the patient has a support person in this potentially difficult time.

c. If an ultrasound reveals an intrauterine pregnancy with the presence of fetal cardiac activity, how would you discuss the result?

- Over 85% of patients with fetal cardiac activity on US go on to have full term pregnancies.
- Mention a lack of evidence to support the need to limit activities.
- If bleeding or cramping continues or begins again, repeat the evaluation.
- Determine Rh status and need for Rhogam as appropriate.
- If a termination is desired, you can offer abortion services or a referral.

2. A 38-year-old G2 P1 patient is seeing you in clinic for vaginal bleeding. They are sexually active with a partner that makes sperm, and has been using condoms intermittently. They began having vaginal bleeding about 5 days ago, and it is now decreasing. Their last menstrual period was 8 weeks ago. Their urine pregnancy test is positive. They bring in tissue and you see gestational sac and chorionic villi.

a. How would you proceed with evaluation?

- Finding gestational sac and chorionic villi means it was not an ectopic pregnancy, except in the rare case of heterotopic pregnancy.
- History suggests a complete EPL, especially given decreasing bleeding.
- As with all cases, it is essential to assess for hemodynamic stability, or need for evaluation for anemia or infection. These concerns would prompt a physical exam and labs.
- If their bleeding and cramping are ongoing, an US is optional to evaluate the contents of the uterus.
- If the overall picture is consistent with an incomplete abortion, the patient should be offered expectant, medication, or aspiration management.

b. How would you approach her initially with these results? How would you answer her if she asks, “Was this miscarriage my fault?”

- Avoid preconceived notions about her feelings about this pregnancy. For example, even though she has a small infant at home, do not assume that this pregnancy was undesired.
- Tell her an early pregnancy loss is common, unlikely to occur in subsequent pregnancies, and not a woman’s fault, even though many women feel guilty.
- After discussing the results, await her response and consider open-ended questions about her expectations, such as *“How are you feeling about what is happening?”* or *“How do you feel about what I have told you?”*

c. “Will this happen again?”

- EPL is common, and in the majority of cases one or two previous EPLs does not predict subsequent EPL. About 65% of patients with unexplained recurrent pregnancy loss have a successful next pregnancy ([ACOG 2016](#))
- If a patient is seeking to conceive or pregnancy is desired, encourage a follow-up visit to discuss ways to support healthy pregnancies, such as actively managing chronic medical conditions, and minimizing smoking, alcohol or drug intake. Making a plan to access high quality preconception and prenatal care provides an opportunity to mitigate racial/ethnic and socioeconomic disparities in care.
- Following three consecutive EPLs (or two for patients with advanced age), it is appropriate to initiate evaluation for conditions such as chromosomal abnormalities, anatomic problems, luteal phase defects, or immunologic disorders such as anti-phospholipid syndrome potentially contributing to recurrent EPL.

d. What other evaluation or management would you initiate? When can they attempt to conceive again?

- Address contraceptive goals, methods and use. In most cases the person can attempt to conceive when they feel emotionally and physically ready.
- For this gestational age, Rh testing and Rhogam are not indicated.
- Offer a follow-up visit (phone or in-clinic) for continuity and support.

3. A 24 yo G1P0 patient with vaginal spotting for 2 days. They are in a relationship with one partner and are interested in becoming pregnant. The last menstrual period was 6 weeks 2 days ago and the urine hCG is positive. They deny abdominal pain or passage of tissue. The patient is tearful and distraught.

a. Does this patient need an ultrasound? How would you assess them without the use of ultrasound?

- It is unclear if this is an IUP or if the pregnancy is viable.
- With a stable patient, you can either obtain US and / or serial hCG levels.
- US (if available) may provide answers more quickly. See Chapter 3 [page 56](#) for evaluation of bleeding in the setting of pregnancy of unknown location.
- If unavailable, begin evaluation with a physical exam and hCG level.
- Examination should assess for hemodynamic stability, an open os and/or tissue, uterine size, and assessment for adnexal masses or tenderness.
- Inform of the possibility of ectopic pregnancy, and give ectopic precautions pending further results.

b. On examination, you find a closed cervical os, no gestational tissue, and a nontender uterus consistent with 6-week gestation in size without adnexal tenderness or enlargement. You are able to obtain a transvaginal ultrasound, which shows Mean sac diameter of 16mm with a yolk sac and no embryo. How do you interpret these results? What are the next steps in evaluation?

- The patient's pregnancy is confirmed to be intrauterine because of the presence of a gestational sac and a yolk sac, though the viability is uncertain.
- Differential diagnosis includes:
 - Early IUP, thus the embryo is absent
 - EPL given mean sac diameter of 16-24mm and no embryo and absence of embryo for 6 weeks or greater since the last menstrual period
- Since we can see this pregnancy on US and the patient is stable, we do not need to draw serial hCG levels, instead we can repeat the US in 7-10 days.
- If unable to obtain an US at this visit, plan to draw an hCG level before the patient leaves the office. This can expedite the workup if an off-site US is inconclusive.
- In patients with desired pregnancies, diagnosis based on a more conservative, or slower, rate of increase is preferred, as it can help avoid misclassification of a desired IUP as EPL.
- With a viable IUP, the hCG change over 2 days can range from an increase of 35% to the traditionally expected doubling. Using an increase of > 53% in 2 days you will detect 99% of viable IUPs ([Barnhart 2009](#)).
- For patients experiencing EPL, a decline in hCG level is expected. An hCG decline of >50% in 2 days supports a diagnosis of resolving EPL.

c. An hCG level drawn at the initial evaluation is 4000. The hCG done 48 hours later is 3200.

Assuming that we are unable to obtain an US at this visit we can get information from hCG level drawn. Based on their examination and initial hCG level, this patient could be experiencing EPL. The second hCG level declined, which is not expected for a viable IUP. For patients with a desired pregnancy, you may use a cut off of an increase of 35% in order to avoid misclassification of an IUP as an EPL or ectopic.

