Good Practice Guide for **abortion care from 20 weeks of pregnancy**

SERIES **Times of abortion**

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CONSORCIO LATINOAMERICANO
CONTRA EL ABORTO INSEGURO

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Good Practice Guide for
abortion care from 20 weeks of pregnancy

Consorcio Latinoamericano Contra el Aborto Inseguro - CLACAI

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Contents

Glossary

To facilitate the reading and understanding of this document, this glossary defines the following key terms.

Dilation and Evacuation (D&E): A procedure to evacuate the uterus in pregnancies typically beyond 12 to 14 weeks. It involves cervical preparation and is characterized by uterine evacuation using forceps and aspiration[1].

Gestational duration/time: The duration of pregnancy, estimated from the first day of the last menstrual period (LMP) or through ultrasound measurements.

Good Practice Guide (GPG): A set of evidence-informed recommendations designed to support healthcare professionals and decision-makers in the clinical management of a specific condition, including diagnosis, treatment, counseling, and procedural care. GPGs are developed collaboratively and aim to guide best practices. They may be issued by governmental bodies, health institutions, civil society organizations, or expert panels. They recognize the complexity and context-specific nature of abortion care, aiming to promote the highest standards of well-being and eliminate harmful practices.

Good practice guidance (GPg): Recommendation elaborated to assist the health care practitioner with patient care decisions about appropriate diagnostic, therapeutic, or other clinical procedures for specific clinical circumstances.

Induction of fetal asystole (IFA): A procedure used to induce cessation of fetal cardiac activity, performed either by surgical means (e.g., transection of the umbilical cord) or pharmacologically, via injection of drugs through the amniotic cavity or directly to the fetus body[2].

Induced abortion: The complete expulsion or extraction of an embryo or fetus (regardless of gestational duration) following a deliberate termination of an ongoing pregnancy through medication or surgical means, which is not intended to result in a live birth. Induced abortions are distinct from spontaneous abortions (miscarriages) and stillbirths[3].

Manual Vacuum Aspiration (MVA): Evacuation of uterine contents using plastic cannulas attached to a manual vacuum aspirator (typically a 60 mL syringe)[4].

Medication abortion: Induced abortion using pharmacological agents[5].

Procedural abortion: Induced abortion via transcervical techniques, such as vacuum aspiration (manual or electric) or dilation and evacuation (D&E)[6].

Products of pregnancy: Refers to the fetus and placenta.

[1] WHO (2022a). Abortion care guideline. https://www.who.int/publications/i/item/9789240039483

[2] Paro, H., Ramón Michel, A., Ortiz, G. y Repka, D. (2024). *Los tiempos del aborto. Documento 2: Asistolia: Por una mejor calidad en la atención del aborto*. Red Jurídica del Consorcio Latinoamericano Contra el Aborto Inseguro (CLACAI). https://clacaidigital.info/bitstream/handle/123456789/3191/Los-tiempos-del-aborto-N2-Asistolia.pdf?sequence=1&isAllowed=y

[3] World Health Organization (WHO) (2024). ICD-11 International Classification of Diseases for Mortality and Morbidity Statistics. Eleventh Revision. Reference Guide. https://icdcdn.who.int/icd11referenceguide/en/html/index.html

[4] WHO, 2022a.

[5] WHO, 2022a.

[6] WHO, 2022a.

Executive Summary

Section 1: Initial approach for individuals seeking abortion from 20 weeks of pregnancy

1.1 Counseling

GPg 1.1.1: What is it? What should be offered in this space?

- Counseling is a key moment of the abortion process during which decisions, needs, desires, possibilities, and ambivalence are discussed.
- Healthcare professionals are responsible for providing accurate information, a sense of safety and reassurance, and for listening with empathy and attentiveness, without judgment or questioning.
- It is important to balance the amount of information offered and what the individual asks for, wants, would like to know, or needs to know.

GPg 1.1.2: How to create an environment of trust and safety?

- Recognize that all reasons for seeking an abortion are valid.
- Discuss timelines, the different phases and stages, and what to expect at each point in the process.
- Use clear, precise language that is free from stigma, prejudice, or judgment.

GPg 1.1.3: Who can participate in counseling?

- Members of the healthcare team, regardless of specific professional background, may provide counseling, as long as they possess listening skills, and the ability to honor silence.
- Counseling should not be the sole responsibility of one person, as multiple encounters may be needed throughout the process.

GPg 1.1.4: Do we talk about pain?

- Counseling should include discussions about pain as a personal experience, the right to avoid suffering, and options for pain management.
- Options should include both medication and other care strategies (e.g., ambulation, warm showers, heat packs, massage, relaxation exercises, and accompaniment).

GPg 1.1.5: Who provides accompaniment?

- Choosing to undergo the abortion process with the support of a significant person is entirely up to the individual having the abortion.
- The care team will welcome the accompaniment person as part of the process, share relevant topics, and allow space for questions or concerns to be addressed.

GPg 1.1.6: Which techniques to offer?

- During counseling, it is important to emphasize that induction of fetal asystole (IFA) is a necessary step from 20 weeks of pregnancy to prevent survival after expulsion. IFA involves an ultrasound-guided abdominal injection and represents an irreversible point in care.

- Until 24 weeks, two therapeutic options are available: medication abortion or dilation and evacuation (D&E). The advantages and disadvantages of each are discussed during counseling.
- Beyond 25 weeks, medication abortion is the only option to be offered.

GPg 1.1.7: Do we talk about contraception?

- Counseling presents an opportunity to explore contraceptive preferences from a comprehensive, person-centered perspective.
- The care team will provide appropriate information based on eligibility criteria and method availability, while respecting the individual's preferences, experiences, and reproductive journey.
- It is important to consider the person's fears and ambivalence, and to avoid pressuring or devaluing decisions to delay or decline contraceptive use.

1.2 Informed consent

GPg 1.2: Informed consent

- The purpose of informed consent is to enable individuals to make well-informed decisions regarding each procedure in their care - including the right to withhold consent, regardless of how advisable a procedure may appear.
- Informed consent is personal. Only the individual undergoing the procedure can provide it, after receiving information that is appropriate, complete, understandable, and accessible.
- Informed consent safeguards several fundamental rights, including autonomy, freedom, dignity, equality, and non-discrimination. It is grounded in the respect for bioethical principles such as beneficence, non-maleficence, and justice. It promotes trust in health systems while ensuring confidentiality and privacy are respected.

GPg 1.2.1: Characteristics and general principles of informed consent

- Informed consent must be obtained prior to the procedure - it cannot be granted retroactively.
- Consent must be voluntary and informed, and the information provided must be accurate, up-to-date, and understandable.
- The consent process must include information about the procedure, its effects, risks, benefits, alternatives, and rights.

GPg 1.2.2.1: Considerations regarding the consent process

- The information provided for induced abortions from 20 weeks should include: the risks and benefits of the techniques used at each stage; procedural details, including timelines and the specific steps involved; expected symptoms at each stage; warning signs; and what to expect after the procedure.
- Coercion, pressure, or undue influence in the decision-making process should be anticipated and actively prevented. This includes maintaining confidentiality and privacy between the healthcare team and the individual seeking abortion care.

- Effective communication among healthcare professionals is essential, especially as abortions from 20 weeks may involve multiple stages of care and different providers or facilities.
- Changes of mind or ambivalence should be interpreted as part of the consent process.

GPg 1.2.2.2: Considerations regarding documentation

- Consent is obtained through a single consolidated form. If multiple forms are required - due to the involvement of different healthcare teams or facilities, or specific legal obligations - the documentation should be limited to a maximum of two forms.
- While dialogue between healthcare teams and the individual requiring an induced abortion occurs throughout the care process, particular attention is given at the time of signing the consent form to ensure meaningful communication.
- In addition to a signed copy of the consent form, explanatory annexes may be provided in accessible formats, containing information on the procedure, warning signs, and emergency contact details.
- The consent form should be clear, concise and accurate, including the following information: details of treatment, including the method and modality chosen; confirmation that the individual has received and understood relevant information; the right to withdraw consent, including the latest point at which it can be revoked; signature of the consenting individual; signature of the healthcare professional who facilitated the decision-making process.

GPg 1.2.3: Considerations regarding informed consent in childhood and adolescence

- The substitution of the decision of a child or adolescent should not be allowed or promoted. Decisions regarding their healthcare must not be made by others without considering their opinion.
- A supportive and confidential environment is necessary to encourage the individual to express their needs, questions, and concerns.
- Health professionals should adapt the informed consent process, using appropriate language, adequate timing and communication tools, such as illustrations or visual materials, to ensure understanding of the procedure and its implications.
- In cases where local laws require the involvement of a legal representative, it is essential to ensure the meaningful participation of the individual and to uphold their right to be heard. The involvement of an adult must not override or replace the individual's opinion, which should be central in the process.
- It is important to guarantee that information will not be disclosed without the individual's consent, unless required in cases of imminent risk or sexual violence.
- It is advisable to facilitate the presence of a trusted support person during and after the care process, though this should not be a prerequisite for accessing healthcare.

GPg 1.2.4: Supported decision-making model for persons with disabilities

- Persons with disabilities are recognized as capable of making decisions about their reproductive rights through the provision of appropriate support and reasonable accommodations that facilitate the expression of their preferences regarding abortion care.

- Abortion services must ensure that their facilities and procedures are accessible to persons with disabilities.
- It is important to establish contact with the person with disability to determine whether they require and desire support in decision-making or in expressing their preferences.
- Persons supporting the decision-making regarding an induced abortion should be selected by the person with disability from within their trusted circle.
- Persons with disabilities may communicate their preferences through various means, including written or pictorial forms, sign language, gestures, vocalizations and body language.
- Confidentiality and privacy must always be respected. Health professionals must not assume a desire for family or caregiver involvement.
- If, after exhausting all possible supports and accommodations, it is still not feasible to ascertain the individual's preferences regarding induced abortion, healthcare teams should apply the "best interpretation of preferences". This should involve an interdisciplinary team and trusted members of the person's circle, drawing on known life history, previously expressed views, and other relevant considerations to guide case-specific decisions.

1.3 Clinical evaluation

GPg 1.3

- A comprehensive clinical evaluation is essential for identifying risk factors prior to an induced abortion from 20 weeks of pregnancy. This evaluation includes obstetric, gynecological, sexual, social, clinical and surgical history, medication use and allergies.

1.4 Laboratory and other complementary investigations

GPg 1.4

- Ultrasound scans are indicated in pregnancies from 20 weeks to determine fetal measurements, placental insertion and fetal malformations.
- It is important to clearly explain the reasons for performing the ultrasonographic exam, what to expect from this investigation, and to respect the person's preferences regarding being informed about the diagnosis or results.
- Hemoglobin and hematocrit tests are routinely indicated in cases from 20 weeks of pregnancy. Rh factor testing is offered to individuals with an unknown Rh status.
- Coagulogram and serum creatinine measurements are indicated in the presence of any risk factor for hemorrhage, in addition to gestational duration (two or more previous cesarean births, a previous cesarean birth and anterior placenta, suspected or diagnosed placenta accreta).
- Screening for sexually transmitted infections (HIV, syphilis, hepatitis B and C, gonorrhea, and chlamydia) is also offered.

Section 2: Abortion care before the expulsion of products of pregnancy

2.1 Induction of fetal asystole (IFA)

GPg 2.1.1: When should IFA be performed?

- IFA is indicated from 20 weeks of pregnancy before dilation and evacuation (D&E) or medication abortion, although there is nothing to prevent it from being performed before 20 weeks.
- The lack of resources for IFA should not constitute a barrier to access abortion services when gestational duration or fetal conditions are incompatible with survival after expulsion.

GPg 2.1.2: Medications and techniques

- Intracardiac potassium chloride (4-6 mEq) or intrathoracic/intracardiac lidocaine (200-240 mg), intra-amniotic or intrafetal digoxin (1-2 mg) are used to perform IFA.
- Fetal asystole is confirmed with ultrasound performed after minutes of potassium chloride and lidocaine injections; or up to one hour after intracardiac digoxin injections; and from 12 to 48 hours after intra-amniotic digoxin injections (experts' opinion).

2.2 Medication abortion

GPg 2.2

- For pregnancies up to 24 weeks, 200 mg of mifepristone (orally) is recommended, followed (after an interval of 24-48 hours) by 400 mcg of misoprostol (vaginally, sublingually or buccally), every three hours, until expulsion of products of pregnancy. When mifepristone is not available, 400 mcg of misoprostol (vaginally, sublingually or buccally) is used every three hours, until expulsion.
- Between 25 and 28 weeks of pregnancy, oral administration of 200 mg of mifepristone is used, followed (after an interval of 24-48 hours) by doses of 200 mcg of misoprostol (vaginally, sublingually or buccally) every four hours. When mifepristone is not available, 200 mcg of misoprostol (vaginally, sublingually or buccally) is used every four hours.
- From 28 weeks of pregnancy, 200 mg of mifepristone (orally) is recommended, followed (after an interval of 24-48 hours) by 50-100 mcg of misoprostol (vaginally) every four hours. When mifepristone is not available, 50-100 mcg of misoprostol (vaginally) is used every four hours.
- Mifepristone may be administered concurrently with IFA, followed by a waiting period of 24 to 48 hours before initiating induction with misoprostol. In protocols that do not include mifepristone and rely solely on misoprostol, a transcervical Foley catheter may be inserted, and the first dose of misoprostol administered after confirmation of successful IFA, to reduce the overall induction time (experts' opinion).
- In persons with pregnancies from 24 to 27 weeks and more than one previous cesarean birth, reduced doses of misoprostol and close monitoring during the induced abortion process are suggested. The insertion of a transcervical Foley catheter may also be considered in combination with misoprostol.
- In persons with pregnancies beyond 28 weeks and a history of cesarean birth, transcervical Foley catheter combined with high-dose oxytocin induction may be used.

- After fetal expulsion, 10 IU of oxytocin is administered intramuscularly or intravenously.
- If there are no signs of infection or hemorrhage, placental expulsion can be waited for up to 4 hours.
- Routine surgical evacuation should not be used, nor should routine ultrasound be performed after a medication abortion.

2.3 Dilation and Evacuation (D&E)

GPg 2.3.1: Cervical priming for D&E

- Cervical priming for dilation and evacuation (D&E) is performed using a combination of mechanical dilators and pharmacological agents (mifepristone + misoprostol, or misoprostol alone).
- Cervical dilators are generally inserted one day before the procedure, with a paracervical block.
- Mifepristone, when available, is administered orally 24 to 48 hours before the procedure.
- Misoprostol is administered 1 to 3 hours before the procedure, either sublingually or vaginally.

GPg 2.3.2: Uterine evacuation

- To prevent post-abortion hemorrhage, paracervical block with lidocaine and vasopressin, as well as intravenous administration of 30 IU of oxytocin in 500 mL of normal saline are recommended during the procedure of D&E.
- The use of ultrasound guidance during D&E is indicated.
- Single-dose antibiotic prophylaxis before or during D&E is also recommended.

2.4 Pain management

GPg 2.4

- For pain relief in medication abortion, NSAIDs (e.g., ibuprofen) are used prophylactically and routinely. Additional methods for pain management include opioids, antiemetics, and epidural analgesia.
- A stepwise approach - beginning with oral NSAIDs, followed by intravenous NSAIDs, then opioids, and finally epidural analgesia (if available), always in combination with non-pharmacological methods - is considered effective for pain management in medical abortion (experts' opinion).
- When epidural anesthesia is not available, the use of opioids and derived agents is an alternative for pain relief.
- For procedural abortion (D&E), NSAIDs (e.g., ibuprofen), paracervical block, and conscious sedation are routinely provided.
- Deep sedation with propofol or general anesthesia may also be used for pain relief during D&E.

2.5 Confirmation of complete evacuation

GPg 2.5.1: Medication abortion

- During fetal expulsion, continuous support and supervision by the healthcare team is recommended, along with careful handling of the fetus after expulsion.
- Complete evacuation in medication abortion is confirmed through visual inspection of the products of pregnancy and monitoring of clinical signs and symptoms, (stable vital signs, reduced vaginal bleeding and abdominal pain).
- Surgical intervention and ultrasonography are not routinely indicated following medication abortion.
- Uterine aspiration is only indicated upon clinical evidence of incomplete abortion.

GPg 2.5.2: Dilation and Evacuation

- Visual inspection of the products of pregnancy, along with clinical signs of complete evacuation during aspiration at the end of the D&E procedure, are used to confirm complete uterine evacuation.
- Ultrasound imaging during D&E may also be used to confirm complete evacuation of the uterus.
- Sharp uterine curettage should not be used to verify the success of the abortion.
- Anti-D immunoglobulin is offered to all Rh-negative persons from 20 weeks of pregnancy, during the process of an induced abortion or within 72 hours of an induced abortion, at a dose of 300 mcg administered intramuscularly.

2.6 Profilaxia anti-D

GPg 2.6

- La inmunoglobulina anti-D es ofrecida a todas las personas Rh negativas con 20 semanas o más de embarazo dentro de las 72 horas del aborto inducido, en dosis de 300 mcg de inmunoglobulina anti-D por vía intramuscular.

Section 3: Care after expulsion of products of pregnancy

3.1 Lactation inhibition

GPg 3.1

- Lactation inhibition with a single oral dose of 1 mg of cabergoline is indicated after an induced abortion from 20 weeks of pregnancy.
- When cabergoline is not available, mechanical methods for lactation inhibition may be offered.

3.2 Contraceptive counseling

GPg 3.2.1: Which contraceptive methods to offer?

- If the person who had an abortion wishes to initiate contraception, the healthcare team should offer all eligible methods and provide counseling on their use, risks, benefits, and failure rates.

GPg 3.2.2: When to initiate contraception?

- For hormonal methods (oral pills, injectables, vaginal ring, patch, or implant), contraception may be initiated on the same day as the D&E procedure.
- Hormonal methods may be initiated on the same of the first dose of mifepristone or misoprostol in medication abortion, except for the vaginal ring, which is inserted after expulsion of products of pregnancy (experts' opinion).
- For the intrauterine device (IUD), insertion may be performed immediately after the D&E procedure or at the time of the medication abortion is determined successful, except in cases of post-abortion hemorrhage or infection.