For example considering that this is a desired pregnancy:

Initial hCG = 4000

Repeat hCG done on day 2

Initial hCG x minimal expected % rise on day 2 = minimal expected rise (for a desired pregnancy)

$$4000 \times 0.35 = 1400$$

Initial hCG + expected rise = minimum expected 2nd hCG

$$4000 + 1400 = 5400 \text{ (by day 2 should be } > 5400 \text{)}$$

If this was a non-desired pregnancy, the following calculations could be used if diagnostic aspiration is negative for POC and you are considering ectopic management.

Initial hCG x expected % rise on day 2 = expected rise

$$4000 \times 0.53 = 2120$$

Initial hCG + expected rise = minimum expected 2nd hCG

$$4000 + 2120 = 6120 \text{ (by day 2 should be } > 6120 \text{)}$$

d. A repeat ultrasound was done 12 days after the initial ultrasound showed a Mean sac diameter was 26mm with a yolk sac and no embryo. How do you interpret these results? What are your next steps?

- The initial US results were suspicious for EPL, though not diagnostic. The repeat US shows a Mean sac diameter greater than 25 mm with no embryo and the absence of an embryo 11 days or more after a scan that showed a gestational sac with a yolk sac. These findings are diagnostic for EPL. Refer to Ch 3 [page 53](#) Diagnostic Criteria.

e. If EPL is confirmed and completed, what kind of patient support may be of use?

- Reminding them that EPL is not their fault may address unspoken fears.
- They have now had 2 spontaneous abortions, so there is a > 70% chance of successful future pregnancy. Further work-up is recommended at this time, as described in Teaching Points for Exercise 8.2.b.
- Useful resources for support include family and community, or counseling resources such as a miscarriage support group.
- With desired pregnancies, giving space to grieve is crucial. You can encourage them to take time or find a grieving practice. Set up additional follow-up appointments as needed.

4. A 29 yo patient at 10 weeks by LMP calls in for a telehealth visit for vaginal bleeding. The patient had a visit 3 weeks ago confirming a viable intrauterine pregnancy, and intends to continue the pregnancy. Upon reviewing medical history, the patient discloses weekly cocaine use, and wants to know if they should go to the emergency room to see if this is an early pregnancy loss, but has fears about legal consequences of their substance use during this pregnancy. How would you manage and advise this patient?

- Medical management includes all principles of EPL management. Establish hemodynamic stability. Offer in-person visit or referrals for serial hCG testing and US. Discuss management options including expectant management, medication management, or uterine aspiration.
- Leading medical organizations oppose policies criminalizing individuals for conduct allegedly harmful in pregnancy ([ACOG 2020](#)). This is in recognition that confidentiality and trust are paramount to the patient-provider relationship, that criminalization of pregnant people violates medical ethics and HIPPA. Policies criminalizing pregnant people prevent many from seeking out health care services.
- As of 2022, 24 states and District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes, while only 19 states have created treatment programs for those pregnant patients ([Guttmacher 2022](#)).
- People of color and low-income people are more likely to be targeted and have been disproportionately criminalized by these policies.
- Advising this patient will depend on your practice setting, institutional policies, and state mandated reporting requirements. Consider advising the patient to seek medical care while consulting a legal aid agency (see Chapter 9 [page 178](#), Legal Resources) table regarding their legal protections and rights. Reassure safety of seeking care through your practice if possible, and discuss support you can offer in management.
- Consider working in your institution to develop patient-centered policies so that every provider can implement these best practices in caring for people with substance use disorders, prioritizing assistance in access to treatment over reporting patients to law enforcement.

9. BECOMING A PROVIDER, ADVOCATE AND LEADER

Updated 2022 by Monica Agarwal, MD, Sheila Attaie, DO, and Anna Sliwowska, MD

This chapter is designed to aid clinicians who desire to gain additional training and become an abortion provider in their post-training practice. It offers an overview of training and practice opportunities in clinical and advocacy work, leadership development, interviewing strategies, next steps, and mechanisms for ongoing support.

CHAPTER LEARNING OBJECTIVES

Following completion of this chapter, you should be better able to:

- Identify training, post-training, and fellowship opportunities to build and maintain your skills as well as expand access to reproductive health services
- Reflect on your personal identities and considerations relevant to becoming an abortion provider
- Center and uplift training opportunities, networking, mentorship, and support for providers of racial, ethnic, and gender-diverse backgrounds
- Consider avenues for experience in reproductive health, rights and justice advocacy

READINGS / RESOURCES

- Innovating Education in Reproductive Health (IERH)
 - [Advancing Health Equity](#)
- Center for Reproductive Rights - <https://reproductiverights.org/>
- SisterSong Women of Color for Reproductive Justice
- Success stories from providers who have incorporated abortion services in ways that have worked for them (IERH) [Snapshots](#)
- [Paul et al \(eds\)](#). Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care (Wiley-Blackwell, 2009)
 - Appendix: Resources for Abortion Providers
- Related Chapter Content:
 - Supplemental Chapter: Becoming a Trainer
 - Supplemental Chapter: Practice Integration

SUMMARY POINTS

SKILL

- Continue building your knowledge base in all aspects of reproductive healthcare — including clinical care, new literature and evidence, patient advocacy, and telemedicine and self-managed medication abortion options.
- Obtain clinical experience during or after professional training. Becoming a provider increases access!
- Consider that equity in provider training includes prioritizing providers of racial, ethnic, and gender diverse backgrounds.
- Utilize additional training and mentorship opportunities (e.g., reproductive rights and justice) to center the desires and autonomy of historically marginalized communities (e.g., BIPOC, people with disabilities, LGBTQIA+) in your practice.

SAFETY

- Build relationships and consult with other reproductive health providers.
- Know when to refer for medical conditions that preclude self-managed, telemedicine, or outpatient care.
- Make arrangements for hospital back up that you may occasionally need.
- Consider personal security precautions as an abortion provider, including digital and online security.