3.3 Before discharge

GPg 3.3

- Discharge may be considered after an observation period of 2 to 12 hours if the person meets the following criteria: ambulatory, stable blood pressure and pulse, and controlled vaginal bleeding and pain.
- Healthcare professionals should provide verbal and written instructions upon discharge.
- The following are warning signs that require immediate return to a healthcare facility: increased cramping or abdominal pain, heavy vaginal bleeding such as soaking more than two pads (or equivalent) per hour for two consecutive hours, and fever.
- Before discharge, counseling should also include what to expect in the coming weeks: vaginal bleeding may persist for up to two weeks, and sexual activity may be resumed once heavy bleeding stops or whenever the person feels ready.

3.4 Follow-up

GPg 3.4

- A follow-up consultation - either in person or via telemedicine - may be offered 7 to 14 days after treatment to provide contraceptive services, emotional support, and to address any concerns the person may have during that period.

Section 4: Care after expulsion of products of pregnancy

4.1 Post-abortion hemorrhage

GPg 4.1

- Prophylactic oxytocin - 10 IU intramuscularly after fetal expulsion in medication abortion, or 30 IU in 500 mL of normal saline during D&E - and paracervical block with lidocaine plus epinephrine or vasopressin during D&E can help prevent post-abortion hemorrhage.
- Upon suspicion of post-abortion hemorrhage, the following assessments are indicated: bimanual examination to assess for uterine atony, cervical inspection to detect lacerations, repeat uterine aspiration, or ultrasound examination to identify retained pregnancy tissue or hematometra.
- Management of post-abortion hemorrhage depends on the underlying cause of bleeding, which may include: uterine atony, retained tissue, cervical or vaginal laceration, uterine perforation or rupture, or coagulopathies.
- Intravenous administration of 1 g of tranexamic acid is indicated in all cases of post-abortion hemorrhage, regardless of the cause.
- A diagnosis of post-abortion hemorrhage demands: placement of an intravenous (IV) line, supplemental oxygen, fluid resuscitation, and transfusion of blood products, as clinically indicated.

4.2 Uterine perforation or rupture

GPg 4.2

- In most cases, uterine perforation during cervical dilation can be managed expectantly.
- When perforation occurs during the use of sharp forceps in dilation and evacuation (D&E), laparoscopy is indicated to investigate and repair possible injuries to other organs.
- Measures that can help reduce the risk of uterine perforation during D&E include: performing a bimanual examination before beginning the procedure, avoiding contact with the uterine fundus, and using ultrasound guidance during the procedure whenever possible.
- Uterine rupture during medication abortion requires surgical intervention for both diagnosis and treatment.

4.3 Post-abortion infection

GPg 4.3

- Upon suspicion of post-abortion infection, evaluation to assess for retained pregnancy tissue is necessary.
- (Re)evacuation of the uterus by aspiration is indicated when retained tissue is diagnosed and should not be delayed until completion of antimicrobial therapy in clinically unstable patients.
- Most cases of typical endometritis can be managed on an outpatient basis with ceftriaxone plus doxycycline, with or without metronidazole.

Introduction

This Good Practice Guide (GPG) aims to strengthen and enhance the conditions that ensure access to quality abortion care. It is part of the initiative Times of Abortion by the Consorcio Latino Americano contra el Aborto Inseguro (CLACAI).

This guide recognizes the need for the provision of abortions from 20 weeks of pregnancy. It establishes the standards of comprehensiveness and quality that should guide care. It acknowledges that these practices often generate tension within healthcare teams and present significant barriers for users seeking services.

The reasons why girls, adolescents, women, and other individuals capable of becoming pregnant may require an abortion beyond 20 weeks of pregnancy are varied: sexual violence or coercion[7]; the time each individual needs for decision-making; barriers to accessing the healthcare system; lack of information; transportation difficulties; situations of extreme vulnerability affecting autonomy; health conditions that arise or worsen with pregnancy progression; fetal conditions incompatible with extrauterine life, among others[8].

Although circumstances may be diverse, in countries where abortion access is regulated after 20 weeks and procedures are recorded, data show that the vast majority of abortions occur before the 12th week. For example, in 2021 in the United States, prior to the reversal of *Roe v. Wade*, the Centers for Disease Control and Prevention reported 622,108 abortions: 93.5% took place before the 13th week, 5.7% between weeks 14 and 20, and only 0.9% after week 21[9]. In Canada, the Canadian Institute for Health Information reported that in 2017, 30.4% of abortions occurred before week 8, 35.6% between weeks 9 and 12, and 3.2% at or beyond week 21[10]. Recent data from Argentina show that following the passage of Law 27.610 on Voluntary Termination of Pregnancy and Post-Abortion Care, the majority of abortions in the public health system are provided on an outpatient basis. In 2023, providers reported that 7 to 9 out of every 10 abortion requests were received before the 12th week[11]. In Mexico City, 9 out of 10 people accessed induced abortion services before week 12 between 2008 and 2012[12].

Although relatively infrequent, abortions beyond 20 weeks of pregnancy do occur and require an enabling environment to be carried out with the necessary quality and care for all involved - both the person undergoing the procedure and the healthcare professionals providing the service.

[7] Son niñas, no madres (2024). *Embarazo de niñas y adolescentes, violencia sexual e impunidad en América Latina y el Caribe (LAC)*. https://www.ninasnomadres.org/alza-la-voz/wp-content/uploads/2024/04/Embarazo-en-ni%C3%B1as-LAC.pdf

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[9] U.S. Centers for Disease Control and Prevention (CDC). *Abortion Surveillance Findings and Reports*. https://www.cdc.gov/reproductive-health/data-statistics/abortion-surveillance-findings-reports.html

[10] ARCC, 2019.

[11] Romero, M., Keefe-Oates, B., Krause, M., Ramón Michel, A. y Ramos, S. (2024). *Reporte anual 2023: Logros de la política de acceso al aborto y amenazas actuales*. Centro de Estudios de Estado y Sociedad (CEDES). http://repositorio.cedes.org/handle/123456789/4787

[12] Saavedra Avendano, B., Schiavon, R., Sanhueza, P., Ríos Polanco, R., García Martínez, L. y Darney, B. G. (2018). Who presents past the gestational age limit for first trimester abortion in the public sector in Mexico City? *Plos One, 13*(2). https://doi.org/10.1371/journal.pone.0192547

Why a Good Practice Guide?

A Good Practice Guide (GPG) seeks to provide guidance based on the experience of implementing guidelines that have been validated in clinical practice by health professionals.

This GPG compiles a series of conceptual and procedural recommendations for the provision of induced abortions from 20 weeks of pregnancy. It brings together experiences, evidence, and research from professionals across various disciplines and who operate in contexts where organizational conditions of the health system, legal frameworks, sociocultural factors, professional training, and community engagement vary. It is precisely this diversity that enriches the production of this document.

The variety of circumstances across Latin America that affect access to abortion from 20 weeks highlights the need for these recommendations. Acknowledging that such care is influenced by numerous factors, it is essential to identify common quality practices that exist across the region. This contributes to debates that foster policy development and informed decision-making at different levels and in sectors related to (or impacting) sexual and reproductive health, thus promoting autonomy and freedom of those choosing to abort.

How was it developed?

This GPG was developed through exchanges that took place during a regional in-person meeting held in Bogotá in April 2024, which brought together 32 multidisciplinary specialists from Argentina, Bolivia, Brazil, Colombia, Ecuador, El Salvador, Honduras, Mexico, and Peru.

The regional meeting was enriched by three national meetings held in Argentina, Colombia, and Mexico, involving groups with similar composition. Each national meeting followed a predefined agenda and methodology, with coordination aimed at strengthening the regional meeting. These in-person meetings were followed by virtual meetings and webinars, which are, anyhow, reflected in this GPG.

As such, this document is the result of extensive debate and consensus-building. Rather than being a definitive or unilateral guide, it is a living document that will continue to evolve based on its application by healthcare providers, decision-makers, and other institutional actors committed to safeguarding the health and well-being of those seeking abortion care.

In summary, this guide focuses on the good practices of professionals who ensure access to abortion services. It is intended as a supportive and consultative tool that fosters more compassionate and beneficial approaches and interventions, protecting the lives and choices of all people who undergo abortions, including those beyond 20 weeks of pregnancy, as well as those who support them.

Scope and objectives

This document compiles existing scientific evidence and the experiences of healthcare professionals across Latin America working in both the public and private sectors, as well as the experiences of abortion accompaniment groups who work in coordination with institutional providers.

The primary objectives of this GPG are to provide guidance to healthcare teams and professionals delivering safe abortion care from 20 weeks of pregnancy, and to equip them with tools to better respond to the expectations and needs of both users and care teams.

Its specific objectives include:

- to systematize and to share quality care practices in the provision of abortion services from 20 weeks of pregnancy in different countries of the region, in order to counter stigmatizing, technically inadequate, or abusive practices;
- to produce a reference tool that contributes to the development of comprehensive care policies in abortion services, grounded in evidence of safe and respectful practices, aligned with the decisions of those seeking abortions;
- to offer a technical instrument to strengthen, support, and expand the capacity of teams ensuring access to induced abortion services from 20 weeks of pregnancy.

Structure of this GPG

This GPG is divided into four sections, according to the moments of abortion care:

1. Initial approach for individuals seeking abortion from 20 weeks of pregnancy
2. Management of the expulsion of products of pregnancy
3. Care after expulsion of products of pregnancy
4. Management of abortion complications

Healthcare professionals and decision-makers can refer to the **Executive Summary** at the beginning of this GPG for quick reference and explore the supporting scientific evidence on the four main sections of this document. Each section is further subdivided into specific topics, and a good practice guidance is provided under each subheading.

In addition to practices validated by official guidelines and scientific publications, this GPG incorporates expert clinical experience. When such experience is not supported by scientific evidence, it is explicitly identified as “expert’s opinion”.

The GPG also includes supplementary materials in the **Annexes**.

1. Initial approach for individuals seeking abortion from 20 weeks of pregnancy

1.1 Counseling

1.1.1 What is it? What should be offered in this space?

The individual who has decided to undergo an abortion is the central figure in the abortion process, which begins with counseling.

This space represents **a key moment in which decisions, needs, desires, possibilities, distress, passions, ambivalence, and future plans are explored**. Healthcare personnel have the responsibility to provide a sense of safety and reassurance to the individual seeking care. Supporting and validating this decision is an act of profound care and respect for autonomy.

Counseling assumes a unique significance when it comes to abortions from 20 weeks of pregnancy. This distinctiveness is shaped by the societal discourse surrounding abortion at these gestational stages. Situating these pregnancies within the material conditions of every one, their health status, the power dynamics they navigate, and the complexity of the sexual lives of girls, adolescents, women, and other people capable of becoming pregnant, will help guide the process.

As gestational duration increases, meaningful dialogue becomes increasingly important. It is essential to remain open and to listen without gestures or expressions that might discourage or question a decision already made - or one that is still being made. These conversations may also involve discussing the trajectory of the pregnancy, consultations in other healthcare settings, and the barriers encountered in accessing abortion services.

Rather than being a mere procedural requirement, the moment of counseling is a crucial component of the abortion process. It influences how subsequent moments are experienced and **requires time commitment from the healthcare team**.

Another key element in counseling is **making space for the individual to express a desire to say goodbye to the fetus** - particularly in the context of intended pregnancies. This involves respecting personal beliefs and worldviews. At the same time, it must be acknowledged that healthcare settings may face limitations - often due to legal constraints - in meeting certain requests. By remaining sensitive to the individual's needs, it is possible to co-create alternatives that honor the significance of this moment.

1.1.1 Good practice guidance

- Counseling is a key moment of the abortion process during which decisions, needs, desires, possibilities, and ambivalence are discussed.
- Healthcare professionals are responsible for providing accurate information, a sense of safety and reassurance, and for listening with empathy and attentiveness, without judgment or questioning.
- It is important to balance the amount of information offered and what the individual asks for, wants, would like to know, or needs to know.

1.1.2 How to create an environment of trust and safety?

Below is a set of topics considered good practices to ensure access to abortion beyond 20 weeks of pregnancy. These points form a continuum and are closely connected to the considerations previously discussed:

- Recognize that all reasons for seeking an abortion are valid - and that none is required. **Listen to all stated reasons and give them legitimacy**, even if the person is unable to fully articulate them.
- **Promote well-being** within the moment of counseling by offering attentive listening and addressing doubts, fears, and concerns of all kinds.
- **Establish connection** through eye contact, physical presence, and a willingness to dedicate time.
- Strengthen the individual's decision to undergo an abortion. If there are doubts, assist in mitigating them so that the person can arrive at an autonomous and informed decision.
- Foster a sense of safety and reassurance, reinforcing **the idea that choosing to have an abortion is not wrong**.
- Build trust by emphasizing that **the individual is not alone in making this decision**. In fact, the development of safe medical techniques for abortion underscores its legitimacy.
- **Clearly explain the process, timelines, and the various steps and phases involved**. Describe what will happen at each moment, where each part of the process will take place (especially if different from the counseling setting), and identify which professionals will be involved.
- **Use accessible language**, adapting communication to the individual's needs. Provide clear and concrete examples.
- Do not use stigmatizing, demeaning, or judgmental language. Phrases such as "Why did you wait so long?", "You will feel pain like if you were in labor," "It's a very advanced pregnancy," or "This is a late-term abortion" are harmful and do not contribute to a healing or supportive healthcare environment.

Balancing between the amount of information provided and what the individual wants, needs, or would like to know is a soft skill that can be learned and built. It is important to pause periodically and check in with the individual to ensure their needs and expectations are being met. To help adjust the pace of the interaction, questions like “How are we doing so far?” or “Shall we continue with the consultation?” can be useful. The goal is to avoid bureaucratic, mechanical, or routine-based approaches to this moment.

1.1.2 Good practice guidance

- Recognize that all reasons for seeking an abortion are valid.
- Discuss timelines, the different phases and stages, and what to expect at each point in the process.
- Use clear, precise language that is free from stigma, prejudice, or judgment.

1.1.3 Who can participate in counseling?

There is no specific professional profile required to provide abortion counseling. **What is essential, however, is working with all members of the care team to develop skills in active listening, effective communication, and respectful attention to silence.**

Counseling requires progressive training, as well as opportunities for reflection among those involved in the care process. Each case is unique, and the needs and skills required are dynamic. For this reason, **the responsibility for counseling should not fall solely on one individual**.

For some teams, it may be helpful to identify a set of core topics to be addressed in an initial moment. This outline can provide a sense of structure and help ensure a comprehensive approach. Still, counseling should not be seen as a one-time, limited interaction between the person seeking an abortion and healthcare providers. Rather, it should be understood as a process that unfolds over time. It is therefore advisable to establish some shared understanding and systematization of what should be addressed first.

1.1.3 Good practice guidance

- Members of the healthcare team, regardless of specific professional background, may provide counseling, as long as they possess listening skills, and the ability to honor silence.
- Counseling should not be the sole responsibility of one person, as multiple encounters may be needed throughout the process.

1.1.4 Do we talk about pain?

Counseling is the appropriate space to talk about pain as a unique experience for every one, about the right not to suffer unnecessarily, and about the possibility of adjusting pain management strategies throughout the abortion process. It is also the space to discuss treatment options, procedures, timelines, and possible pain relief alternatives - both pharmacological and non-pharmacological.

The healthcare team should be sensitive to the various factors that may amplify the perception of pain and should be prepared to mitigate it in a way that is appropriate for the individual. Comparative examples such as "It feels like contractions" or "It's like giving birth" should be avoided, as they reinforce stigma and confusion about the abortion experience.

Non-pharmacological options such as ambulation, warm showers, heat packs, massage, relaxation techniques, and accompaniment should all be considered. At the same time, teams should implement pharmacological protocols that offer stepped care approaches to ensure appropriate response and the individual's well-being.

If the person asks about fetal pain, it is important to mention that it is highly unlikely that the fetus is capable of experiencing pain[13].

1.1.4 Good practice guidance

- Counseling should include discussions about pain as a personal experience, the right to avoid suffering, and options for pain management.
- Options should include both medication and other care strategies (e.g., ambulation, warm showers, heat packs, massage, relaxation exercises, and accompaniment).

1.1.5 Who provides accompaniment?

The individual undergoing an abortion has the full right to decide whether they wish to be accompanied during the process. However, healthcare providers can assist in identifying significant individuals within the person's support network who may offer emotional or practical support. If the individual chooses to be accompanied, the care team should facilitate this presence by creating a space for the exchange of information. Topics will be shared with the accompaniment

[13] Scientific evidence regarding fetal pain is inconclusive. Although there is no indication for fetal anesthesia or analgesia during labor and delivery procedures - such as forceps or vacuum-assisted births (see RCOG, 2022) -, recent studies have proposed anesthetic techniques for fetal surgeries (see Bellieni & Anand, 2025; Thill, 2023). However, the issue of fetal pain is not applicable to discussions on induced abortion, particularly because quality care protocols for abortions beyond 20 weeks include the induction of fetal asystole.
Bellieni, C. V. y Anand, K. J.S. (2025). Direct evidence of fetal responses to noxious stimulations: A systematic review of physiological and behavioral reactions. Early Human Development, 201. https://doi.org/10.1016/j.earlhumdev.2025.106196 .
Paro et al., 2024.
Royal College of Obstetricians and Gynaecologists (RCOG) (2022). RCOG Fetal Awareness Evidence Review, December 2022. https://www.rcog.org.uk/media/gdtnncdk/rcog-fetal-awareness-evidence-review-dec-2022.pdf
Thill, B. (2023). The fetal pain paradox. Frontiers in Pain Research, 4. https://doi.org/10.3389/fpain.2023.1128530

person, and they will be invited to ask questions or raise concerns. This involvement is intended to help reinforce measures that promote care and well-being throughout the abortion process.

Additionally, **the accompaniment person must be informed about the timeline and implications of the procedure, to fully understand and assume their role**. If the individual undergoing the abortion has a disability, they may require a support system to ensure that their decision is carried out autonomously. In such cases, the decision to be accompanied remains with the person having the abortion.

1.1.5 Good practice guidance

- Choosing to undergo the abortion process with the support of a significant person is entirely up to the individual having the abortion.
- The care team will welcome the accompaniment person as part of the process, share relevant topics, and allow space for questions or concerns to be addressed.

1.1.6 Which techniques to offer?

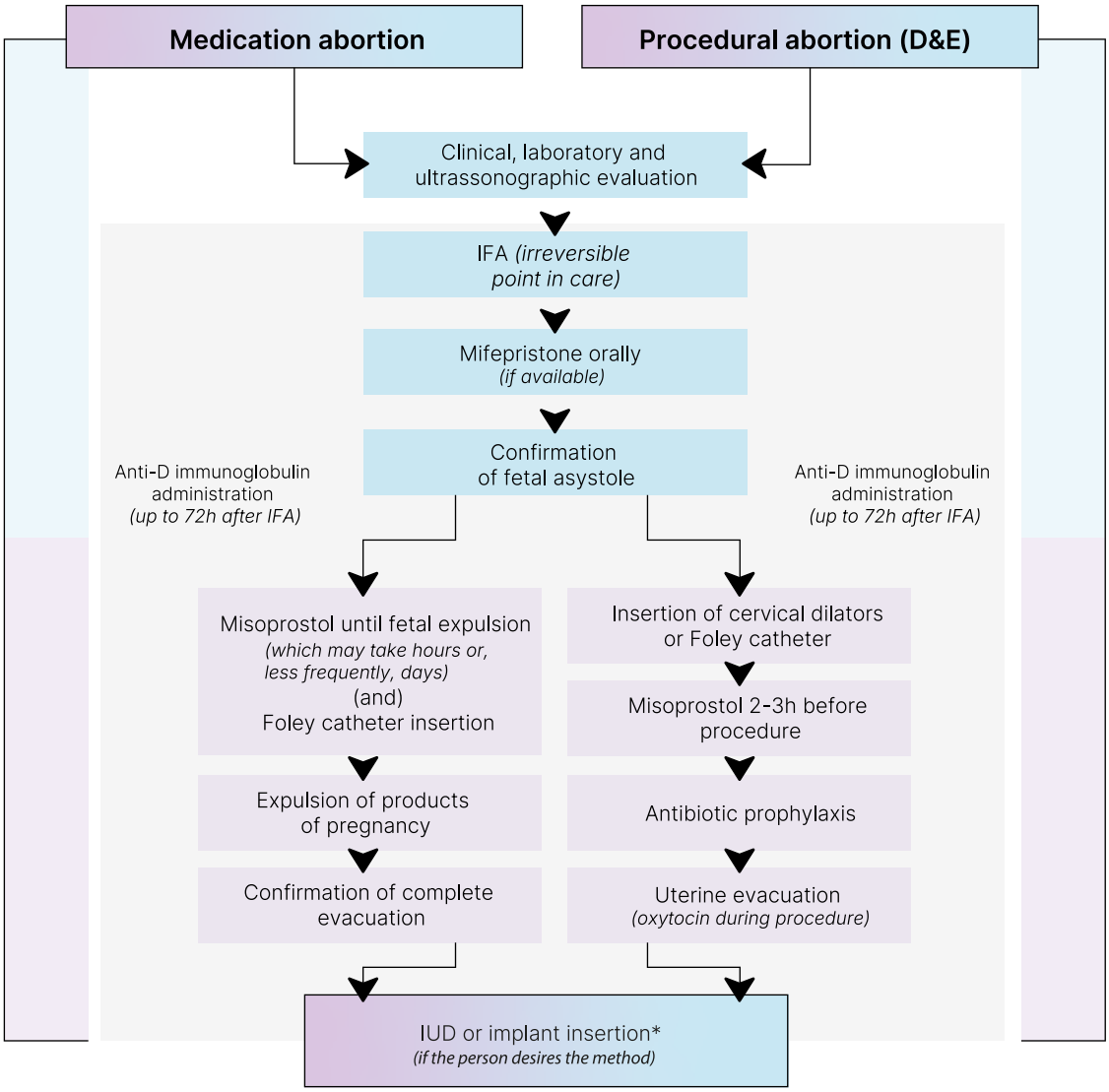
The techniques used for induced abortion depend on the individual's preferences, gestational duration, and the availability of medications and trained providers. The care team also considers the effectiveness and safety of each method and discusses these with the individual as part of the counseling process. It is important to mention that ultrasound is a standard component of abortion care from 20 weeks of pregnancy. During this exam, the person will not see images or hear sounds unless they explicitly choose to do so.

To initiate the procedure for an induced abortion, induction of fetal asystole (IFA) is recommended. This may involve the use of ultrasound to guide the injection. It is essential to explain that IFA is necessary to prevent fetal survival. In selected cases involving fetal anomalies incompatible with life, when no survival is expected at birth, it may be appropriate to discuss the possibility of omitting this step. Although there remains a possibility of the individual changing their mind about the decision to abort, it is crucial to note that IFA represents an irreversible point in the abortion process.

The stages that follow IFA are also addressed during counseling (Figure 1). Typically, an induced abortion from 20 weeks of pregnancy spans at least two days. On the first day, IFA is performed and mifepristone is administered (when available). On the second or third day (depending on the health team's preference), dilation and evacuation (D&E) is performed or induction with misoprostol is initiated - which may take several hours, or occasionally days, to result in fetal expulsion.

Figure 1.

Stages of induced abortion from 20 weeks of pregnancy



**Implants may be inserted on the initial day of treatment*

Until 24 weeks of pregnancy, there are two clinical options: medication abortion or dilation and evacuation (D&E). Medication abortion typically requires less provider intervention but is associated with greater vaginal bleeding, pain, and uncertainty about the timing of fetal expulsion. In comparison, D&E results in fewer adverse events, less pain, shorter time to expulsion, lower cost, and higher satisfaction among individuals who undergo the procedure[14]. However, D&E is less accessible in Latin America, as it requires specialized training.

The advantages and disadvantages of each method should be discussed during counseling *(Table 1)*.

For pregnancies after 24 weeks, medication abortion is the only therapeutic option. It is important to inform that dosage adjustments are made according to gestational duration and clinical assessment.

Table 1.

Information for counseling and technique election for induced abortion

	Medication Abortion	Procedural abortion (D&E)
Preferred if the person wishes to:	• Avoid surgery • See or have contact with the fetus after expulsion	• Have a faster procedure *(10–30 minutes)* • Experience less bleeding, pain, dizziness, and vomiting
Advantages	• Can be performed after 24 weeks	• Rapid procedure • IUD can be inserted at the time of the procedure
Disadvantages	• Unpredictable duration *(can take hours or days)* • Slight risk of uterine rupture in people with prior uterine scar *(<3%)*	• Requires cervical preparation at least one day prior • Slight risk of cervical laceration or uterine perforation (<1%) • Cannot be performed after approximately 24 weeks • Requires a trained specialist

[14] Atrio, J. M., Sonalkar, S., Kopp Kallner, H., Rapkin, R. B., Gemzell-Danielsson, K., Lohr, P. A. (2025). Surgical versus medical methods for second-trimester induced abortion. Cochrane Database Syst Rev. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006714.pub3/epdf/full.

1.1.6 Good practice guidance

- During counseling, it is important to emphasize that induction of fetal asystole (IFA) is a necessary step from 20 weeks of pregnancy in order to prevent survival after expulsion. IFA involves an ultrasound-guided abdominal injection and represents an irreversible point in care.
- Until 24 weeks, two therapeutic options are available: medication abortion or dilation and evacuation (D&E). The advantages and disadvantages of each are discussed during counseling.
- Beyond 25 weeks, medication abortion is the only option to be offered.

1.1.7 Do we talk about contraception?

Girls, adolescents, women, and other people capable of becoming pregnant often face barriers to access contraceptive methods that are timely, affordable, and aligned with their preferences. These challenges may include unnecessary requirements, high costs, and unjustified delays. Counseling, therefore, presents an important opportunity to address contraception from a comprehensive, person-centered perspective. However, care teams should be mindful not to initiate a discussion about contraception with individuals undergoing abortion for an intended pregnancy who express a desire to conceive again in the near future.

As with abortion care, the person remains the decision-maker throughout this process. This means providing appropriate and structured information[15], considering eligibility criteria[16], typical-use effectiveness rates, the advantages and disadvantages of each method, and the availability of options - always respecting the individual's preferences, lived experiences, and reproductive history[17]. It is critical that this opportunity does not become a source of pressure to adopt a method. In routine clinical practice, it is well established that method preference and acceptability are key predictors of continued use. Therefore, an active effort must be made to acknowledge any fears or ambivalence, and to avoid stigmatizing or devaluing decisions to delay or forgo contraceptive use.

If the individual wishes to initiate a method, the care team should offer all eligible options and provide counseling on their use, risks, benefits, and failure rates under typical use.

[15] Bizjak, I., Envall, N., Emtell Iwarsson, K., Kopp Kallner, H. y Gemzell-Danielsson, K. (2024). Contraceptive uptake and compliance after structured contraceptive counseling - secondary outcomes of the LOWE trial. *Acta Obstetricia et Gynecologica Scandinavica*, 103(5), pp. 873-883. https://doi.org/10.1111/aogs.14792

[16] WHO (2015). *Medical eligibility criteria for contraceptive use (5th ed.)*. https://www.who.int/publications/i/item/9789241549158

[17] WHO (2022b). *Family planning: a global handbook for providers* (4th ed.). https://www.who.int/publications/m/item/family-planning--a-global-handbook-for-providers--4th-ed

1.1.7 Good practice guidance

- Counseling presents an opportunity to explore contraceptive preferences from a comprehensive, person-centered perspective.
- The care team will provide appropriate information based on eligibility criteria and method availability, while respecting the individual's preferences, experiences, and reproductive journey.
- It is important to consider the person's fears and ambivalence, and to avoid pressuring or devaluing decisions to delay or decline contraceptive use.

1.2 Informed Consent

Informed consent is a right that ensures all actions carried out within the scope of healthcare are taken voluntarily. It is a dynamic and individualized process that extends throughout the entire continuum of care and occurs continuously at each clinical encounter. This process is grounded in effective communication and requires a full, accurate, updated, and relevant exchange of information, conveyed in a clear and accessible manner. The goal is to ensure that all individuals involved are presented with meaningful options and fully understand the necessary information to make informed and authentic decisions. Informed consent enables users to make well-informed decisions about each procedure within their care - including the right to withhold consent, regardless of how advisable a procedure may appear. **The outcome of this process is a decision made freely and without coercion, threats, undue influence, or improper incentives, to either accept or refuse a health intervention**.

Informed consent is essential to the realization of human rights such as autonomy, personal freedom in making decisions about one's health and body, dignity, and non-discrimination[18]. From a bioethical perspective, it is closely associated with the principle of autonomy, as it promotes non-interference in personal decision-making and fosters conditions that enable individuals to make choices freely and with full understanding[19]. In addition, informed consent is related to the principles of beneficence, non-maleficence, and justice[20]. It also helps build and maintain trust between individuals and health systems or professionals. As a core component of healthcare, informed consent must be framed within the guarantees of confidentiality and privacy in healthcare[21].

[18] Inter-American Court of Human Rights. Case of I.V.* v. Bolivia, Judgment of November 30, 2016. https://jurisprudencia.corteidh.or.cr/en/vid/883974476
Inter-American Court of Human Rights. Case of Guachalá Chimbo et al. v.. Ecuador, Judgment of March 26 2021. https://jurisprudencia.corteidh.or.cr/en/vid/883975241

[19] Beauchamp, T. y Childress, J. (2009). Principles of Biomedical Ethics (6th ed.). Oxford University Press.

[20] Beauchamp and Childress, 2009, p. 103.

[21] Guerrero, A., Acevedo Guerrero, N. y López Turconi, P. (2024). El secreto médico profesional y la salud reproductiva desde una perspectiva bioética y legal. En P. Lugo, A. B. Salinas Cerrillo, A. Guerrero, N. Acevedo-Guerrero, P. López Turconi, M. E. Batres Morales, S. M. Tecún León, G. L. Reyes Vásquez, N. Mejía, L. Velásquez, P. Capdevielle y J. A. Mejía Rivera (Eds.), Una mirada regional a los Derechos Sexuales y Reproductivos (pp. 61-100). Optio. https://optio.org/wp-content/uploads/2025/01/E-Book_Una-mirada-regional-a-los-derechos-sexuales-y-reproductivos-2.pdf.

1.2 Good practice guidance

- The purpose of informed consent is to enable individuals to make well-informed decisions regarding each procedure in their care - including the right to withhold consent, regardless of how advisable a procedure may appear.
- Informed consent is personal. Only the individual undergoing the procedure can provide it, after receiving information that is appropriate, complete, understandable, and accessible.
- Informed consent safeguards several fundamental rights, including autonomy, freedom, dignity, equality, and non-discrimination. It is grounded in the respect for bioethical principles such as beneficence, non-maleficence, and justice. It promotes trust in health systems while ensuring confidentiality and privacy are respected.

1.2.1 Characteristics and general principles of informed consent

Informed consent must meet the essential characteristics of being prior, voluntary, comprehensive, and informed. These characteristics are interdependent: **voluntary and comprehensive consent requires a proper understanding of the information provided, which must be both clear and relevant to the individual's personal values, preferences, and life plans.**

It is important to emphasize that **consent cannot be granted retroactively after a procedure**. The Inter-American Court of Human Rights (IACHR) has recognized exceptions to this rule only in cases of medical urgency or emergency, or in instances involving public health concerns that may justify a coactive action[22]. Such exceptions must be interpreted narrowly, and the reasons for their application, along with the measures taken, must be thoroughly documented.

Additionally, **informed consent must be unequivocal and must accurately reflect the individual's autonomous decision**. This means that the individual must receive accurate, up-to-date, and understandable information regarding the procedures, potential effects, risks, benefits, available alternatives, and rights. At the same time, the individual is expected to provide relevant information regarding their biopsychosocial background and personal preferences, enabling the healthcare team to tailor appropriate care strategies.

The mere act of signing an informed consent form does not exempt healthcare professionals from legal or ethical responsibility in the event of malpractice or negligence. It is essential to ensure a transparent and thorough process, with multiple opportunities for information exchange, proper documentation in the medical record, and not solely reliance on the signature of the consent form.

[22] Inter-American Court of Human Rights. Case of I.V.* v. Bolivia, Judgment of November 30, 2016. https://jurisprudencia.corteidh.or.cr/en/vid/883974476
Inter-American Court of Human Rights. Case of Guachalá Chimbo et al. v.. Ecuador, Judgment of March 26 2021. https://jurisprudencia.corteidh.or.cr/en/vid/883975241

1.2.1 Good practice guidance

- Informed consent must be obtained prior to the procedure—it cannot be granted retroactively.
- Consent must be voluntary and informed, and the information provided must be accurate, up-to-date, and understandable.
- The consent process must include information about the procedure, its effects, risks, benefits, alternatives, and rights.

1.2.2 Specific considerations for informed consent in induced abortions from 20 weeks

In the context of induced abortions performed from 20 weeks, safeguarding the informed consent process is particularly important. This is due to the deeply personal nature of the decision, which may involve higher levels of integrity, self-awareness, and dignity from individuals making the decision. Accordingly, additional safeguards must be established to ensure adequate protection of the individual's rights and autonomy[23].

1.2.2.1 Considerations regarding the consent process

Adequate information must be provided in the context of an induced abortion. For procedures performed from 20 weeks of pregnancy, the information shared should explicitly include:

- the risks and benefits associated with the technique used at each stage of the process;
- procedural details, including expected timelines and step-by-step descriptions of how each part of the intervention will be conducted;
- expected symptoms that may occur at each phase of the process, along with warning signs that require clinical attention;
- what to expect after treatment, including information on the return of fertility, post-abortion care, contraception options, and other relevant considerations[24].

Informed consent is understood as a dynamic process of information exchange. For consent to be valid, it must result from a process of communication that is clearly understood by all parties and reflects the autonomous decision of the individual.

[23] Schuck, P. H. (1994). Rethinking Informed Consent. *The Yale Law Journal, 103*(4), pp. 899-959. https://www.jstor.org/stable/797066
Corte Constitucional de Colombia. Sentencia T-850/02, 2002. https://www.corteconstitucional.gov.co/relatoria/2002/T-850-02.htm
Corte Constitucional de Colombia. Sentencia T-1031/04, 2004. https://www.corteconstitucional.gov.co/relatoria/2004/t-1031-04.htm
Corte Constitucional de Colombia. Sentencia T-063/12. https://www.corteconstitucional.gov.co/relatoria/2012/t-063-12.htm

[24] Canadian Medical Protective Association (CMPA) (2006). *Consent: A guide for Canadian physicians.* https://www.cmpa-acpm.ca/en/advice-publications/handbooks/consent-a-guide-for-canadian-physician

This process should involve a meaningful interaction between the individual and the healthcare provider or care team and their accompaniment person, if the individual wishes to have one. Importantly, this interaction should not imply a paternalistic approach in which the healthcare provider imposes decisions upon the individual[25].

It is essential to actively prevent any form of coercion, pressure, or undue influence in the individual's decision-making process. As part of obtaining informed consent for an induced abortion, **it is important to ensure that the individual is making medical decisions free from coercion or influence by third parties**. This consideration is especially critical in contexts marked by high vulnerability or gender-based violence. It must be ensured that the individual is not being pressured by a partner, family member, or anyone else. Confidentiality and privacy must be always maintained during interactions between the healthcare team and the person seeking abortion care. Any supportive presence or accompaniment during the procedure should be arranged solely at the request of the individual. Should there be any indication of coercion or undue influence, appropriate protocols applicable within the legal and healthcare frameworks of each country must be activated.

Given that abortions from 20 weeks of pregnancy may involve multiple stages of care and, at times, the involvement of various healthcare professionals or facilities, **it is crucial to maintain effective communication among health professionals**. Such communication ensures that the pregnant individual receives all necessary information and can express questions or concerns at any stage, without the assumption that consent was obtained merely through a one-time discussion. Consistent communication among the care team also facilitates early identification of any concerns related to compromised informed consent.