ROLE

- Understand and apply the tenets of reproductive justice to patient care. Become a leader, advocate, and mentor in the reproductive rights and justice movements.
- Consider the power of storytelling (with patient permission) in advocacy efforts.
- Use established local and national networks to build a collaborative community, find answers to medical and administrative questions, and learn best practices.
- Value your impact as a provider of pregnancy evidence-based and patient-centered options counseling, contraceptive information, and reproductive health services.
- Overcome commonly reported barriers, including lack of authority to implement services, liability coverage, and staff resistance, by building relationships with key stakeholders and involving staff early in the process.
- Be patient and persistent as the process of integrating care may take time.

BUILDING AND MAINTAINING YOUR SKILLS

There are many options to consider in developing and maintaining your skills, knowledge and leadership in reproductive health, rights and justice, both during and after training. Support can be identified through help of mentors and existing national networks and organizations.

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GAINING AND MAINTAINING CLINICAL COMPETENCY

Studies show that both training availability and procedural volume are positively correlated with future abortion provision, regardless of previous intention to provide (Turk 2014, Goodman 2013, Steinauer 2008).

As of 2020, medication abortion accounts for more than half of the abortions in the United States. As medication abortion is becoming more common, provider training should center on medication abortion as well as aspiration abortion. Many clinics are only capable of offering mifepristone and misoprostol for abortion or miscarriage management, so obtaining this training is vital to providing care. Expanding clinical care to include medication management for early pregnancy loss and abortion is an important step in familiarizing providers with these medications, normalizing their use in primary care, and expanding access to full-spectrum reproductive healthcare. As abortion in the U.S. becomes more restricted, training in medication abortion may be especially important, and new providers entering care can help increase access.

It can be advantageous to gain experience in medication and procedural abortion during professional training, as both credentialing and malpractice can be covered under interagency agreements between your training program and a high-volume clinical site. However, there are also opportunities after training, including through the following organizations:

- [Midwest Access Project](#)
- [Medical Students For Choice](#)
- [TEACH Leadership Fellowship](#)
- [Clinical Abortion Training Centers](#)
- [Nurses for Sexual and Reproductive Health- Training Opportunity for RNs](#)
- [Reproductive Health Access Project \(RHAP\)](#)
 - [Reproductive Health and Advocacy Fellowship](#)
 - [GAPS Fellowship](#)
 - [Miscarriage Care Initiative](#)

Each skill can be delineated into clear steps with observable competencies for learners and for trainers-in-training (Cappiello 2016). Important aspects of clinical competence in medication and aspiration abortion include patient-centered counseling and the ability to identify and triage complications as they arise (Levi 2012). The number of cases to achieve competence and confidence in medication or aspiration abortion will vary between individuals, training environment, and exposure to complications or complex cases. Your reproductive health trainers can help you estimate what it will take to achieve competency in the services you hope to provide. (See Chapter 13).

BUILDING A STRONG KNOWLEDGE BASE

Please consider using the following resources to develop foundational knowledge, review evidence-based practices, and expand understanding:

- Online resources
 - [Innovating Education](#): videos, materials, and resources on abortion, early pregnancy loss, contraception, counseling, and more
 - [National Abortion Federation](#): online courses on abortion, contraception, ultrasound, trans-inclusive abortion care, and values clarification
 - [Reproductive Health Access Project Contraceptive Pearls](#): sign up and review previous pearls
 - [Reproductive Health Access Project](#): resources and patient information on abortion, contraception, and miscarriage management
 - [Nurses for Sexual and Reproductive Health \(NSRH\)](#): online learning portal for members with educational modules on sexual and reproductive health
 - [Partners in Contraceptive Choice and Knowledge](#): provider and patient resources and webinars
 - [AbortionPillCME](#): See one, do one, teach one medication abortion training
 - [Access Listserv](#): National listserv to participate in ongoing discussions. Membership requires referral by a current participant for security reasons.
 - [TEACH Curriculum](#): complete supplemental readings in each chapter
- Medical journals:
 - [Contraception](#)
 - [Green Journal \(Obstetrics & Gynecology\)](#)
 - [BMJ Sexual and Reproductive Health](#)
 - [Journal Watch Women's Health](#)
 - [International Journal of Gynecology and Obstetrics](#)
 - [American Family Physician](#)
- Books
 - [Reproductive Justice](#), Loretta Ross and Rickie Solinger
 - [Radical Reproductive Justice: Foundation, Theory, Practice, and Critique](#), Loretta Ross, Lynn Robers, Erika Derkas, et al.
 - [Killing the Black Body](#), Dorothy Roberts
 - [Sister Outsider](#), Audre Lorde
 - [You're The Only One I've Told: The Stories Behind Abortion](#), Meera Shah
 - [Shout your Abortion](#), Amelia Bonow, Emily Nokes (Editors)
 - [The Turnaway Study](#), Diana Greene Foster
 - [Policing the Womb](#), Michele Goodwin
- Textbooks
 - [Management of Unintended and Abnormal Pregnancy](#), Maureen Paul
 - [Contraceptive Technology](#), Robert Hatcher
 - [Radical Reproductive Justice](#), Whitney Peoples and Loretta Ross
 - [Procedures in Primary Care](#), Grant Fowler
- Podcasts
 - [The Women Centered Health Podcast](#)
 - [Beyond the A Word](#)

- [Self-Managed: an abortion story](#)
- [Contraception Journal](#)
- Annual reproductive health conferences:
 - [SisterSong](#)
 - [National Abortion Federation](#)
 - [Contraceptive Technology](#)
 - [The Annual National Reproductive Health Conference](#)
 - [Society of Teachers in Family Medicine](#) (Group on Abortion events)
 - [Abortion Care Network](#)
 - [Society of Family Planning](#)

ACHIEVING DIVERSITY, EQUITY, AND INCLUSION IN TRAINING AND PROVISION

The framework of reproductive justice (See Chapter 1 [page 3](#)) should be employed in training to achieve diversity, equity, and inclusion in both training environments and abortion care ([BMMA 2020](#), [Ross 2017](#)). The pervasiveness of white supremacy in medicine, and reproductive health specifically, has harmed Black, Indigenous, [Latinx/e/a](#) and other communities of color for generations. This has sustained white providers in positions of power and / or providing abortions for communities with whom they may share little background. For example, recent analysis shows large differences in provider and patient ethnicities ([AAMC 2019](#), [Guttmacher 2016](#)).

Ethnicity	Physicians	Patients
White	56%	39%
Black	5%	28%
Hispanic	5.8%	25%

Patients may prefer providers of the same racial and ethnic background, and although further study is needed, shared racial/ethnic backgrounds may foster better relationships, continuity, and health outcomes ([Miller 2022](#)). In order to better meet the health needs of marginalized and diverse populations, we need to increase abortion provider diversity ([Ma 2019](#), [Smedley 2001](#)). Priority should be placed on supporting and training providers of diverse racial, ethnic, and socioeconomic backgrounds, mirroring and honoring the diversity of patients and people. Beyond training, space should also be made in leadership positions in order to effectively change the systems we operate and organize in.

Given the hierarchical nature of training environments and historical systemic discrimination in medicine, support and mentorship should also be provided around navigating power structures and discrimination. Abortion providers also experience additional layers of discrimination given the politicization and polarization of reproductive healthcare which should be acknowledged and addressed ([León 2018](#)).

MENTORSHIP

Mentorship is a powerful tool in creating a more diverse and enriched abortion provider community. As a trainee, connect with larger communities of reproductive healthcare providers (see Organizational Resources Table below [page 176](#)), reach out to faculty who can serve as a reference or connection to other communities, attend conferences, or join the [AMSA Mentorship Sprint](#). After training, you can mentor a student or trainee, help fill gaps in training at their school or program, or lead a project related to reproductive health and justice.

LANDSCAPE AND LIMITATIONS

There are many reasons why abortion training and provision is limited including declining number of abortion cases nationwide, limited funding for abortion provision and training, saturation of providers in urban coastal areas, government or institutional policy limiting abortion provision to OB/GYNs or fellowship-trained physicians (excluding advanced practice clinicians and primary care physicians), and the COVID-19 pandemic limiting space for trainees. The SCOTUS decision overturning Roe in June 2022, will have seismic impacts on the landscape of abortion training across all states. ([Center for Reproductive Rights 2022](#), [Kurtzman 2022](#)) We will be following these anticipated changes.

It is also important to note that clinics in provider shortage areas may be more willing to help with credentialing and malpractice, but back-up and security issues may be more challenging. For more information on training outside of your program's standard curriculum or after graduation, (see Organizational Resources Table below [page 175](#)).

LEADERSHIP, ADVOCACY AND POLICY

Advocacy is essential to keeping reproductive healthcare safe, legal, and accessible. Educational and advocacy organizations have created advanced curricula and structured electives to help programs integrate these opportunities into training ([see Organizational Resources Table](#)).

LEADERSHIP

Consider collaborating with faculty or reproductive health organizations to tap into other teaching, research, or advocacy projects during training. For example:

- Work with faculty to help lead didactic sessions for incoming trainees, such as values clarification or papaya workshops.
- Speak at a meeting of Medical Students for Choice or Nurses for Sexual and Reproductive Health. Consider mentoring other trainees.
- Work with faculty to expand reproductive health services in your clinics. Successful projects have included protocols for EC access, management of EPL in outpatient settings, and clinic integration of medication abortion.
- Collaborate on a research project, conference presentation, or article publication with guidance from faculty and community mentors.
- Consider participating in the [Leadership Training Academy](#) (PRH)
- Consider joining your [local RHAP cluster](#) or the national AAFP Reproductive Health [Member Interest Group](#) (MIG)
- Connect with [Doctors for America](#), a multi-specialty organization focused on physician advocacy with webinars, an annual conference as well as the Copello Health Advocacy Fellowship

ADVOCACY AND POLICY

Access to abortion care has been under increasing threat due to state and federal legislative restrictions, and religious mergers. Laws that increase disparities in abortion access have included public and private insurance prohibitions, required waiting periods, mandated counseling, and targeted regulation of abortion provider (TRAP) laws, and even outright bans. In spite of data suggesting that early abortion safety, efficacy and acceptability are equivalent between physicians and advanced practice clinicians ([WHO 2022](#)), states have varying policies

or limitations on practice by specialty. For example, at the time of this writing, over half of U.S. states prohibit APCs from performing any abortions, and one state (MS) only allows OBGYNs to perform abortions ([Guttmacher 2022](#)). Regulations like these are not applied to provision of comparable medical services, such as uterine aspiration for early pregnancy loss.

As a provider, your opinions and expertise are highly respected by both the public and legislators. You have the potential to influence policy and legislation on a local and national level. Providers can be effective and powerful advocates with their wealth of patient stories, medical knowledge, understanding of research, and experience advocating on behalf of patients ([Earnest 2010](#)). Patient stories can humanize patients and shift the way lawmakers think about the complexity of abortion care and access. Be sure to utilize ethical storytelling practices and obtain consent before sharing people's private experiences. More resources on ethical storytelling and working with abortion storytellers can be found at [Planned Parenthood Advocacy Fund of Massachusetts](#) and [WeTestify](#), an organization founded and led by abortion storytellers.

Examples include:

- Join your relevant professional organizations, both locally and nationally. Your dues help organizations lobby and advocate for you and your patients.
- Join a lobby day coordinated by a reproductive rights organization. Scheduling and talking points are usually provided by the organization. There are now many virtual lobby days in addition to in-person visits to legislators.
- Join a clinic or hospital committee on practice, training or quality to influence institutional policies.
- Write an op-ed about your experiences as a trainee or provider.
- Provide written or oral testimony when your state or municipality is considering policies to expand or restrict reproductive health services.
- Work within the state or national chapter of your professional organization to pass resolutions to influence policy.
- Join a curriculum advisory for your specialty or ACGME Residency Review Committee to ensure curricular inclusion of sexual and reproductive health.
- Advocate within your organization to develop and expand scope of practice
- Advocate for transparency in medical education regarding faith-based restrictions that may interfere with training.