Changes of mind or potential ambivalence expressed by the individual should be understood as part of the consent process. When there are indications that the individual is reconsidering their decision or experiencing ambivalence, it is important not to assume it as a refusal or an inability to make decisions. Such responses are common in the context of non-reversible procedures and may reflect the individual's psychological or emotional processing. Respecting the moral agency and personal responsibility of individuals seeking an induced abortion requires acknowledging that decision-making in these circumstances may be non-linear, requiring time and multiple encounters to reach a final decision. Conversely, some individuals may make a swift and firm decision, which should not be viewed as the result of external influence unless accompanied by other signs suggesting coercion. To adequately support this process, the following practices are recommended:

- Provide time and space for the individual to ask questions about the procedure.
- Validate the individual's decision at different points of care and allow additional time for reflection, as needed.
- Facilitate consultation with persons from the individuals' circle of trust (only if the person expresses the desire to do so).
- If the individual chooses to decline or withdraw their request for the procedure, maintain open access to abortion services in case they wish to return later.

[25] Inter-American Court of Human Rights. Case of I.V. v. Bolivia. Preliminary Objections, Merits, Reparations and Costs. Judgment of November 30, 2016. Series C No. 329. paragraph 166. https://jurisprudencia.corteidh.or.cr/en/vid/883974476

All aspects of the informed consent process should be documented in the clinical record. **In line with best practices for clinical documentation, the healthcare record should reflect how informed consent was obtained, both before and throughout the abortion process**. It is important to register instances of information exchange, any changes in decision-making, withdrawal from treatment, and any identified signs or reports of coercion or pressure, along with the corresponding actions taken to address these concerns.

1.2.2.1 Good practice guidance

- The information provided for induced abortions from 20 weeks should include: the risks and benefits of the techniques used at each stage; procedural details, including timelines and the specific steps involved; expected symptoms at each stage; warning signs; and what to expect after the procedure.
- Coercion, pressure, or undue influence in the decision-making process should be anticipated and actively prevented. This includes maintaining confidentiality and privacy between the healthcare team and the individual seeking abortion care.
- Effective communication among healthcare professionals is essential, especially as abortions from 20 weeks may involve multiple stages of care and different providers or facilities.
- Changes of mind or ambivalence should be interpreted as part of the consent process.

1.2.2.2 Considerations regarding documentation

The use of a single, consolidated informed consent form should be encouraged. Although induced abortion is a low-risk practice, **most countries require written informed consent** to ensure that the individual has been adequately informed and has made a free and autonomous decision.

Informed consent is an ongoing process throughout the entire continuum of care, but it is recommended that a single consent form be used to cover the whole process. This approach ensures that the individual understands that each stage is an integral and inseparable part of the treatment - including cases beyond 20 weeks of pregnancy, which may require interventions such as the induction of fetal asystole.
The consent form to be signed should be concise and focused, summarizing the individual's decisions regarding the selected methods or techniques at each stage, the treatment methods and the disposition of products of pregnancy. To avoid excessively lengthy documents that may contain non-essential information, it is advisable to accompany the primary consent form with annexes that provide key, relevant information to support decision-making.

In practice - or in accordance with local regulations - it may be necessary to use more than one document, especially when multiple healthcare teams or facilities are involved. Nevertheless, it is preferable to limit the documentation to no more than two separate documents, to prevent confusion, fragmentation of care, or overstatement of treatment risk.

A moment of interaction should occur at the time of signing the consent form, in which the required information is provided verbally (or in the most accessible format for the individual) within a private and appropriate setting that facilitates meaningful interactions. Only after this interaction can the consent form be signed, certifying that the process has occurred. **Supplementary materials may include annexes** written in plain language, videos in local sign language, illustrations, and emergency contact information to provide continuous support.

It is essential that both the main consent form and any annexes are available in various formats (physical or digital, written, audio, video, pictographic) and in multiple idioms, ensuring clear and comprehensible language.

The form should be clear, concise, and accurate, and include at minimum the following information:

- Description of treatment details, including the method and modality chosen.
- Confirmation that the individual has received and understood information on all relevant and available alternatives, as applicable to their case.
- Explanation of the right to withdraw consent, including the latest point at which consent can be revoked, based on the chosen method.
- The individual's signature, which is indispensable even in the case of minors or individuals with disabilities, though it may be accompanied by signatures of those who provided decision-making support.
- The signature of the healthcare professional who facilitated the decision-making process, including the provision of an opportunity for dialogue and clarification of any doubts.

1.2.2.2 Good practice guidance

- Consent is obtained through a single consolidated form. If multiple forms are required - due to the involvement of different healthcare teams or facilities, or specific legal obligations - the documentation should be limited to a maximum of two forms.
- While dialogue between healthcare teams and the individual requiring an induced abortion occurs throughout the care process, particular attention is given at the time of signing the consent form to ensure meaningful communication.
- In addition to a signed copy of the consent form, explanatory annexes may be provided in accessible formats, containing information on the procedure, warning signs, and emergency contact details.
- The consent form should be clear, concise and accurate, including the following information: details of treatment, including the method and modality chosen; confirmation that the individual has received and understood relevant information; the right to withdraw consent, including the latest point at which it can be revoked; signature of the consenting individual; signature of the healthcare professional who facilitated the decision-making process.

1.2.3 Considerations regarding informed consent in childhood and adolescence

Children and adolescents are frequently presumed to lack the capacity for autonomous, responsible decision-making regarding their own healthcare. Consequently, in many countries, their decisions are not legally recognized as valid. Under a substitute decision-making model, an adult deemed capable is often required to make decisions on their behalf. However, the adoption of the Convention on the Rights of the Child (CRC) has established a paradigm shift, recognizing children and adolescents as rights-holders, rather than merely objects of protection[26].

This shift requires that their autonomy be acknowledged and that they be supported in making decisions, in accordance with their individual circumstances and evolving capacities. The process of informed consent and the provision of health services must align with this rights-based framework. As outlined in Article 12 of the CRC: "States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child"[27].

Determining a young person's maturity and their ability to form and express an informed judgment presents a clinical and ethical challenge for healthcare teams. **Health professionals should focus on implementing strategies that ensure adolescents are able to express their consent in a manner that is voluntary, informed, and meaningful**. In the context of induced abortion, particularly from 20 weeks, this includes not only consent to the procedure itself, but also engagement in decisions regarding the method and overall management of care.

To appropriately implement this model in clinical practice, healthcare teams should:

- **Recognize the individual's evolving autonomy**: ensure that the individual can participate in decision-making, with the necessary support, in line with their capabilities.
- **Do not allow or promote the substitution of their decision**: prevent others from making decisions on their behalf without serious consideration of the individual's perspective. Ensure their opinion is taken as central to all decision-making processes[28].
- **Foster a supportive and confidential environment**: create a space where the individual feels comfortable expressing their needs, questions and concerns.
- **Adapt the informed consent process**: modify the language, timing, and communication tools (e.g., illustrations, visual aids) to ensure comprehension of the procedure and its implications.

[26] United Nations (UN) (1989). *Convention on the Rights of the Child* (CRC). https://www.refworld.org/legal/agreements/unga/1989/en/18815

[27] UN, 1989, art. 12.

[28] UN's Committee on the Rights of the Child (CRC) (2003). *General comment No. 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child*. https://www.refworld.org/legal/general/crc/2003/en/18641

- **Respect the individual's values and preferences:** incorporate their priorities and beliefs into the care plan and decision-making process.
- **Ensure confidentiality:** guarantee that personal health information will not be shared without their explicit consent, except in cases of imminent risk or sexual violence, and only where required by applicable local laws.
- **Facilitate access without parental involvement:** enable access to sexual and reproductive health services without requiring parental or guardian consent. Assess and support their social network: encourage the presence of a trusted support person, while making clear that their involvement is not a prerequisite for receiving care.
- **Apply the principle primacy of the individual's best interests:** prioritize their well-being and rights throughout the decision-making process. Respect their right to participate actively, to be heard, and to make decisions in accordance with their progressive autonomy.
- **Develop institutional policies and guidelines:** implement protocols that allow for individualized, rights-based approaches to informed consent for children and adolescents.

1.2.3 Good practice guidance

- The substitution of the decision of a child or adolescent should not be allowed or promoted. Decisions regarding their healthcare must not be made by others without considering their opinion.
- A supportive and confidential environment is necessary to encourage the individual to express their needs, questions, and concerns.
- Health professionals should adapt the informed consent process, using appropriate language, adequate timing and communication tools, such as illustrations or visual materials, to ensure understanding of the procedure and its implications.
- In cases where local laws require the involvement of a legal representative, it is essential to ensure the meaningful participation of the individual and to uphold their right to be heard. The involvement of an adult must not override or replace the individual's opinion, which should be central in the process.
- It is important to guarantee that information will not be disclosed without the individual's consent, unless required in cases of imminent risk or sexual violence.
- It is advisable to facilitate the presence of a trusted support person during and after the care process, though this should not be a prerequisite for accessing healthcare.

1.2.4 Considerations regarding informed consent for persons with disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) explicitly grants equal recognition before the law of persons with disabilities and affirms their legal capacity, which includes the right to exercise rights and duties[29]. The CRPD recognizes the right to receive support and reasonable accommodations necessary for persons with disabilities to express their preferences, access information and make informed decisions[30].

Article 23 of the CRPD also affirms that **persons with disabilities have sexual and reproductive rights, including the right to make autonomous decisions regarding reproduction and fertility**. In this context, the CRPD urges States to adopt measures that support their decision-making, incorporating safeguards to prevent abuse, conflicts of interest, and undue influence[31]. Full recognition of the legal capacity of persons with disabilities in matters of sexual and reproductive health implies the adoption of a supported decision-making model, moving away from substitute decision-making approaches and ensuring that no health procedures are conducted without informed consent.

Additionally, article 2 of the CRPD expresses that denial of reasonable accommodations or support necessary to express one's preferences and access healthcare services - regardless of the type or degree of disability - may constitute disability-based discrimination[32].

1.2.4.1 Supported decision-making model for persons with disabilities

This model, derived from the social model of disability, is positioned as an alternative to the historically dominant substitute decision-making model in healthcare contexts. Under the supported decision-making approach, persons with disabilities are recognized as capable of making decisions about their reproductive rights, when provided with the support and accommodation necessary to express their preferences regarding specific aspects of care related to induced abortion[33]. To ensure the effective application of this model in the informed consent process, the following practices are recommended for healthcare teams and professionals:

- **Healthcare services offering abortion care must ensure that their facilities, procedures, and communication practices are fully accessible to persons with disabilities**. This includes physical accessibility of spaces and adaptations in communication formats and language[34].

[29] UN (2006). *Convention on the Rights of Persons with Disabilities*. https://www.refworld.org/legal/resolution/unga/2007/en/49751

[30] UN, 2006, art. 9 and 12.

[31] UN, 2006, art. 23 and 12.

[32] UN, 2006, art. 2.

[33] Acevedo Guerrero, N. (2022). Una aproximación al modelo de autonomía con apoyos para la toma de decisiones en salud sexual y reproductiva de las personas con discapacidad. In Dirección General de Derechos Humanos, Igualdad de Género y Asuntos Internacionales del Consejo de la Judicatura Federal de México (CJF) and Instituto O'Neill para el Derecho de Salud Nacional y Global de la Universidad de Georgetown (Eds.), *Los Derechos Sexuales y Reproductivos y el Poder Judicial en América Latina* (p. 108). https://www.cjf.gob.mx/micrositios/dgdhigai/resources/publicaciones/derechosSexualesReproductivosPoderJudicialAmericaLatina.pdf

[34] Dirección Nacional de Salud Sexual y Reproductiva (2022). Protocolo para la atención integral de las personas con derecho a la interrupción voluntaria y legal del embarazo (IVE/ILE). Ministerio de Salud de Argentina. https://redaas.org.ar/wp-content/uploads/1.-Protocolo-para-la-atencion-integral-de-las-personas-con-derecho-IVE-ILE-.-Actualizacion-2022.-Res.-1063_2023.pdf

- **It is important to establish contact with the person with a disability to assess whether they need and wish to receive support in making or expressing their decision**. The implementation of support mechanisms must never be imposed as a condition for access to care. Regardless of medical history or diagnostic labels, it is recommended to establish contact and relationship with the individual to assess the type and intensity of support required, based on their specific circumstances[35].
- **Persons supporting the decision-making for an induced abortion must be chosen by the individual with disability and identified from within their circle of trust**. This may include family members, community members, healthcare providers, professionals from civil society organizations, or disability rights advocates[36]. Supporters may or may not be the same individuals who assist in other areas of the person's life. Supporters must respect the individual's preferences, ensure confidentiality, and maintain the privacy of the decision-making process[37].
- **Persons with disabilities may require the use of audiovisual aids, videos, images and other tools to support the process of informed consent**. These may include "hearing aids, augmentative and alternative communication boards, pictograms, sign language, guide-interpreters, or any other tool familiar to the individual"[38]. The use of such tools does not imply a separate consent form; instead, they serve to facilitate the consent process.
- **Additional consultation time or extended sessions with healthcare teams may be needed to allow the individual with disability to process information and ask questions**. Multiple interactions may help build trust between the person with disability and the healthcare team.
- **Persons with disabilities may express their preferences through diverse means**. It is important to consider other means of non-verbal communication, such as written communication through images, gestures, body language, vocalizations that may indicate approval, comfort or disapproval, or the use of digital communication devices (e.g., mobile phones or computers). Health systems must ensure staff are trained to provide appropriate support and accommodation for these diverse communication needs[39].
- **Interdisciplinary teams can facilitate the decision-making processes of persons with disabilities**. Professionals in psychology, social work, nursing, and other relevant disciplines can support this process.
- Safeguards must be in place to ensure the individual's preferences are prioritized. **The healthcare team must focus on what the individual with disability wishes, not on the desires of family members or subjective interpretations of what is "best" for them**. Documentation in the clinical record, maintenance of

[35] Dirección Nacional de Salud Sexual y Reproductiva, 2022, p. 33.
Resolución 1904/2017 sobre la adopción del reglamento encaminado a garantizar que las personas con discapacidad accedan a información adecuada y suficiente sobre sus derechos sexuales y reproductivos. Ministerio de Salud y Protección Social de Colombia. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-1904-de-2017.pdf

[36] Resolución 1904/2017 del Ministerio de Salud y Protección Social de Colombia.

[37] Resolución 1904/2017 del Ministerio de Salud y Protección Social de Colombia.

[38] Dirección de Prestación de Servicios y Atención Primaria y Oficina de Promoción Social (s.f.). *Orientaciones técnicas para la implementación del consentimiento informado para personas con discapacidad, en el marco de los derechos sexuales y derechos reproductivos* (p. 10). Ministerio de Salud y Protección Social de Colombia. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/PS/orientaciones-tecnicas-consentimiento-pcd3.pdf

[39] Acevedo Guerrero, 2022, p. 108.

confidentiality and privacy, and a thorough informed consent process are key safeguards of the person's autonomy.

- Privacy and confidentiality must be guaranteed during all consultations. **Health professionals must not assume that a person with a disability wishes to be accompanied or supported by family members or caregivers**.
- In cases where, despite the use of accommodations and support, **it is not possible to determine the individual's preferences related to an abortion procedure, the standard of the "best interpretation of preferences" should be applied**[40]. This involves taking into consideration the individual's life history and prior expressions of preferences, input from trusted persons within their support network and any relevant personal, social, or contextual information. This process aims to answer: "What would the person likely have wanted, had they been able to express their will?[41]"

1.2.4.1 Good practice guidance

- Persons with disabilities are recognized as capable of making decisions about their reproductive rights through the provision of appropriate support and reasonable accommodations that facilitate the expression of their preferences regarding abortion care.
- Abortion services must ensure that their facilities and procedures are accessible to persons with disabilities.
- It is important to establish contact with the person with disability to determine whether they require and desire support in decision-making or in expressing their preferences.
- Persons supporting the decision-making regarding an induced abortion should be selected by the person with disability from within their trusted circle.
- Persons with disabilities may communicate their preferences through various means, including written or pictorial forms, sign language, gestures, vocalizations and body language.
- Confidentiality and privacy must always be respected. Health professionals must not assume a desire for family or caregiver involvement.
- If, after exhausting all possible supports and accommodations, it is still not feasible to ascertain the individual's preferences regarding induced abortion, healthcare teams should apply the "best interpretation of preferences". This should involve an interdisciplinary team and trusted members of the person's circle, drawing on known life history, previously expressed views, and other relevant considerations to guide case-specific decisions.

[40] Resolución 1904/2017 del Ministerio de Salud y Protección Social de Colombia, art. 8

[41] Ley 1996 de 2019 por medio de la cual se establece el régimen para el ejercicio de la capacidad legal de las personas con discapacidad mayores de edad, art. 4, párr. 3. Congreso de la República de Colombia. https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=99712

1.3 Clinical evaluation

Following the decision to undergo an induced abortion, it is essential to proceed with a comprehensive clinical assessment of the pregnant person. **In addition to estimating gestational duration, the clinical evaluation aims to identify any risk factors that could increase the likelihood of complications during or after treatment**. In the presence of such risk factors, the healthcare team must be prepared to implement appropriate interventions or referrals, when necessary.

The clinical evaluation of individuals seeking induced abortion from 20 weeks of pregnancy should include the following components[42]:

Reason for seeking abortion care	• Circumstances surrounding pregnancy (particularly relevant if documentation is needed for legal or reporting purposes, such as in cases of pregnancy resulting from rape, whether the pregnancy was intended or unintended). • Pregnancy symptoms and possible complications, including vaginal bleeding. • Recent use of physical methods (e.g., insertion of foreign objects) in an attempt to self-induce abortion.
Obstetric history	• Outcomes and details of previous pregnancies, including: ectopic or molar pregnancy, spontaneous or induced abortion, Postpartum or post-abortion hemorrhage, fetal demise, live births, mode of birth (e.g., vaginal birth, cesarean section).
Gynecological history	• First day of last menstrual period (LMP) and menstrual cycle characteristics (e.g., regularity, duration). • History of gynecological surgeries. • Past or current use and experience with contraceptive methods. • Uterine malformations.
Sexual history	• History or symptoms suggestive of sexually transmitted infections (STIs).
Clinical and surgical history	• Presence of chronic conditions such as: hypertension, epilepsy, coagulopathies, liver or cardiac disease, diabetes mellitus, sickle cell anemia, asthma, severe psychiatric illness • Prior hospitalizations or surgical procedures.