Many organizations have chapters for trainees or early career clinicians, and provide funding for meeting attendance. For organizations that provide materials, support, and training for clinician advocates, see Organizational Resources Table below [page 177](#).

FINDING PRACTICE OPPORTUNITIES

There are many job opportunities available that can include reproductive health care provision. In what setting do you visualize your future participation in reproductive health services?

You may join a setting where reproductive health services are already integrated or are the main focus of the practice. If services are not yet integrated, you can have both the excitement and challenge of pioneering them at a site. It may be possible to offer some services initially, and expand with time. Below are a few ways to begin thinking about the integration of reproductive health into your future work. You can also utilize the [Abortion Clinic Toolkit Checklist](#) for further strategies.

STRATEGIES FOR INTERVIEWING

When considering employment opportunities, think about these questions when you interview and evaluate whether reproductive healthcare and abortion provision will be possible in different practice settings.

- What is the current scope of practice specifically regarding reproductive health care? For example, does the site already provide prenatal and obstetric services? What is the patient population being served?
- What is the range of contraceptive services accessible to patients, and are there any barriers to starting or stopping a contraceptive method?
- What is the political atmosphere of the area? Consider talking to other regional reproductive health providers BEFORE approaching a new job site directly.
- How are prenatal care, early pregnancy loss, and / or abortion referrals managed? Ask how they respond to patients who ask for abortion services.
- Consider how your personal identities may reflect the patient population. Talk about the importance of continuity of care to your patients, or the importance of including these topics for trainees.
- Share a success story (with patient permission) from your training—a patient who was able to be seen by their own continuity provider and how comfortable it was receiving their reproductive health services in a familiar setting.
- If appropriate, consider letting them know that you have special training in abortion care, advocacy, and administrative set-up; and that you would be willing to spearhead the effort to bring a broader array of these services to the practice or training program. (See Ch. 10 Practice Integration)
- With contract negotiations, pay close attention to exclusivity clauses or stipulations that would restrict abortion provision. For example, some religiously-affiliated organizations specifically prohibit abortion provision even outside of their setting.

JOINING EXISTING CLINICAL SERVICES

Consider becoming a contract clinician for a high-volume abortion provider either in your community or other parts of the country that lack providers. This can be done as your primary work or to supplement another position. It is a great way to maintain your skills, add variety to your job responsibilities, and become more involved in the reproductive health community. You can work as a contract clinician in your own community or with a telehealth organization. Ask your mentors if they would be willing to provide you phone backup to allow you to feel more comfortable as a new provider. Speak with your mentors and contacts about the regional needs where you are going, and level of experience suggested to apply. National programs, including Clinical Abortion Staffing Solutions (CASS) can match trained clinicians with clinics currently in need of abortion providers.

JOINING FACULTY

One way to build on your skills is to work at a professional training program that needs or already offers reproductive health services. Working alongside more experienced clinicians is a great way for early providers to solidify their experience and confidence. Gaining insight into the steps that your training program took to integrate reproductive health care services can help you be prepared to consider replicating the model in a different setting in the future. RHEDI (Reproductive Health Education in Family Medicine) can connect you with many family medicine residencies around the country. Interested advanced practice clinicians should contact the Primary Care Initiative at UCSF's ANSIRH Program.

BECOMING A TRAINER

Consider becoming a trainer in your own training program or at another site. This is a great way to advance your own skills while becoming a resource person to others. It will also ensure that you are keeping abreast of the latest research and advances. More detailed information is available in [Chapter 11: Becoming a Trainer](#).

STRENGTHENING ENABLERS TO PRACTICE INTEGRATION

Clinical training alone is often not sufficient for providers to overcome the barriers to abortion provision after training. To increase abortion provision and access, organizations and advocates should work to strengthen enablers of provision, such as strong mentorship and support networks ([Summit 2020](#), [Goodman 2013](#)). Consider gradually building on the types of reproductive health care you offer in your setting. For example, begin expanding contraceptive services and abortion referrals, followed by integrating miscarriage management. Cultivate relationships with key stakeholders, involve staff early in the process, and find support from mentors and reproductive health organizations. Be patient and persistent, as the process will take some time. Keep returning to your core beliefs about the importance of expanding care for your patients.

EXPANDING CONTRACEPTIVE METHODS IN YOUR PRACTICE

Consider whether your practice environment ensures that patients have easy access to the full range of contraceptive options like IUDs and implants. Insertions and removals are core skills to acquire during training. For privileges to insert and remove the contraceptive implant, it is necessary to take a training class offered directly by the [pharmaceutical company](#). Integrating new methods into your practice can usually be done with minimal effort, equipment, and a bit of research on product ordering and reimbursement (see <https://larcprogram.ucsf.edu>). Working to minimize barriers to access, by improving logistics or same-visit services, are other areas for productive improvement. For more tools, (see <http://beyondthepill.ucsf.edu>.)

INTEGRATING MANAGEMENT OF EARLY PREGNANCY LOSS (EPL)

Expanded options for managing EPL - including expectant, medication, and aspiration management - can be integrated into one's outpatient clinic setting or into Emergency Department services. The counseling, consent, and follow-up for different management options are addressed in [Chapter 8 page 152](#).

- Mifepristone and / or misoprostol can be pre-ordered and available on-site for patients who desire medication management ([Prine 2003](#)). Due to a recent modification of the REMS restriction on Mifepristone in which the “in-person dispensing” requirement was removed, Mifepristone will be available by prescription at certified pharmacies. Once the law goes into effect in the states that allow it, pharmacies will need to become certified to dispense the drug.
- Manual vacuum aspiration requires further training of clinic staff in order to ensure safety (see [Practice Integration Chapter for step-by-step planning](#)).

Because EPL does not involve a viable pregnancy, its management is not considered an abortion for funding or malpractice purposes, and can be treated like any other minor surgical procedure that you routinely provide. Integrating EPL management might be a stepping-stone towards integrating abortion care in your practice, as the skills and equipment are similar, but the path may be more readily approachable.

IMPROVING REFERRALS IN YOUR PRACTICE SETTING

Taking an active role in improving referral processes at your practice may be an excellent first step in expanding access to abortion care ([Zurek 2015](#)), and especially important as targeted legislation restricting abortion access has resulted in facility closures and greater complexity in obtaining services. Providing referrals and logistical support (see Chapter 2 [page 30](#)) can help counter misperceptions and can assist with complex social or medical circumstances faced when accessing care. Improving care coordination is especially important in settings with limited access where patients face greater stigma. Familiarize yourself with [local and national](#) abortions funds, as they play a crucial role in helping patients get to definitive care.

PERSONAL SECURITY

As you develop your skills and begin your job search, reflect on how public you want to be as an abortion provider. This decision will be influenced by your local environment, family situation, race and/or religion. Your stance may evolve as your career, personal relationships, and political environment change. Regardless of how public you decide to be, it is important to consider personal security precautions. It may be safer to begin with tighter security and become more lax in the future, than the reverse. Taking some basic precautions may also help reduce the stress of living and working in an environment where you could be targeted.

Here are some tips to consider for maintaining personal and online security:

- Set social media accounts to private
- Avoid personal photographs connected to your name
- Avoid having your name on public records (ie apartment/home lease or mortgage, car registration)
- Opt-out of having your private information accessible to data-mining companies by following instructions in the “privacy statement” or in website FAQs.
 - Most sites require that you send in a written letter with some proof of your identity and statement that your safety is at risk. There is no cost for doing this. More information and a sample letter are available for you [here](#).
- Talk to providers in your area about their own personal security precautions and develop your safety plan before you get started rather than to remedy problems after they occur.
- [National Abortion Federation](#) can provide personal security assessments, staff preparedness trainings, law enforcement assistance, referrals for security, security alerts, and incident reporting mechanisms.
- See [Personal Security Tips](#) for more specific advice
- See [Chapter 10 Practice Integration](#)

ORGANIZATIONAL AND PATIENT RESOURCES

Training Opportunities	
Rotations	
Clinical Abortion Training Centers	
	A consortium of abortion clinics committed to providing opportunities for clinicians to learn abortion care in small group clinical settings.
NSRH: Nurses for Sexual and Reproductive Health	
	Karen Edlund Future Nurse Leader Fellowship is a 6-month fellowship for nursing students to help foster leadership in sexual and reproductive health and reproductive justice.
Midwest Access Project	
	Project matches trainees (including students, physicians, and APCs) to abortion training sites in the Midwest.
MSFC: Medical Students for Choice	
	International organization providing externships for medical students and resident physicians. They provide financial and logistical support for abortion training.
Residencies	
CREATE: Continuing Reproductive Education for Advanced Training Efficacy	
	Program open to family medicine residents in select programs in California. Includes opportunities to obtain additional abortion training within residency.
NSRH: Nurses for Sexual and Reproductive Health	
	6-month Training in Abortion Care (TAC) residency available for registered nurses.
RHEDI: Center for Reproductive Health Education in Family Medicine	
	List of family medicine residencies that offer abortion training
	Resident Scholars Program for Workforce Diversity offers 1-year mentorship in reproductive health to BIPOC family medicine residents
Ryan Residency Training Program	
	Listing of OBGYN residencies with opt-out family planning rotations.
Fellowships	
LTA: Leadership Training Academy	
	Program through Physicians for Reproductive Health (PRH) provides physicians with training to become effective advocates. The training consists of webinars and 2 in-person meetings over 8 months. Note that this program does not offer clinical abortion training.
Obstetric fellowships	
	These fellowships provide family physicians with further training in full spectrum reproductive health care. Ask specifically about inclusion of abortion training.
RHAP: Reproductive Health Access Project	
	Reproductive Health Care and Advocacy Fellowship is a 1-year clinical training program open to family medicine physicians
	GAPS fellowship is a 1-year program offering support to family medicine physicians looking to integrate abortion services into their clinical practice
TEACH: Training in Early Abortion for Comprehensive Healthcare	
	TEACH Leadership Fellowship is a part-time 1-year fellowship open to family medicine residents with some prior abortion training.

Employment and Networking Opportunities

Employment

CASS: Clinical Abortion Staffing Solutions

Joint effort between NAF and PP matches clinicians with clinics and health centers with an immediate need for abortion providers.

PP: Planned Parenthood

See geographic affiliate-specific opportunities on their website.

Abortion Care Network

Network of independent abortion clinics outside of Planned Parenthood.

Professional Networks

AAFP: American Academy of Family Physicians

[Reproductive Health Member Interest Group \(MIG\)](#) helps AAFP members integrate comprehensive reproductive health care, including abortion and miscarriage management, into their practices.

CIAC: Clinicians in Abortion Care

Membership group sponsored by NAF representing certified nurse-midwives (CNMs), nurse practitioners (NPs), physician assistants (PAs), registered nurses (RNs), and students of those professions, working to increase access to comprehensive reproductive health and abortion care.

NAF: National Abortion Federation

Mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care.

RHAP: Reproductive Health and Access Network

Clusters of clinicians who organize regionally and nationally through online listservs and in-person meetings.

RHEDI Access Listserv

National, private discussion group to discuss clinical, educational, and administrative issues in offering comprehensive reproductive health care services.

SFP: Society of Family Planning

SFP supports abortion and contraception science. The SFP Research Fund provides support for abortion and contraception research.