[42] WHO (2023a). *Clinical practice handbook for quality abortion care*. https://iris.who.int/bitstream/handle/10665/369488/9789240075207-eng.pdf?sequence=1

Medication use and allergies	• Routine or long-term medication use. • Recent ingestion or administration of medications or herbal substances intended to induce abortion (dose, route, and timing). • Documented drug allergies.
Social history	• Presence and quality of social support networks. • History or ongoing experience of intimate partner violence (IPV) or coercion by family members. • Other social determinants that may impact care. • Previous or current use of alcohol or substance use (licit or illicit).

1.3 **Good practice guidance**

- A comprehensive clinical evaluation is essential for identifying risk factors prior to an induced abortion from 20 weeks of pregnancy. This evaluation includes obstetric, gynecological, sexual, social, clinical and surgical history, medication use and allergies.

1.4 Laboratory and other complementary investigations

From 20 weeks of pregnancy, the use of ultrasound is indicated for determining fetal measurements and placental insertion[43], and for detecting fetal malformations that could affect the process of uterine evacuation[44].

Among the complementary investigations, ultrasound is probably the one with the greatest potential to impact the person undergoing an abortion. An ultrasonographic exam is intrinsically related to the body, its images, and to the symbolic burden it usually carries. Therefore, it is important to clearly explain the reasons for performing the exam, what to expect from this investigation, and to avoid describing what is being observed. The person undergoing an ultrasonographic exam should not feel that they are expected to view the images and/or listen to the sound of the fetal cardiac activity. Likewise, it is important that the person expresses their preferences regarding being informed of the diagnosis or results.

If the professional performing the ultrasonographic exam is not part of the team, they should be trained to work with sensitivity and respect toward the person requesting abortion, in order to provide a moment of care that does not cause any discomfort.

Additionally, **Rh factor testing** is offered to all individuals with an unknown Rh status[45]. This test is necessary for the administration of anti-D immunoglobulin to Rh-negative individuals with 20 or more weeks of pregnancy.

Routine evaluation also includes anemia screening through **hemoglobin and hematocrit tests**.[46] This is because a pregnancy of 20 weeks or more is a moderate risk factor for hemorrhage, even though this risk is less than 1%.

In the presence of any other risk factors for post-abortion hemorrhage, **coagulogram and serum creatinine** measurements are also indicated[47].

[43] Placenta accreta should be suspected where there is an anterior, previa or low-lying placenta in individuals with a previous cesarean birth. A transvaginal ultrasound and Doppler should be included to confirm or rule out the diagnosis in such cases. In the case of a diagnosis of placenta accreta, abortion should be induced in a hospital setting.
Premkumar, A., Huysman, B., Cheng, C., Einerson, B. D. y Moayedi G. (2025). Placenta accreta spectrum in the second trimester: a clinical conundrum in procedural abortion care. *American Journal of Obstetrics & Gynecology, 232*(1), pp. 92-101. https://www.ajog.org/article/S0002-9378(24)00820-2/abstract

[44] National Abortion Federation (NAF). Clinical Policy Guidelines for Abortion Care 2024. National Abortion Federation, 2024. https://prochoice.org/wp-content/uploads/2024-CPGs-FINAL-1.pdf
Kerns JL, Brown K, Nippita S, Steinauer J. Society of Family Planning Clinical Recommendation: Management of hemorrhage at the time of abortion. Contraception. 2023 Sep 20:110292. https://doi.org/110.1016/j.contraception.2023.110292.

[45] OMS, 2023.
Documentation of Rh status may be obtained by on-site testing, outside source, or self-report. (NAF, 2024).

[46] Kerns et al., 2024.
NAF, 2024.

[47] Kerns et al., 2024.

Risk factors for hemorrhage after an abortion include[48]:

- Two or more previous cesarean birth
- A previous cesarean birth and an anterior placenta
- Suspected or diagnosed placenta accreta

Serological tests for HIV, viral hepatitis (B and C), and syphilis can be offered as a screening opportunity but should not delay the treatment for induced abortion. Similarly, screening for gonorrhea and chlamydia is indicated, preferably through nucleic acid amplification tests (NAATs) using urine samples or vaginal swabs[49].

Individuals who do not accept screening for sexually transmitted infections should have their decisions respected.

1.4 **Good practice guidance**

- Ultrasound scans are indicated in pregnancies from 20 weeks in order to determine fetal measurements, placental insertion and fetal malformations.
- It is important to clearly explain the reasons for performing the ultrasonographic exam, what to expect from this investigation, and to respect the person's preferences regarding being informed about the diagnosis or results.
- Hemoglobin and hematocrit tests are routinely indicated in cases from 20 weeks of pregnancy. Rh factor testing is offered to individuals with an unknown Rh status.
- Coagulogram and serum creatinine measurements are indicated in the presence of any risk factor for hemorrhage, in addition to gestational duration (two or more previous cesarean births, a previous cesarean birth and anterior placenta, suspected or diagnosed placenta accreta).
- Screening for sexually transmitted infections (HIV, syphilis, hepatitis B and C, gonorrhea, and chlamydia) is also offered.

[48] Kerns et al., 2024.
[49] NAF, 2024.
WHO (2023b). *Laboratory and point-of-care diagnostic testing for sexually transmitted infections, including HIV*. https://iris.who.int/bitstream/handle/10665/374252/9789240077089-eng.pdf?sequence=1

2. Abortion care before the expulsion of products of pregnancy

2.1 Induction of fetal asystole

Induction of fetal asystole (IFA) consists of inducing the cessation of fetal cardiac activity in order to ensure that induced abortions after 20 weeks of pregnancy do not result in a live birth[50].

2.1.1 When should IFA be performed?

IFA can be considered before 20 weeks at the preference of the pregnant person or the healthcare team, for legal reasons, or to avoid errors in perinatal mortality statistics and the need for a live birth certificate[51].

Most clinical guidelines recommend IFA from 20-22 weeks of pregnancy before the induction of abortion with misoprostol[52] or dilation and evacuation (D&E), as the likelihood of fetal expulsion with signs of life increases significantly at this gestational time.

This means that IFA constitutes the standard of care for abortions from 20 weeks. However, in services where resources for IFA are unavailable, it remains possible to proceed with the induced abortion if gestational duration or fetal conditions are incompatible with survival after expulsion.

2.1.1 Good practice guidance

- IFA is indicated from 20 weeks of pregnancy before dilation and evacuation (D&E) or medication abortion, although there is nothing to prevent it from being performed before 20 weeks.
- The lack of resources for IFA should not constitute a barrier to accessing abortion services when gestational duration or fetal conditions are incompatible with survival after expulsion.

[50] Paro, H. (2023). *Los tiempos del aborto. Documento 1: Términos y otros asuntos clave*. Red Jurídica del Consorcio Latinoamericano Contra el Aborto Inseguro (CLACAI). https://clacaidigital.info/handle/123456789/3184

[51] Paro, 2023.

[52] International Federation of Gynecology and Obstetrics (FIGO). *FIGO Position Statement: Improving Access to Abortion Beyond 12 Weeks of Pregnancy*. Available at: https://www.figo.org/resources/figo-statements/improving-access-abortion-beyond-12-weeks-pregnancy.
RCOG (2022). *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales*. https://www.rcog.org.uk/guidance/browse-all-guidance/other-guidelines-and-reports/termination-of-pregnancy-for-fetal-abnormality-in-england-scotland-and-wales/
Guilbaud, L., Maurice, P., Dhombres, F., Maisonneuve, É., Rigouzzo, A., Darras, A. M. y Jouannic, J. M. (2020). Geste d'arrêt de vie fœtale: techniques pour les interruptions médicales de grossesse des deuxième et troisième trimestres. *Gynécologie Obstétrique Fertilité & Sénologie, 48*(9), pp. 687-692. https://www.sciencedirect.com/science/article/abs/pii/S2468718920300738?via%3Dihub

2.1.2 **Medications and techniques**

IFA is mostly performed with medications: injectable digoxin (intra-amniotic, intrafetal, or intracardiac), injectable potassium chloride (intracardiac) or lidocaine (intracardiac or intrathoracic)[53]. The intra-amniotic injection of digoxin has the advantage of being easily administered without the need for fetal medicine specialists in the healthcare team. However, the intracardiac injection of potassium chloride or lidocaine is more effective than the intra-amniotic injection of digoxin[54].

Time required to confirm asystole depends on the medication and the route of administration used. **Confirmation of fetal asystole is usually performed by ultrasound**. With intracardiac potassium chloride, asystole can be confirmed immediately after the procedure. The intracardiac or intrathoracic injection of lidocaine usually results in asystole within up to 5 minutes (*Table 2*)[55].

Specialists agree that the waiting time required for the use of intra-amniotic digoxin ranges from 12 to 48 hours with no significant post-injection failure rates. Most services that use intra-amniotic digoxin usually confirm asystole after 24 hours, but different contexts may require confirmation up to 48 hours after the first digoxin injection. The intracardiac injection of digoxin usually works in less than an hour, and the intrathoracic or intrafetal injection may take 6 to 12 hours (experts' opinion).

If cessation of fetal cardiac activity is not reached with the first IFA procedure, injection should be repeated.[56]

[53] Tufa T. H., Prager, S., Lavelanet, A. F. y Kim, C. (2020). Drugs used to induce fetal demise prior to abortion: a systematic review. *Contraception: X, 2*. https://doi.org/10.1016/j.conx.2020.100046

[54] Efficacy of the intra-amniotic injection of digoxin is 92%, while efficacy of the intracardiac injection of potassium chloride or lidocaine is 100%.
Jackson, R. A., Teplin, V. L., Drey, E. A., Thomas, L. J. y Darney, P. D. (2001). Digoxin to Facilitate Late Second-Trimester Abortion: A Randomized, Masked, Placebo-Controlled Trial. *Obstetrics & Gynecology, 97*(3), pp. 471-476. https://journals.lww.com/greenjournal/abstract/2001/03000/digoxin_to_facilitate_late_second_trimester.29.aspx
Pasquini, L., Pontello, V. y Kumar, S. (2008). Intracardiac injection of potassium chloride as method for feticide: experience from a single UK tertiary centre. *BJOG: an International Journal of Obstetrics & Gynaecology, 115*(4), pp. 528-531. https://doi.org/10.1111/j.1471-0528.2007.01639.x
Reeves, M. F., Goldfarb, C. N., Rubin, S. L., Kuperstock, J. L., DiBianco, L. y Picciotto, A. (2022). Transabdominal lidocaine to induce fetal demise: a cohort study. *BMJ Sexual & Reproductive Health, 48*(4). https://doi.org/10.1136/bmjsrh-2021-201350

[55] WHO, 2023a.
Tufa et al., 2020.
Reeves et al., 2022.

[56] Tufa, T. H., Lavelanet, A. F., Belay. L., Seboka, B. y Bell, J. (2020). Feasibility of intra-amniotic digoxin administration by obstetrics and gynecology trainees to induce fetal demise prior to medical abortion beyond 20 weeks. *BMJ Sexual & Reproductive Health, 46*(4). https://doi.org/10.1136/bmjsrh-2019-200396
Reeves et al., 2022.

Table 2.

Medicines and techniques used for IFA*

Medicine	Efficacy	Safety	Dosage	Route of administration	Confirmation of fetal asystole (with ultrasound)
Potassium chloride (KCl)	100%	Cardiac events on pregnant person are rare	4 - 6 mEq	Intracardiac. Injection requires a trained health professional.	Immediately after injection
Digoxin (intracardiac or intra-amniotic injection)	92% (intra-amniotic injection) 100% (intracardiac injection)[57]	Serum levels on pregnant person are safe (below therapeutic levels)	1 - 2 mg	Intracardiac, intrafetal or intra-amniotic. Intrafetal and intra-amniotic routes are technically easier than the intracardiac one. Intra-amniotic route does not require ultrasound guidance.	12 a 48 hours after injection
Lidocaine (intracardiac or intra-thoracic injection)	100% (intracardiac injection)[58]	Usual dosages are safe to the pregnant person	200 - 240 mg	Intrathoracic or intracardiac. Injection requires a trained health professional.	2 to 5 minutes after injection

* There is no scientific evidence regarding the use of combined medicines for IFA. Thus, IFA with more than one medicine is not recommended outside the context of research.

Source: WHO (2023)

2.1.2 **Good practice guidance**

- Intracardiac potassium chloride (4-6 mEq) or intrathoracic or intracardiac lidocaine (200-240 mg), intra-amniotic or intrafetal digoxin (1-2 mg) are used to perform IFA.
- Fetal asystole is confirmed with ultrasound performed after minutes of potassium chloride and lidocaine injections; or up to one hour after intracardiac digoxin injections; and from 12 to 48 hours after intra-amniotic digoxin injections (experts' opinion).

[57] Although no clinical trials are available to assess the efficacy of intrafetal digoxin injection, expert observations suggest a success rate ranging between 92% and 100%.

[58] 98% of intracardiac lidocaine injections result in asystole without the need for an additional injection. If cardiac activity persists after confirmation with ultrasound within 5 minutes, a second injection should be administered. Reeves et al., 2022.

2.2 Medication abortion

The preferred regimen for medication abortion for persons with no previous cesarean birth is a combination of mifepristone and misoprostol. When mifepristone is not available, the misoprostol-only regimen may be offered.

Experts' opinion indicates that the required number of misoprostol doses tends to be lower when IFA is performed concurrently with the oral administration of 200 mg of mifepristone, followed by a latency period of 24 to 48 hours before initiating induction with misoprostol. In misoprostol-only regimens, a Foley catheter may be inserted transcervically, and the first dose of misoprostol can be administered after confirmation of fetal asystole[59].

In pregnancies up to 24 weeks, the preferred regimen consists of administering 200 mg of mifepristone orally, with the person returning to the health facility after 24 to 48 hours for induction with 400 mcg of misoprostol vaginally, sublingually or buccally, every 3 hours, with no dose limit, until expulsion[60].

However, when mifepristone is not available, misoprostol-only treatment is often the only option for individuals seeking an induced abortion. In such cases, the recommended dose is 400 mcg of misoprostol (vaginally, sublingually, or buccally) every three hours, with no dose limit, until expulsion[61].

In pregnancies between 25 and 27 weeks, the preferred regimen consists of 200 mg of mifepristone orally, followed (after a 24-48 hour interval) by doses of 200 mcg of misoprostol (vaginally, sublingually, or buccally) every four hours[62]. When mifepristone is unavailable, the alternative regimen is the administration of 200 mcg of misoprostol (vaginally, sublingually, or buccally) every four hours, with no dose limit, until expulsion[63].

Although there are few studies on medication abortion exclusively in pregnancies from 28 weeks onward, a dose of 50 to 100 mcg of misoprostol (vaginally) every four hours, preceded by 200 mg of mifepristone (orally) in a 24-48-hour interval[64] is often used. When mifepristone is not available, the alternative regimen is the administration of 50-100 mcg of misoprostol (vaginally) every four hours, with no dose limit, until expulsion[65].

[59] Zwerling, B., Edelman, A., Jackson, A., Burke, A. y Prabhu, M. (2023). Society of Family Planning Clinical Recommendation: Medication abortion between 14 0/7 and 27 6/7 weeks of gestation. *Contraception: an international reproductive health journal, 129*. https://doi.org/10.1016/j.contraception.2023.110143
Rezk, M. A. A., Sanad, Z., Dawood, R., Emarh, M. y Masood, A. (2014). Comparison of intravaginal misoprostol and intracervical Foley catheter alone or in combination for termination of second trimester pregnancy. *The Journal of Maternal-Fetal & Neonatal Medicine, 28*(1), pp. 93-96. https://doi.org/10.3109/14767058.2014.905909

[60] WHO, 2022a.
FIGO (2023). *FIGO Mifepristone & Misoprostol and Misoprostol Only Dosing Charts 2023*. Available at: https://www.figo.org/figo-mifepristone-misoprostol-and-misoprostol-only-dosing-charts-2023.

[61] WHO, 2022a.
FIGO, 2023.

[62] FIGO, 2023.
National Institute for Health and Care Excellence (NICE) and RCOG (2019). *Abortion care*. https://www.nice.org.uk/guidance/ng140.

[63] FIGO, 2023.
NICE and RCOG, 2019.

[64] FIGO, 2023.

[65] FIGO, 2023.
NICE and RCOG, 2019.

Misoprostol can be safely used for abortion induction up to 28 weeks' pregnancy in persons with previous cesarean birth. The risk of uterine rupture in such cases is similar to the risk in women without an uterine scar[66]. In individuals with more than one prior cesarean birth, the increased risk of uterine rupture does not contraindicate the use of misoprostol after mifepristone. However, experts' opinion suggests reducing the dose in pregnancies from 24 weeks[67] and providing close monitoring for the person undergoing treatment. In these cases, a transcervical Foley catheter can also be used to reduce induction time[68].

In pregnancies over 28 weeks with a history of cesarean birth, a transcervical Foley catheter and high doses of oxytocin may be offered[69]. An escalating regimen with 5 IU of oxytocin in 500 mL of 5% glucose solution in an infusion pump at 167 mL/h (over 3 hours), followed by a 1-hour pause with glucose solution, and increases of 5 IU of oxytocin with each regimen, up to 30 IU of oxytocin or fetal expulsion, may be considered. This regimen has an average expulsion time of 12 hours and a 97% expulsion rate within 48 hours[70].

After fetal expulsion, 10 IU of oxytocin is administered intramuscularly[71]. If the person has an intravenous (IV) line, the IV route is preferred[72]. Expectant management for the expulsion of the placenta in medication abortion is not associated with a higher risk of retained placenta or post-abortion hemorrhage when compared to dilation and evacuation[73]. Therefore, if there are no signs of infection or excessive bleeding, placental expulsion can be managed expectantly for up to 4 hours[74].

There is no indication for routine surgical evacuation after a medication abortion, which is only the case when there is clinical evidence of incomplete abortion[75]. Routine ultrasound is also not indicated to investigate the persistence of placental tissue (*Table 3*)[76]. **There is no indication for antibiotic prophylaxis** in medication abortions[77].