Advocacy Opportunities	
Reproductive Rights Organizations	
ACLU: American Civil Law Union	
	ACLU works in courts, legislatures, and communities to defend and preserve the right to abortion.
CRR: Center for Reproductive Rights	
	CRR uses the law to advance reproductive freedom as a fundamental human right.
Feminist Majority Foundation	
	Research and action programs focused on advancing the legal, social and political equality of women.
Jane's Due Process	
	Texas-based organization working to help minors seeking abortions across the country.
NARAL Pro-Choice America	
	Political action around issues of abortion.
National Partnership for Women & Families	
	Promotes fairness in the workplace, reproductive health and rights, access to quality, affordable health care and policies that help parents meet the dual demands of work and family.
NWLC: National Women's Law Center	
	Champions laws and policies that help achieve gender justice. Topic areas include abortion, equal pay, child care, Title IX. Also assists patients with insurance coverage for contraception (coverher.org)
PRH: Physicians for Reproductive Health	
	Organization that uses evidence and organized action to champion reproductive rights. Provides advocacy training through LTA fellowship, mentioned above.
Reproductive Justice Organizations	
The Knights and Orchids Society	
	Builds the power of TLGB Black people across the south providing health and wellness services.
NAWHERC: The Native American Women's Health Education Resource Center	
	Documents reproductive justice issues and uses activism to promote the voices of Native women.
NAPAWFL: National Asian Pacific American Women's Forum	
	Works on a broad range of issues with Asian Pacific American women, including reproductive justice.
National Latina Institute for Reproductive Health	
	Ensures the fundamental human right to reproductive health for Latinas, their families and their communities through education, advocacy and coalition building.
Sister Song	
	Builds networks to improve institutional policies and systems that impact the reproductive lives of marginalized communities, and trains the next generation of activists.
SPARK Reproductive Justice NOW	
	Political home for Black women and youth, centering Black queer women, trans and non binary folk.
URGE: Unite for Reproductive and Gender Equity (previously CHOICE USA)	
	Mobilizes and supports the diverse upcoming generation of leaders in reproductive justice.
WeTestify	
	Dedicated to the leadership and representation of people who have abortions, increasing abortion storytellers, and shifting the media narrative of the context and complexity of accessing abortion care.

Faith-based Organizations	
Catholics For Choice	
	Information and advocacy on abortion and reproductive health care issues within a catholic framework.
Faith Aloud	
	Clergy counseling line for spiritual and religious support around abortion, parenting, and more.
Religious Coalition For Reproductive Choice	
	National organization of pro-choice clergy and churches. Can provide spiritual counseling.
Patient Resources	
Patient Support	
All Options: 888-493-0092	
	Talkline that can provide options counseling.
Exhale: 866-4-EXHALE	
	Offers nonjudgemental, supportive counseling to individuals with abortion experiences and their partners, friends and allies.
If/when/how Repro Legal Helpline: 844-868-2812	
	Provides legal information and support to people navigating complex laws in order to obtain abortions or self-manage abortions.
M+A Hotline: 833-246-2632	
	Provides medical support to people self-managing abortion or miscarriage.
NAF Hotline: 800-772-9100	
	Provides counseling and support, abortion referrals, and abortion funding.
National Network of Abortion Funds	
	Network of independent organizations that provide financial assistance to women to pay for abortions.
Plan C	
	Trusted resource with state-specific information about how to source abortion pills via telemedicine and online pharmacies.
ReproCare Healthline: 833-226-7821	
	Anonymous healthline provides peer-based emotional support, medical information, and referrals to people having an abortion at home with pills.

Patient Education	
Advocates for Youth	
	Champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health.
Bedsider	
	An online birth control support network to help patients find birth control that's right for them and learn how to use it consistently and effectively. Great interactive tools for patients and providers.
Coalition for Positive Sexuality	
	Information about all aspects of sexuality along with information about parental involvement laws.
Euki App	
	App providing patient-centered, gender inclusive information on comprehensive reproductive healthcare and abortion care
Go Ask Alice!	
	This site is run by Columbia University's Health Education Program and provides accurate and non-judgmental information.
My Sistahs	
	Information about sexual health run by and for young women of color.
Reproductive Health Access Project	
	Organization working directly with primary care providers to integrate abortion, contraception, and miscarriage care into their practices, including providing patient educational handouts and zines
Scarleteen	
	Sex education for the real world with a section for men as well.
SIECUS Sex Ed for Social Change	
	SIECUS develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates the right of individuals to make responsible sexual choices.

CHAPTER 9 EXERCISES: BECOMING A PROVIDER

EXERCISE 9.1

1. In which setting(s) do you visualize your future participation in reproductive health or abortion care? Do you imagine joining a team that already offers services? Or do you picture starting services at a new site? Do you see yourself adding reproductive health services in a setting where access is currently limited?
2. Do you see yourself as a trainer or joining a professional training or residency program as faculty?
3. How will you connect with other providers in your region?
4. How do you frame this discussion with potential employers? How would you ascertain if your potential employer is open to offering abortion services?
5. If an employer thought Title X clinics couldn't provide abortions, what would you say to them?

EXERCISE 9.2 - Employment negotiations

1. Preparation is key to successful interviewing and negotiations with a future employer. Examine your practice priorities and rank them by their relative importance. What strategies can you use to ensure that your priorities are met?
2. Creating a list of questions prior to your interview will help you prepare. What information would you want to obtain? How will you address parts of the interview process that will be more challenging for you?

EXERCISE 9.3 - Managing stigma: the decision to disclose



(Adapted from The Providers Share Workshop, [Debbink 2012](#))

For most people talking about their work hardly registers as a decision. For abortion providers, doing so always involves assessments (sometimes unconscious) of risks and benefits, for oneself as well as family members. Below is an exercise to help:

- Deepen awareness of ways disclosure is negotiated in your life
- Evaluate the risks and benefits of the decision to disclose or not, and
- Increase control over disclosure decisions.

Exercise Instructions

See table below, and select a relationship in which issues of disclosure arise. Explore the risks and benefits of disclosure (to you or the relationship). If you have time, make a possible disclosure plan, and role-play. Repeat with additional relationships as applicable.