[66] Zwerling et al., 2023.
Goyal, V. (2009). Uterine Rupture in Second-Trimester Misoprostol-Induced Abortion After Cesarean Delivery: A Systematic Review. *Obstetrics & Gynecology, 113*(5), pp. 1117-1123. https://doi.org/10.1097/aog.0b013e31819dbfe

[67] Zwerling et al., 2023.

[68] El Sharkwy, I. A. E., Elsayed, M. L., Ahmed, M. A., Alnemer, A. A. A. (2019). Low-dose vaginal misoprostol with or without Foley catheter for late second-trimester pregnancy termination in women with previous multiple cesarean sections. *The Journal of Maternal-Fetal & Neonatal Medicine, 32*(22). https://doi.org/10.1080/14767058.2018.1470236

[69] Premkumar, A., Manthena, V., Vuppaladhadiam, L., Van Etten, K., McLaren, H. y Grobman, W. A. (2024). The use of adjunctive mechanical dilation at the time of induction termination and adverse health outcomes: a systematic review. *American Journal of Obstetrics & Gynecology, 6*(2). https://doi.org/10.1016/j.ajogmf.2023.101263.

[70] Yapar, E. G., Senöz, S., Urkütür, M., Batioglu, S. y Gökmen, O. (1996). Second trimester pregnancy termination including fetal death: comparison of five different methods. *European Journal of Obstetrics & Gynecology and Reproductive Biology (EJOG), 69*(2), pp. 97-102. https://www.ejog.org/article/0301-2115(95)02548-0/abstract

[71] Dickinson, J. E. y Doherty, D. A. (2009). Optimization of third-stage management after second-trimester medical pregnancy termination. *American Journal of Obstetrics & Gynecology, 201*(3), p. 303. https://doi.org/10.1016/j.ajog.2009.05.044
Zwerling et al., 2023.

[72] WHO (2020). *WHO recommendation on routes of oxytocin administration for the prevention of postpartum haemorrhage after vaginal birth*. http://iris.who.int/bitstream/handle/10665/336308/9789240013926-eng.pdf?sequence=1.

[73] Jacques, L., Heinlein, M., Ralph, J., Pan, A., Nugent, M., Kaljo, K. y Farez, R. (2024). Complication rates of dilation and evacuation and labor induction in second-trimester abortion for fetal indications: A retrospective cohort study. *Contraception: an international reproductive health journal, 102*(2), pp. 83-86. https://doi.org/10.1016/j.contraception.2020.04.018

[74] Zwerling et al., 2023.

[75] NICE and RCOG, 2019.
Zwerling et al., 2023.

[76] Costescu, D. y Guilbert, É. (2018). SOGC Clinical Practice Guideline Nº 360. Induced Abortion: Surgical Abortion and Second Trimester Medical Methods. *Journal of Obstetrics & Gynaecology Canada, 40*(6), pp. 750-783. https://doi.org/10.1016/j.jogc.2017.12.010

[77] WHO, 2022a.

2.2 Good practice guidance

- For pregnancies up to 24 weeks, 200 mg of mifepristone (orally) is recommended, followed (after an interval of 24-48 hours) by 400 mcg of misoprostol (vaginally, sublingually or buccally), every three hours, until expulsion of products of pregnancy. When mifepristone is not available, 400 mcg of misoprostol (vaginally, sublingually or buccally) is used every three hours, until expulsion.
- Between 25 and 28 weeks of pregnancy, oral administration of 200 mg of mifepristone is followed (after an interval of 24-48 hours) by doses of 200 mcg of misoprostol (vaginally, sublingually or buccally) every four hours. When mifepristone is not available, 200 mcg of misoprostol (vaginally, sublingually or buccally) is used every four hours.
- From 28 weeks of pregnancy, 200 mg of mifepristone (orally) is recommended, followed (after an interval of 24-48 hours) by 50-100 mcg of misoprostol (vaginally) every four hours. When mifepristone is not available, 50-100 mcg of misoprostol (vaginally) is used every four hours.
- Mifepristone may be administered concurrently with IFA, followed by a waiting period of 24 to 48 hours before initiating induction with misoprostol. In protocols that do not include mifepristone and rely solely on misoprostol, a transcervical Foley catheter may be inserted, and the first dose of misoprostol administered after confirmation of successful IFA, in order to reduce the overall induction time (experts' opinion).
- In persons with pregnancies from 24 to 27 weeks and more than one previous cesarean birth, reduced doses of misoprostol and close monitoring during the induced abortion process are suggested. The insertion of a transcervical Foley catheter may also be considered in combination with misoprostol.
- In persons with pregnancies beyond 28 weeks and a history of cesarean birth, transcervical Foley catheter combined with high-dose oxytocin induction may be used.
- After fetal expulsion, 10 IU of oxytocin is administered intramuscularly or intravenously.
- If there are no signs of infection or hemorrhage, placental expulsion can be waited for up to 4 hours.
- Routine surgical evacuation should not be used, nor should routine ultrasound be performed after a medication abortion.

2.3 Dilation and Evacuation (D&E)

2.3.1 Cervical priming for D&E

Cervical priming for D&E from 20 weeks of pregnancy is performed using cervical dilators and pharmacological agents. Insertion of cervical dilators typically occurs one day prior to the evacuation procedure in an outpatient setting. Once osmotic dilators reach maximum dilation - generally within 6 to 24 hours - same-day cervical preparation may be possible[78].
If cervical dilators are unavailable, cervical priming can be performed using a transcervical Foley catheter[79].

For the insertion of cervical dilators (laminarias or osmotic dilators), a paracervical block with a local anesthetic agent (such as bupivacaine or lidocaine) is used. The number of dilators required depends on the gestational duration.

The person may be discharged with a prescription for non-steroidal anti-inflammatory drugs (oral analgesia) and should be advised of the possibility of spontaneous expulsion of dilators prior to the procedure. They must be instructed to return to the healthcare facility before the scheduled procedure if they experience any of the following signs or symptoms[80]:

- excessive vaginal bleeding (equal to or heavier than menstruation);
- cramping not relieved by anti-inflammatory medication;
- rupture of membranes, indicated by the passage of clear fluid from the vagina, soaking clothing or legs;
- fever (body temperature over 37.5°C);
- expulsion of the dilators: in such cases, the individual should count and report the number of expelled dilators to the healthcare provider.

For cervical priming with pharmacological agents, 200 mg of oral mifepristone is administered 24 to 48 hours prior to the procedure, followed by **400 mcg of misoprostol** administered sublingually 1 to 2 hours prior, or vaginally 2 to 3 hours prior to the procedure[81].

[78] WHO, 2023a.

[79] Chandrasekaran, S., Paul, M., Ruggiero, S., Monschauer, E., Blanchard, K. y Robinson, Y. (2021). Foley catheter and misoprostol for cervical preparation for second-trimester surgical abortion. *Contraception: an international reproductive health journal, 104*(4), pp. 437-441. https://doi.org/10.1016/j.contraception.2021.06.015
Sium, A. F., Prager, S., Wolderufael, M., Abubeker, F. A., Tufa, T. H. y Grentzer, J. M. (2022). Foley catheter for cervical preparation prior to second trimester dilation and evacuation: A supply-based alternative for surgical abortion: A case series. *Contraception: X, 4*. https://doi.org/10.1016/j.conx.2022.100085

[80] WHO, 2023a.

[81] WHO, 2023a.

2.3.1 Good practice guidance

- Cervical priming for dilation and evacuation (D&E) is performed using a combination of mechanical dilators and pharmacological agents (mifepristone + misoprostol, or misoprostol alone).
- Cervical dilators are generally inserted one day before the procedure, with a paracervical block.
- Mifepristone, when available, is administered orally 24 to 48 hours before the procedure.
- Misoprostol is administered 1 to 3 hours before the procedure, either sublingually or vaginally.

2.3.2 Uterine Evacuation

Prior to initiating uterine evacuation, a paracervical block with lidocaine combined with vasopressin is recommended to reduce the risk of cervical bleeding[82].
After removal of cervical dilators, cervical dilation should be assessed via vaginal examination. If dilation is less than 4 cm, mechanical dilators (such as Pratt dilators) should be used under ultrasound guidance.

Uterine evacuation using Sopher or Bierer forceps is performed under ultrasound guidance. To prevent post-abortion hemorrhage, 30 IU of oxytocin in 500 mL of normal saline is administered intravenously during the evacuation[83]**. Single-dose antibiotic prophylaxis is also recommended before or during the D&E procedure** (*Table 3*)[84].

2.3.2 Good practice guidance

- To prevent post-abortion hemorrhage, paracervical block with lidocaine and vasopressin, as well as intravenous administration of 30 IU of oxytocin in 500 mL of normal saline are recommended during the procedure of D&E.
- The use of ultrasound guidance during D&E is indicated.
- Single-dose antibiotic prophylaxis before or during D&E is also recommended.

[82] Kerns et al., 2024.

[83] Whitehouse, K., Tschann, M., Soon, R., Davis, J., Micks, E., Salcedo, J., Savala, M. y Kaneshiro, B. (2019). Effects of Prophylactic Oxytocin on Bleeding Outcomes in Women Undergoing Dilation and Evacuation: A Randomized Controlled Trial. *Obstetrics & Gynecology, 133*(3), pp. 484-491. https://doi.org/10.1097/AOG.0000000000003104

[84] WHO, 2023a.
Ipas (2023). *Actualizaciones clínicas en salud reproductiva*. https://www.ipas.org/wp-content/uploads/2024/01/Actualizaciones-clinicas-en-salud-reproductiva-CURHS23b.pdf

Table 3.

Medication abortion or dilation and evacuation (D&E) for pregnancies from 20 weeks

	20-21 weeks[6d]	22-24 weeks[6d]	25-27 weeks[6d]	≥ 28 sem
Medication abortion				
IFA	recommended	necessary		
Mifepristona + misoprostol	200 mg mifepristone PO			
	400 mcg misoprostol BU/PV/SL† 3/3h		200 mcg misoprostol BU/PV/SL† 4/4h	25-50 mcg misoprostol PV† 4/4h
Misoprostol§	400 mcg misoprostol BU/PV/SL† 3/3h		200 mcg misoprostol BU/PV/SL† 4/4h	25-50 mcg misoprostol PV† 4/4h
Prevention of post-abortion hemorrhage	10 IU oxytocin intramuscularly after fetal expulsion			
Antibiotic prophylaxis	not recommended			
Dilation and Evacuation (D&E)				
IFA	recommended			
Cervical priming	cervical dilators 24 hours before procedure + 200 mg mifepristone orally 24-48 hours before procedure, if available + 400 mcg misoprostol sublingually or vaginally 1-3 hours before procedure or transcervical Foley catheter 24 hours before procedure + 200 mg mifepristone orally 24-48 hours before procedure, if available + 400 mcg misoprostol sublingually or vaginally 1-3 hours before procedure			
Uterine evacuation	Sopher or Bierer forceps under ultrasound guidance			
Prevention of post-abortion hemorrhage	30 IU oxytocin in 500 mL of saline at speculum placement			
Antibiotic prophylaxis	single-dose metronidazole (500 mg) or single-dose doxycycline (200 mg) or single-dose azithromycin (500 mg) before or during procedure[85]			

IFA: induction of fetal asystole; BU: buccally; PO: orally; PV: vaginally; SL: sublingually
§ Misoprostol-only regimen for countries where mifepristone is unavailable
† 24-48 hours after mifepristone intake
Source: prepared by authors

[85] Ipas, 2023.

2.4 Pain management

Pain management should be person-centered and tailored to the individual needs of those seeking abortion care. To adequately assess pain, verbal or visual numeric rating scales may be useful, particularly in persons under the age of 15, for whom the Wong-Baker FACES Pain Rating Scale may also be employed[86].

Non-pharmacological methods for pain management are recommended in both medication abortion and dilation and evacuation procedures. These may include[87]:

- respectful, nonjudgmental communication;
- verbal reassurance and detailed explanation of the procedure and what to expect, when desired by the person;
- the presence of a chosen support person throughout the process, if requested;
- music for relaxation;
- application of a hot water bottle or heating pad;
- provision of a private space, separate from individuals in labor, when feasible and not posing a barrier to access.

For medication abortion, nonsteroidal anti-inflammatory drugs (NSAIDs)[88] are used routinely and prophylactically for pain relief. Additional methods such as opioids, antiemetics (e.g., metoclopramide), and epidural analgesia may be introduced as needed[89]. The combination of metoclopramide 10 mg administered 10 minutes before and again 4 hours after the first dose of morphine has been shown to reduce both induction time and the number of morphine doses required[90].

In facilities where epidural analgesia is available, this option should always be offered to the person under abortion care. When epidural analgesia is unavailable, opioids such as morphine (2 mg bolus, slow IV injection) or fentanyl (25 mcg bolus, slow IV injection) may be used as alternatives for pain control (*Table 4*)[91]. For adolescents or persons weighing less than 50 kg, weight-based dose adjustments should be considered[92].

A stepwise approach to pain management - beginning with oral NSAIDs, followed by intravenous NSAIDs, then opioid analgesia, and finally epidural analgesia (when available), in combination with non-pharmacological methods - offers good tolerability and adequate comfort during the abortion process (experts' opinion).

[86] Ortiz, G. (2020). Guía técnica. *Atención integral del aborto en menores de 15 años*. Consorcio Latinoamericano Contra el Aborto Inseguro (CLACAI) e Ipas. https://clacaidigital.info/bitstream/handle/123456789/1333/GUIA%20TEC_ATE%20ABORTO_FINAL.pdf

[87] WHO, 2023a.

[88] WHO, 2023a.

[89] WHO, 2023a.
Jackson, E. and Kapp, N. (2011). Pain control in first-trimester and second-trimester medical termination of pregnancy: a systematic review. *Contraception: an international reproductive health journal, 83*(2), pp. 116-126. https://doi.org/10.1016/j.contraception.2010.07.014

[90] Jackson and Kapp, 2011.

[91] Jackson and Kapp, 2011.

[92] Ortiz, 2020.

For procedural abortion (dilation and evacuation – D&E), NSAIDs (e.g., ibuprofen)[93] are also routinely administered. The WHO recommends paracervical block and conscious sedation and discourages routine use of general anesthesia. However, a systematic review including four studies on pain management during D&E concluded that deep sedation (e.g., propofol) or general anesthesia is effective for pain relief and does not increase the risk of complications or adverse effects (*Table 4*)[94].

Table 4.

Non-pharmacological and pharmacological pain management in abortion care from 20 weeks

Regimen	≤ 24 weeks		> 24 weeks
	D&E	Medication	Medication
Non-pharmacological	respectful and nonjudgmental communication; verbal reassurance and emotional support; detailed explanation of what to expect (if the person desires); presence of a support person throughout the process (if desired); music for relaxation; application of a hot water bottle or heating pad[95]; provision of a private space, not shared with individuals in labor		
Oral analgesia	800 mg ibuprofen (PO) + 30 mg codeine (PO)[96] or 10 mg morphine (PO)		
Oral analgesia			
Paracervical block	lidocaine 0.5%-1.0% or bupivacaine 0.25%[97]		
Paracervical block		bolus or continuous epidural block	
Paracervical block		(when epidural block is unavailable) 10 mg metoclopramide (IV) + 0.1-0.2 mg/kg morphine (IV) 10 minutes after and as needed + 10 mg metoclopramide 4 hours after[98]†	
Regional block		0.1-0.2 mg/kg morphine (IV) + 50-100 mcg fentanyl (IV)[99] (*Table 4.1*)	
Intravenous analgesia	propofol + fentanyl	(may be used during expulsion and for fetal extraction) propofol + opioid (*Table 4.2*)	(may be used during expulsion and for fetal extraction) propofol + opioid (*Table 4.2*)
Anestesia general§	propofol		

IV: intravenously; PO: orally

† This regimen has the following advantages: lower doses of morphine required, less pain in the first 6 hours and shorter time to fetal expulsion.

§ The WHO recommends against the use of general anesthesia for dilation and evacuation, despite a recent systematic review published in 2020 showing no significant difference in complications or adverse effects among diverse pain management methods, including general anesthesia[100].

[93] WHO, 2023a.

[94] Jackson, E. and Kapp, N. (2020). Pain management for medical and surgical termination of pregnancy between 13 and 24 weeks of gestation: a systematic review. *BJOG: an International Journal of Obstetrics & Gynaecology, 127*(11), pp. 1348-1357. https://pubmed.ncbi.nlm.nih.gov/32162427/

[95] WHO, 2023a.

[96] WHO, 2023a.

[97] WHO, 2023a.

[98] Jackson and Kapp, 2011.

[99] Jackson and Kapp, 2011.

[100] Jackson and Kapp, 2020.

Table 4.1.

Moderate sedation medicines[101]

	Medicine	Initial dose	Maximum dose	Additional dose
Opioids				
	Fentanyl	50-100 mcg (IV)	200 mcg (IV)	50-100 mcg (IV)
	Pethidine	25-100 mg (IV/IM)		
	Tramadol	50-100 mg (IV/IM)		
	Morphine	0.1-0.2 mg/kg (IV)		
Anxiolytics				
	Midazolam	1-3 mg (IV)	4 mg (IV)	1-2 mg (IV)
	Diazepam	5-10 mg (IV)		
	Lorazepam	1 mg (IV)		

IV: intravenously; IM: intramuscularly

Table 4.2.

Deep sedation medicines[102]

	Medicine	Initial dose
Opioids		
	Propofol + fentanyl	0,5 - 1,0 mg/kg + 100-300 mcg (IV)
	Ketamine + fentanyl	10 mg + 50-100 mcg (IV)
Anxiolytics		
	Midazolam	1-2 mg (IV)
	Diazepam	5-10 mg (IV)
	Lorazepam	1 mg (IV)

IV: intravenously

[101] WHO, 2023a.
Allen, R. H. and Singh, R. (2018). Society of Family Planning clinical guidelines pain control in surgical abortion. Part 1: local anesthesia and minimal sedation. *Contraception: an international reproductive health journal, 97*(6), pp. 471-477. https://www.contraceptionjournal.org/article/S0010-7824(18)30036-2/fulltext

[102] WHO, 2023a.

2.4 Good practice guidance

- For pain relief in medication abortion, NSAIDs (e.g., ibuprofen) are used prophylactically and routinely. Additional methods for pain management include opioids, antiemetics, and epidural analgesia.
- A stepwise approach - beginning with oral NSAIDs, followed by intravenous NSAIDs, then opioids, and finally epidural analgesia (if available), always in combination with non-pharmacological methods - is considered effective for pain management in medical abortion (experts' opinion).
- When epidural anesthesia is not available, the use of opioids and derived agents is an alternative for pain relief.
- For procedural abortion (D&E), NSAIDs (e.g., ibuprofen), paracervical block, and conscious sedation are routinely provided.
- Deep sedation with propofol or general anesthesia may also be used for pain relief during D&E.

2.5 Confirmation of complete evacuation

2.5.1 Medication abortion

During the fetal expulsion process, we suggest support and supervision by the healthcare team, as well as careful handling of the fetus after expulsion.

Confirmation of complete evacuation following medication abortion is based on visual inspection of the fetus and placenta, along with clinical monitoring of the person's condition (e.g., stable vital signs, reduced vaginal bleeding and abdominal pain)[103].

Fewer than 10% of medication abortions require surgical intervention (uterine aspiration) for the removal of retained placental tissue. Therefore, routine ultrasound should not be used to screen for retained products of pregnancy. Uterine aspiration is only indicated when there is clinical evidence of incomplete abortion, such as heavy vaginal bleeding, fever or retained placenta more than 3-4 hours after fetal expulsion[104].

[103] WHO, 2023a.

[104] NICE and RCOG, 2019.
Zwerling et al., 2023.

2.5.1 Good practice guidance

- During fetal expulsion, continuous support and supervision by the healthcare team is recommended, along with careful handling of the fetus after expulsion.
- Complete evacuation in medication abortion is confirmed through visual inspection of the pregnancy tissues and monitoring of clinical signs and symptoms, (stable vital signs, reduced vaginal bleeding and abdominal pain).
- Surgical intervention and ultrasonography are not routinely indicated following medication abortion.
- Uterine aspiration is only indicated upon clinical evidence of incomplete abortion.

2.5.2 Dilation and Evacuation (D&E)

Visual inspection of the products of pregnancy - including four extremities, thorax/ spine, calvarium, and placenta - confirms complete uterine evacuation during a D&E procedure[105]. **When D&E is performed under ultrasound guidance, the ultrasound may also be used to confirm that the uterus has been completely evacuated**.
During aspiration at the end of the D&E procedure, complete evacuation of the uterus may be confirmed by the presence of the following signs[106]:

- red or pink foam appears, and no additional tissue is observed passing through the cannula;
- a gritty sensation is felt as the cannula passes over the surface of the emptied uterus;
- the uterus contracts around the cannula.the person experiences intensified cramping or pain, indicating active uterine contraction.

Sharp uterine curettage should not be used to confirm the success of the abortion procedure[107].

2.5.2 Good practice guidance

- Visual inspection of the pregnancy tissues, along with clinical signs of complete evacuation during aspiration at the end of the D&E procedure, are used to confirm complete uterine evacuation.
- Ultrasound imaging during D&E may also be used to confirm complete evacuation of the uterus.
- Sharp uterine curettage should not be used to verify the success of the abortion.

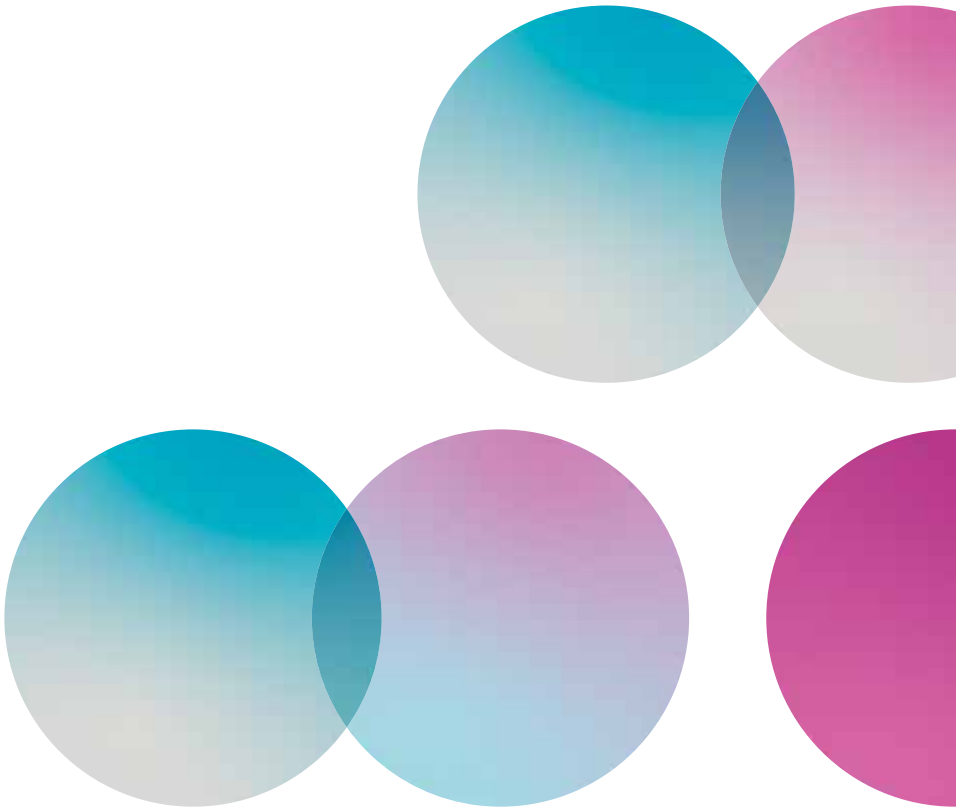
[105] WHO, 2023a.
[106] WHO, 2023a.
[107] WHO, 2023a.

2.6 Anti-D prophylaxis

Anti-D immunoglobulin is offered to all Rh-negative persons from 20 weeks of pregnancy, during the process of an induced abortion or within 72 hours of an induced abortion, at a dose of 300 mcg administered intramuscularly[108].

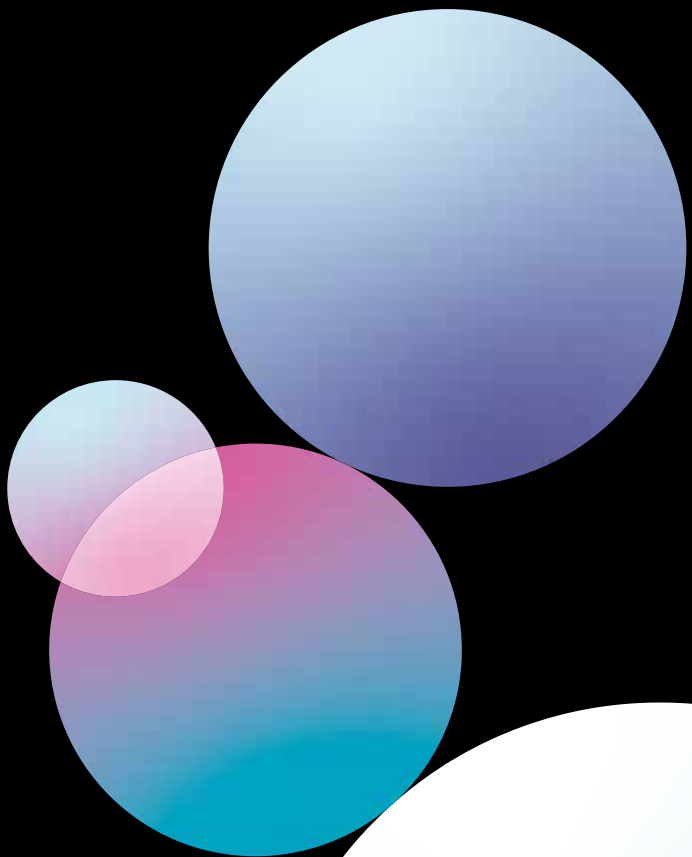
2.6 Good practice guidance

- Anti-D immunoglobulin is offered to all Rh-negative persons from 20 weeks of pregnancy, during the process of an induced abortion or within 72 hours of an induced abortion, at a dose of 300 mcg administered intramuscularly.



[108] Qureshi, H., Massey, E., Kirwan, D., Davies, T., Robson, S., White, J., Jones, J., Allard, S. y British Society for Haematology (2014). BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. *Transfusion medicine (Oxford, England), 24*(1), pp. 8-20. https://pubmed.ncbi.nlm.nih.gov/25121158/

3. Care after expulsion of products of pregnancy



3.1 Lactation inhibition

More than 90% of persons will experience breast symptoms, such as engorgement and breast pain, following an induced abortion from 20 weeks[109]. **For lactation inhibition after an induced abortion (whether medication or procedural), a single oral dose of 1 mg of cabergoline is recommended**[110]. When cabergoline is not available, mechanical methods - such as breast bandage or tight-fitting bras and cold compresses - may be offered[111].

3.1 Good practice guidance

- Lactation inhibition with a single oral dose of 1 mg of cabergoline is indicated after an induced abortion from 20 weeks of pregnancy.
- When cabergoline is not available, mechanical methods for lactation inhibition may be offered.

[109] Henkel, A., Reeves, M. F. y Shaw, K. A. (2024). The experience of breast symptoms after second-trimester abortion or pregnancy loss. *American journal of obstetrics and gynecology, 230*(3), pp. e3-e5. https://doi.org/10.1016/j.ajog.2023.10.025

110 Henkel, A., Johnson, S. A., Reeves, M. F., Cahill, E. P., Blumenthal, P. D. y Shaw, K. A. (2023). Cabergoline for Lactation Inhibition After Second-Trimester Abortion or Pregnancy Loss: A Randomized Controlled Trial. *Obstetrics and gynecology, 141*(6), pp. 1115-1123. https://doi.org/10.1097/AOG.0000000000005190
Cabergoline should be used with caution in persons with hypertension or preeclampsia, since it may increase levels of blood pressure and is associated with intracranial hemorrhage.

[111] WHO, 2023a.
Clinical trials indicate that pharmacological methods are superior to mechanical methods to inhibit lactation. However, mechanical methods may be offered when cabergoline is unavailable.
Oladapo, O. T. y Fawole, B. (2012). Treatments for suppression of lactation. *The Cochrane database of systematic reviews, 2012*(9). https://www.cochrane.org/CD005937/PREG_treatments-for-suppression-of-lactation
Bromocriptine should be avoided for lactation inhibition because, besides its low adherence posology (14 days), its severe side effects (myocardial infarction and cerebrovascular disease) have contraindicated its use for this purpose.
Bernard, N., Jantzem, H., Becker, M., Pecriaux, C., Bénard-Laribière, A., Montastruc, J. L., Descotes, J., Vial, T. y French Network of Regional Pharmacovigilance Centres (2015). Severe adverse effects of bromocriptine in lactation inhibition: a pharmacovigilance survey. *BJOG: an international journal of obstetrics and gynaecology, 122*(9), pp. 1244-1251. https://pubmed.ncbi.nlm.nih.gov/25761676/

3.2 Contraceptive counseling

3.2.1 Which contraceptive methods to offer?

If the person who had an abortion wishes to initiate contraception, the healthcare team should offer all eligible methods and provide counseling on their use, risks, benefits, and failure rates (*Table 5*).

Table 5.

Rates of unintended pregnancy during the first year of use of each contraceptive method

Contraceptive method	Pregnancy rate per 1000 persons
Implants	1
Female sterilization	5
Levonorgestrel IUD	7
Copper-bearing IUD	8
Monthly injectable	30
Progestin-only injectable	40
Combined oral contraceptives	70
Progestin-only pills	70
Combined patch	70
Combined vaginal ring	70

IUD: intrauterine device
Source: WHO, 2022b

3.2.1 Good practice guidance

- If the person who had an abortion wishes to initiate contraception, the healthcare team should offer all eligible methods and provide counseling on their use, risks, benefits, and failure rates.

3.2.2 When to initiate contraception?

If contraception is desired, any contraceptive method can be offered to the person for immediate initiation after the abortion, according to its medical eligibility criteria[112].

If hormonal methods are chosen (oral pills, injectables, ring, patch, or implant), contraception can be started on the same day of the D&E procedure or of the first dose of mifepristone or misoprostol in medication abortion[113].

For those opting for an intrauterine device (IUD), insertion can be performed immediately after the D&E procedure or at the time of the medication abortion is determined successful[114]. However, in cases of post-abortion hemorrhage or infection, IUD insertion should be postponed[115].

3.2.2 Good practice guidance

- For hormonal methods (oral pills, injectables, vaginal ring, patch, or implant), contraception may be initiated on the same day as the D&E procedure.
- Hormonal methods may be initiated on the same of the first dose of mifepristone or misoprostol in medication abortion, except for the vaginal ring, which is inserted after expulsion of products of pregnancy (experts' opinion).
- For the intrauterine device (IUD), insertion may be performed immediately after the D&E procedure or at the time of the medication abortion is determined successful, except in cases of post-abortion hemorrhage or infection.

[112] WHO, 2015.
WHO, 2022b.
Zwerling et al., 2023.
[113] WHO, 2022b.
[114] WHO, 2022a.
[115] WHO, 2022b.
Zwerling et al., 2023.

3.3 Before discharge

Discharge may be considered after an observation period of 2 to 12 hours if the person meets the following criteria: ambulatory, stable blood pressure and pulse, and controlled vaginal bleeding and pain[116].

Upon discharge, the person should receive instructions on the warning signs that require immediate return to a healthcare facility[117]:

- increased cramping or abdominal pain,
- excessive vaginal bleeding (more than two soaked maxi pads per hour for two consecutive hours), and
- fever.

It is also important to provide verbal and written information about expected post-abortion symptoms[118]:

- vaginal bleeding tends to be heavier with medication abortion and may last an average of 10 days (in rare cases, up to 45 days);
- sexual activity may be resumed once the heavier bleeding has stopped or when the person feels ready.

3.3 Good practice guidance

- Discharge may be considered after an observation period of 2 to 12 hours if the person meets the following criteria: ambulatory, stable blood pressure and pulse, and controlled vaginal bleeding and pain.
- Healthcare professionals should provide verbal and written instructions upon discharge.
- The following are warning signs that require immediate return to a healthcare facility: increased cramping or abdominal pain, heavy vaginal bleeding such as soaking more than two pads (or equivalent) per hour for two consecutive hours, and fever.
- Before discharge, counseling should also include what to expect in the coming weeks: vaginal bleeding may persist for up to two weeks, and sexual activity may be resumed once heavy bleeding stops or whenever the person feels ready.

[116] WHO, 2023a.
[117] WHO, 2022a.
[118] WHO, 2023a.
NICE and RCOG, 2019.

3.4 Follow-up

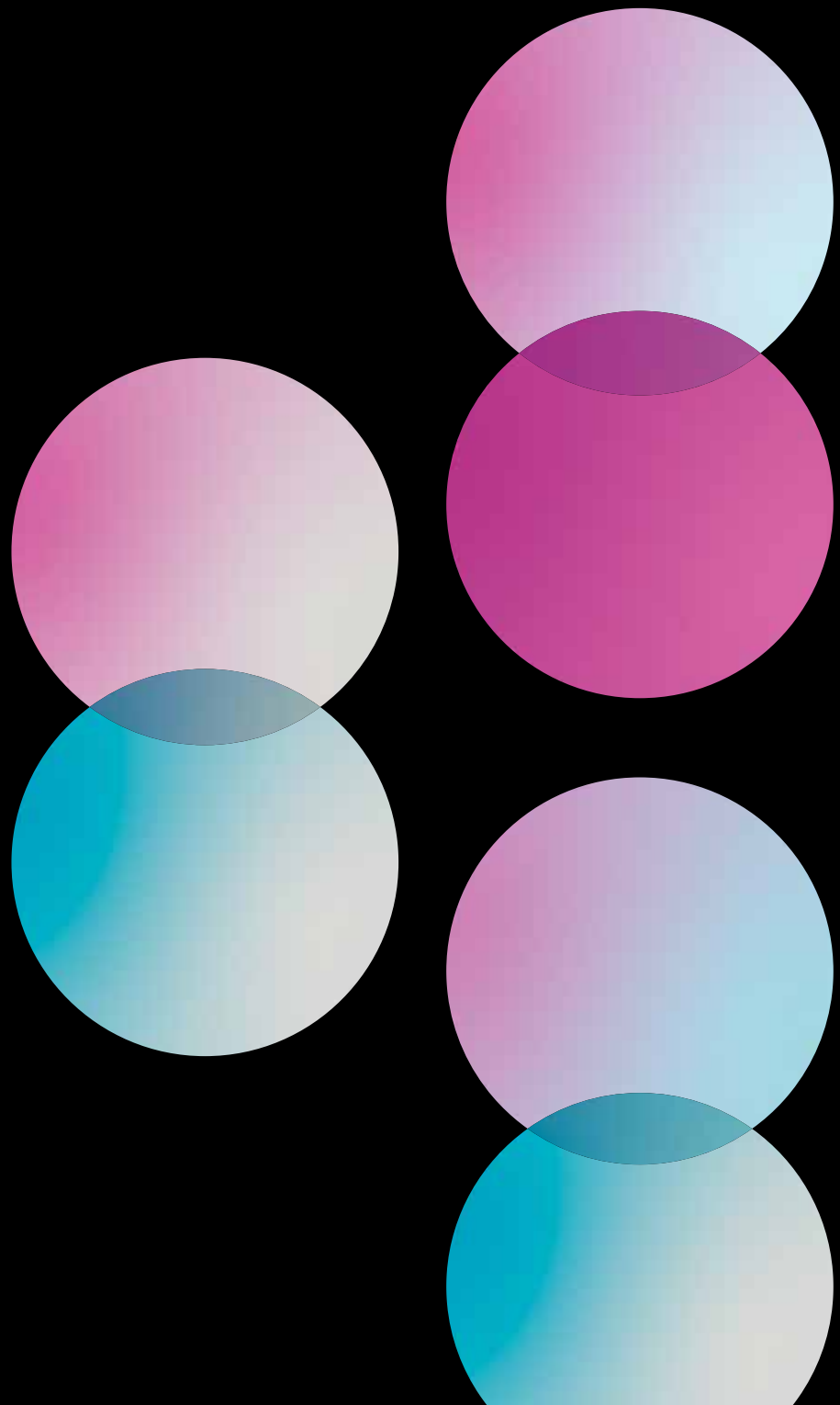
Although there is no evidence supporting the need for routine follow-up after an uncomplicated abortion, **a follow-up consultation - either in person or via telemedicine - may be offered 7 to 14 days after treatment** to provide contraceptive services, emotional support, and to address any concerns the person may have during that period[119].