Relation-ship	Time or Age	Contextual Details/ Consideration	Disclosure		Non-Disclosure		Decision*
			Potential Risks	Potential Benefits	Potential Risks	Potential Benefits	
EXAMPLE Adult Extended Family	Now	My in-laws do not know about my abortion work. They are religiously conservative and anti-choice. I have 2 young children. We are close and rely on their assistance with childcare.	Loss of relationship would be a loss to kids, and loss of family support. Could undermine my work. Risks consequences in their community.	Possibility they accept. Relief from worry about silence, "accidental outing". Extended family could celebrate my successes.	Uncontrolled accidental outing, Persistent strain on relations. Not sure I can disclose to kids –moves to a family secret.	Preservation of innocent relationships and tenuous peace in family. Continued reliance on them for childcare.	*  D ND
							 D ND

*D = I mostly discuss openly, but sometimes choose not to. ND = I never discuss; the risks are too great.

CHAPTER 9 TEACHING POINTS: BECOMING A PROVIDER

EXERCISE 9.1

1. In which setting(s) do you visualize your future participation in reproductive health or abortion care? Do you imagine joining a team that already offers services? Or do you picture starting services on a new site? Do you see yourself adding services in a setting where access is currently limited?

- There are multiple settings in which reproductive health and abortion services may be offered: clinics (community, non-profit, for profit, independent, residency program continuity sites), private doctor's offices, hospitals, and telehealth organizations.
- You could work on expanding services in your current clinical setting to include the full range of contraceptive options, outpatient miscarriage management, medication and / or aspiration abortion.
- There are many ways to get involved: moonlight at a local clinic, join a practice already providing, get involved in teaching other providers, integrate services into your new practice, or provide services through telemedicine.

2. How would you connect with other providers in your region?

- Ask faculty mentors to help introduce you to providers in your new area.
- Look online for providers or ask for contacts on one of the listservs.
- Contact one of the organizations listed to help make an introduction, or to become a member.
- Get on mailing lists of state and local pro-choice groups to get involved in local efforts in your community.
- Attend a regional or national conference.
- Utilize community organizations and networks to identify local mentors with shared identities and backgrounds

3. How do you frame this discussion with potential employers? How would you ascertain if your potential employer is open to offering abortion services?

- Role-playing a discussion with a potential employer may give you maximal benefit from this exercise, in order to consider your comfort with various approaches and possible responses. Specific questions to ask are discussed in Chapter 9 [page 172](#): Strategies for Interviewing section.
- Also note that employment discussions and decisions may be especially fraught in the current legal landscape following Supreme Court decisions. With some states implementing trigger bans, others creating bans at 6 or 15 weeks, the landscape will be in a state of change, which will make it hard to know if abortion care can be ensured as part of a new position.

4. If an employer thought that a Title X clinic couldn't provide abortions, what would you say to them?

- This is not the case. Agencies who receive Title X funding may still perform and self-refer for abortion services. While federally restricted funds can't be used for abortion services directly or indirectly, your clinic may have other revenue streams that do not restrict the type of services you can provide.
- The cost of abortion services and time must be broken out, in most cases, from other services in order to prove that federal funding is not being used to provide abortions. This may require setting up a separate cost center, which is easy to do. More information is available in [Chapter 10: Practice Integration: Reimbursement Issues](#)), and guides to assist with billing are available.
- Title X clinics may provide “factual, neutral information about any option including abortion, as they consider warranted by the circumstances, but may not steer or direct clients towards selecting any option in providing options counseling.” 65 Federal Register, Section 41270.
- If your state has laws restricting state funding from going towards abortion care, consult with a state based legal advocacy group [page 177](#) to help you navigate.

EXERCISE 9.2 – Employment negotiations

1. Preparation is key to successful interviewing and negotiations with a future employer. Examine your practice priorities and rank them by their relative importance. What strategies can you use to ensure that your priorities are met?

- During the interview, highlight your unique contributions to the organization in terms of valuable skills you have as a reproductive health provider.
- Understand your market worth prior to or as a part of the process of these negotiations. How much are you worth elsewhere (the dollar and reputational value of the skills you are bringing in). Don't leave it up to the employer to tell you your market worth; you should go into the negotiation knowing (and literally having thought about how you are going to express that).
- Understand the priorities of the person you are interviewing with and which priorities are aligned or in conflict with yours ([Sarfaty 2007](#), [Herbert 2012](#)).
- After a negotiation, e-mail the other party summarizing the session to be sure you are both on the same page.
- Do not accept an offer until you review the details in writing.
- In academic medicine, terms of employment often are conveyed in a formal letter or contract; the contract supersedes all other agreements.
- Check your contract carefully for clauses that would prevent you from providing abortion services or restrict you from practicing at another site.

2. Creating a list of questions prior to your interview will help you prepare. What information would you want to obtain? How will you address parts of the interview process that will be more challenging for you?

- Get advice from mentors and faculty to obtain different perspectives.
- You will want to understand the scope of your duties and responsibilities.
- Understand the chain of command ([Sarfaty 2007](#), [Herbert 2012](#)).
- Role-playing with a trusted mentor or peer may help you prepare.
- Utilize the [Abortion Clinic Toolkit](#) for generating interview questions.

EXERCISE 9.3 - Managing stigma: the decision to disclose

(Adapted from The Providers Share Workshop, [Debbink 2012](#))

- Abortion providers experience additional layers of discrimination given the politicization and polarization of reproductive healthcare which should be acknowledged and addressed ([León 2018](#))
- If, when, and how you decide to disclose that you provide abortions is a deeply personal issue that this exercise will help you consider.
- Engaging in this exercise with other abortion providers can help foster interpersonal connections, and serve as an effective stigma management tool ([Harris 2011](#))
- Reaching out to others in the field can help provide a supportive environment.
- Your ideas on this can and will likely change with time and circumstances.

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