3.4 Good practice guidance

- A follow-up consultation - either in person or via telemedicine - may be offered 7 to 14 days after treatment to provide contraceptive services, emotional support, and to address any concerns the person may have during that period.

[119] WHO, 2023a.

4. Management of abortion complications



4.1 Post-abortion hemorrhage

All individuals seeking abortion services should be screened for risk factors for post-abortion hemorrhage. This includes a review of past obstetric complications - particularly hemorrhage - history of two or more cesarean sections, presence of a bleeding disorder, diagnosis of fetal demise, obesity, advanced maternal age, and placenta previa or accreta[120].

Healthcare professionals may consider preventive and preparedness measures to manage potential bleeding, including pre-abortion hemoglobin and hematocrit assessment, use of ultrasound during D&E, ensuring ready availability of uterotonic medications, preparing for potential blood transfusion, or referral to a higher-level facility, although evidence to guide these practices is limited[121].

Other preventive measures include prophylactic oxytocin administration after fetal expulsion in medication abortion (10 IU intramuscularly), or during D&E (30 IU in 500 mL of normal saline)[122], paracervical block with lidocaine plus epinephrine or 4 IU of vasopressin during D&E[123].

When post-abortion hemorrhage is suspected, it must be evaluated and managed promptly and systematically. Initial evaluation includes bimanual examination to assess for uterine atony, inspection of the cervix for lacerations, repeat aspiration or ultrasound examination to detect retained pregnancy tissues or hematometra[124].

Cervical lacerations may be treated with direct pressure using gauze or sponge forceps, topical hemostatic agents (e.g., silver nitrate or ferric sulfate solution), or absorbable sutures[125].

Uterine atony requires a rapid, stepwise approach, beginning with uterine massage, followed by uterotonic medications, (re)aspiration, uterine tamponade, and surgical interventions, if needed. The healthcare team should advance quickly to the next step if bleeding is not controlled. When uterotonics are used, additional or repeated doses may be administered if bleeding persists after the initial dose (*Table 6*)[126].

[120] Kerns et al., 2024.
[121] Kerns et al., 2024.
[122] Whitehouse et al., 2019.
[123] Kerns et al., 2024.
[124] Kerns et al., 2024.
[125] Kerns et al., 2024.
[126] Kerns et al., 2024..

Tabl6 6.

Management of post-abortion hemorrhage according to etiology[127]

Etiology	Relative frequency*	Treatment[128]
Uterine atony	50%	Uterine massage. Tranexamic acid 1 g intravenously[129]. Uterotonics (oxytocin 10-40 IV intravenously, methylergonovine maleate 0.2 mg por intramuscularly, misoprostol 800-1000 mcg sublingually). Uterine tamponade with Bakri or Foley balloon. Blood transfusion.
Retained pregnancy tissue	28%	Uterine (re)aspiration with MVA or electric aspiration. Tranexamic acid 1 g intravenously[130].
Cervical or vaginal laceration	10%	Direct pressure with gaze or sponge. Application of topic coagulant agents (such as silver nitrate or ferric subsulfate). Tranexamic acid 1 g intravenously[131]. Surgical repair with absorbable sutures.
Uterine perforation or rupture	7%	Laparoscopy (preferred) or laparotomy (preferred if hemodynamic instability). Tranexamic acid 1 g intravenously[132].
Coagulopathy	5%	Transfusion of coagulation factors (fibrinogen, red blood cells, fresh frozen plasma, cryoprecipitate, platelets). Tranexamic acid 1 g intravenously[133].

* of the total number of cases of post-abortion hemorrhage (approximate frequency)

[127] American College of Obstetricians and Gynecologists (ACOG) (2013). Practice Bulletin Nº 135: Second-trimester abortion. *Obstetrics and gynecology, 121*(6), pp. 1394-1406. https://doi.org/10.1097/01.AOG.0000431056.79334.cc

[128] WHO, 2023a.

[129] WHO (2017). *WHO recommendation on tranexamic acid for the treatment of postpartum haemorrhage*. https://www.ncbi.nlm.nih.gov/books/NBK493081/pdf/Bookshelf_NBK493081.pdf

[130] WHO, 2017.

[131] WHO, 2017.

[132] WHO, 2017.

[133] WHO, 2017.

When bleeding persists despite confirmation of complete uterine evacuation and there are no visible lacerations, other complications such as uterine perforation, coagulopathies or placenta accreta should be considered, If coagulopathies are suspected - such as in cases of disseminated intravascular coagulation (DIC) - transfusion of blood products may be necessary. Surgical interventions, including hysterectomy, uterine compression sutures, uterine artery ligation, or uterine artery embolization, may be required to manage severe hemorrhage that cannot be controlled by other means[134].

A diagnosis of post-abortion hemorrhage demands placement of an intravenous (IV) line, supplemental oxygen, fluid resuscitation, and transfusion of blood products, as clinically indicated[135].

4.1 Good practice guidance

- Prophylactic oxytocin - 10 IU intramuscularly after fetal expulsion in medication abortion, or 30 IU in 500 mL of normal saline during D&E - and paracervical block with lidocaine plus epinephrine or vasopressin during D&E can help prevent post-abortion hemorrhage.
- Upon suspicion of post-abortion hemorrhage, the following assessments are indicated: bimanual examination to assess for uterine atony, cervical inspection to detect lacerations, repeat uterine aspiration, or ultrasound examination to identify retained pregnancy tissue or hematometra.
- Management of post-abortion hemorrhage depends on the underlying cause of bleeding, which may include uterine atony, retained tissue, cervical or vaginal laceration, uterine perforation or rupture, or coagulopathies.
- Intravenous administration of 1 g of tranexamic acid is indicated in all cases of post-abortion hemorrhage, regardless of the cause.
- A diagnosis of post-abortion hemorrhage demands: placement of an intravenous (IV) line, supplemental oxygen, fluid resuscitation, and transfusion of blood products, as clinically indicated.

4.2 Uterine perforation or rupture

Uterine perforation should be suspected when there is a sudden loss of resistance during cervical dilation, allowing an instrument to pass beyond the expected length of the uterus. In many cases, **perforation occurring during cervical dilation can be managed expectantly, with observation for any changes in the person's clinical condition**.

Uterine perforation may also occur during uterine evacuation. **If perforation occurs while using sharp forceps** (e.g., Bierer forceps) **during D&E, laparoscopy** (or laparotomy if laparoscopy is unavailable) **is recommended** to evaluate and repair potential injuries to other organs[136].

[134] Kerns et al., 2024.
[135] Kerns et al., 2024.
[136] WHO, 2023a.

The following measures can reduce the risk of uterine perforation during D&E[137]:

- Perform a bimanual examination before beginning the procedure.Ensure adequate cervical dilation;
- Dilate gently, never using force.
- Avoid reaching the uterine fundus during the procedure.Whenever possible, perform ultrasound-guided uterine evacuation.

Uterine rupture during medication abortion requires surgical intervention for both diagnosis and treatment[138].

4.2 Good practice guidance

- In most cases, uterine perforation during cervical dilation can be managed expectantly.
- When perforation occurs during the use of sharp forceps in dilation and evacuation (D&E), laparoscopy is indicated to investigate and repair possible injuries to other organs.
- Measures that can help reduce the risk of uterine perforation during D&E include performing a bimanual examination before beginning the procedure, avoiding contact with the uterine fundus, and using ultrasound guidance during the procedure whenever possible.
- Uterine rupture during medication abortion requires surgical intervention for both diagnosis and treatment.

4.3 Post-abortion infection

Post-abortion infection may occur in up to 4% of abortions after 20 weeks[139]. The following signs and symptoms are suggestive of post-abortion infection: fever or chills more than 24 hours after the last dose of misoprostol, foul-smelling vaginal or cervical discharge, abdominal or pelvic pain more than 24 hours after the last dose of misoprostol, uterine tenderness on palpation[140].

Upon suspicion of post-abortion infection, evaluation to rule out retained tissue is necessary. If retained tissue is identified, (re)evacuation of the uterus by aspiration is indicated. In **hemodynamically unstable patients**, **surgical evacuation** should not be delayed while awaiting the full course of antimicrobial therapy[141].

[137] WHO, 2023a.
[138] WHO, 2023a.
[139] ACOG, 2013.
[140] ACOG, 2013.
[141] WHO, 2023a.

The antimicrobial treatment regimen depends on the severity of the clinical presentation. Most cases of typical endometritis can be managed on an outpatient basis. Inpatient treatment should be reserved for severe cases, such as those presenting with tachycardia, hypotension, respiratory distress, jaundice, reduced urine output, or altered mental status (*Table 7*)[142].

Table 7.

Suggested antimicrobial treatment regimens for post-abortion infection[143]

Regimen	Doses and route of administration	Treatment setting
Ceftriaxone + doxycycline with or without metronidazole	single-dose 250 mg ceftriaxone (IM) + 100 mg doxycycline (PO) twice a day for 14 days, with or without 500 mg metronidazole (PO) twice a day for 14 days	outpatient
Clindamycin + gentamicin	900 mg clindamycin (IV) every 8 hours + 2 mg/kg gentamicin (IV) (initial dose) and after 1.5 mg/kg every 8 hours or 3-5 mg/kg gentamicin (IV) once a day	inpatient
Cefoxitin + doxycycline	2 g cefoxitin (IV) every 6 hours + 100 mg doxycycline (IV or PO) every 12 hours	inpatient

Adapted from: Harris and Grossman, 2020[144]

IV: intravenously; PO: orally

4.3 Good practice guidance

- Upon suspicion of post-abortion infection, evaluation to assess for retained pregnancy tissue is necessary.
- (Re)evacuation of the uterus by aspiration is indicated when retained tissue is diagnosed and should not be delayed until completion of antimicrobial therapy in clinically unstable patients.
- Most cases of typical endometritis can be managed on an outpatient basis with ceftriaxone plus doxycycline, with or without metronidazole.

[142] WHO, 2023a.

[143] Antimicrobial treatment may be adjusted in accordance with local protocols.

[144] Harris, L. H. y Grossman, D. (2020). Complications of Unsafe and Self-Managed Abortion. *The New England journal of medicine, 382*(11), pp. 1029-1040. https://doi.org/10.1056/NEJMra1908412

Annexes

Annex I

Guidelines for adapting the informed consent form for induced abortion from 20 weeks

The informed consent form for abortions performed from 20 weeks must include, at a minimum, the following four sections. It may also be supplemented with annexes that provide detailed clinical information and outline the care pathway. These supplementary materials allow individuals requesting abortion services to review the information again or share it with trusted persons, depending on local context and cultural norms.

SECTION 1: Identification of the requesting individual

This section must include unambiguous identifying information, ensuring that the person providing consent is the same individual requesting the procedure and authorizing it under the terms outlined in the document.

SECTION 2: Declaration of the decision to undergo an induced abortion

This section must clearly state, in the first person, the individual's decision to undergo an induced abortion. It should also affirm that the decision was made after receiving appropriate information and with the support of the healthcare team and, if applicable, with the assistance of trusted individuals.

SECTION 3: Right to revoke consent

The form must include confirmation that the individual has been informed of their right to revoke consent at any time prior to the point at which the procedure becomes irreversible. Where feasible, a designated space should be provided for documenting the revocation of consent. In all cases, the date and circumstances of revocation - as well as any subsequent actions taken - must be recorded in the clinical record.

SECTION 4: Signatures

The informed consent form must include the signature (or other legally acceptable mark) of the individual requesting treatment. In addition, it must be signed by a member of the healthcare team who has supported the decision-making process by providing information, responding to questions, and discussing care options. When requested by the individual or required by local regulations, the document may also include the signature(s) of persons who provided support or assistance during the decision-making process - such as in the case of minors or individuals with disabilities.

If deemed appropriate, the form may also include information about prior healthcare encounters, to verify compliance with timeframes and other legal or quality-of-care requirements as established by the healthcare facility or jurisdiction.

Example 1

Through this document, I, _____, holder of identification document type _____ No. _____, hereby affirm my free, conscious, and informed decision to request and undergo an induced abortion.

I declare that I have received information about the procedures that will be carried out during the induced abortion, including the potential health risks, as well as the types of support and follow-up care that will be provided by the healthcare team responsible.

I have been informed about the different stages of the induced abortion process, including the induction of fetal asystole procedure as the initial step, and the available techniques for pregnancy expulsion that follow. The benefits, risks, and specificities of each have been clearly explained to me, and I have had the opportunity to ask any questions or raise concerns. I have selected the option I consider most appropriate based on the information received, which is documented in a written annex that has been provided to me.

Based on the information provided, I have chosen the following initial method for the induced abortion:

( ) Medication abortion
( ) Dilation and Evacuation (D&E)

I further declare that I have been sufficiently informed of my right to revoke this consent at any time prior to the initiation of the induction of fetal asystole procedure, after which the procedure becomes irreversible, and the healthcare team is no longer able to suspend the process.

Accordingly, I affirm my free and informed decision to terminate the pregnancy under the terms described in this document.

City:

Date of signature of informed consent (DD/MM/YYYY):

Date of first consultation at this facility (DD/MM/YYYY):

Notes on care (complete only if applicable):

Individual Requesting the Procedure	**Healthcare Professional**
_____	_____
Signature Full name	Signature Full name Professional title and role Professional license number

Individual who provided support during the informed consent process (if applicable)

_____
Signature
Full name
Role in the decision-making process

Example 2

I, _____, holder of identification document type _____ No. _____, and residing in the city of _____, [country] _____, hereby declaring my decision to exercise my right to an induced abortion freely, consciously, and informed.

I confirm that I have received clear, accurate, and appropriate information in a manner that I can understand regarding the following:

- The various methods available to abort from 20 weeks of pregnancy.
- The way each of the techniques necessary to complete the procedure works, including their effects and characteristics, benefits, disadvantages, and risks.
- My rights to receive dignified treatment and quality care, to access information, to exercise autonomy over my decisions, and to privacy and confidentiality.

I have understood the information provided and have had the opportunity to ask questions, all of which have been addressed. I understand that I may ask additional questions at any time, even after signing this consent.

I have had the opportunity to consult with individuals I trust in making my decision, without experiencing undue pressure. I understand that these individuals may also accompany me during the procedure if I request it and when feasible.

The verbal information I have received is also provided in written form in an informational leaflet that has been given to me at this time.

I understand that I may change my decision at any point before the procedure begins, even after signing this consent. I have also been informed of the possible consequences of such a decision.

Accordingly, I freely consent to proceed to an induced abortion by the following method:

( ) Medication abortion
( ) Dilation and Evacuation (D&E)

Date of first consultation at this healthcare facility:
Day _____, Month _____, Year _____

Notes on care (complete only if applicable):

Individual Requesting the Procedure	**Health professional**
_____	_____
Signature	Signature
Printed name (first and last name):	Printed name (first and last name)
Date: Day _____, Month _____, Year _____	Date: Day _____, Month _____, Year _____

Certification of presence of emotional support person or legal representative for a minor or adolescent

_____
Signature

Printed name (first and last name)
Type and number of identification document
Relationship to the individual requesting the procedure
Date: Day ____, Month _____, Year _____

Certification of support in the informed consent process for a person with a disability

_____
Signature

Printed name (first and last name)
Type and number of identification document
Relationship to the individual requesting the procedure
Date: Day ____, Month _____, Year _____

Annexes

Annex II

Suggested written sheet to support the informed consent process

INDUCTION OF FETAL ASYSTOLE
Initial phase of the induced abortion process

The first phase of an induced abortion from 20 weeks of pregnancy is the induction of fetal asystole (IFA). IFA involves the administration of an abdominal injection into the uterus, guided by abdominal ultrasound, using potassium chloride, lidocaine, or digoxin to induce the cessation of fetal cardiac activity.

This procedure is recommended by specialist societies and the World Health Organization (WHO) as part of quality abortion care from 20 weeks of pregnancy.

The injection is typically administered under ultrasound guidance, takes approximately 10 to 15 minutes, and is considered a standard of care in abortions from 20 weeks to prevent fetal survival and to increase the safety and efficacy of the subsequent phases of the abortion process.

Fetal asystole marks an irreversible point in the abortion process. Once the injection is administered, the effect of the medication causes fetal cardiac activity to cease, and the process cannot be halted. Cessation of fetal cardiac activity may occur immediately or up to 48 hours post-injection, without requiring any further intervention by healthcare staff or the individual undergoing the procedure.

Risks associated with IFA are minimal and include injection-related pain (most common), localized infection at the injection site, cardiac arrhythmia. Severe cardiac events are extremely rare, occurring in fewer than 8 per 100,000 procedures.

Following the injection, healthcare providers will monitor and confirm the absence of fetal cardiac activity before proceeding with the next phase. If cardiac activity persists after 48 hours, the injection may need to be repeated. This does not pose additional risks beyond those already mentioned.

Uterine Evacuation: second phase of the induced abortion process

There are two methods for uterine evacuation after 20 weeks of pregnancy:

1. Dilation and Evacuation (D&E):

D&E involves the use of plastic cannulas to aspirate the contents of the uterus and forceps to assist with extraction through the vaginal canal.

Prior to the procedure, cervical dilation is achieved using medications or osmotic dilators placed in the cervix through the vagina the day before the procedure. Mifepristone may also be administered at the time of IFA to ease subsequent instrumentation.

The procedure is typically performed under ultrasound guidance to ensure complete evacuation and reduce the risk of complications.

D&E is conducted in a surgical suite or an appropriately equipped room under regional, general, or intravenous anesthesia, with the possible addition of analgesics or sedatives for pain management.

2. Medication induction

Medication induction involves using medications to induce uterine contractions and expel the pregnancy. It typically starts with mifepristone on the day of induction of fetal asystole, followed one or two days later by misoprostol, administered vaginally or sublingually, which stimulates contractions.

This method may take several hours and, in rare cases, more than one day.

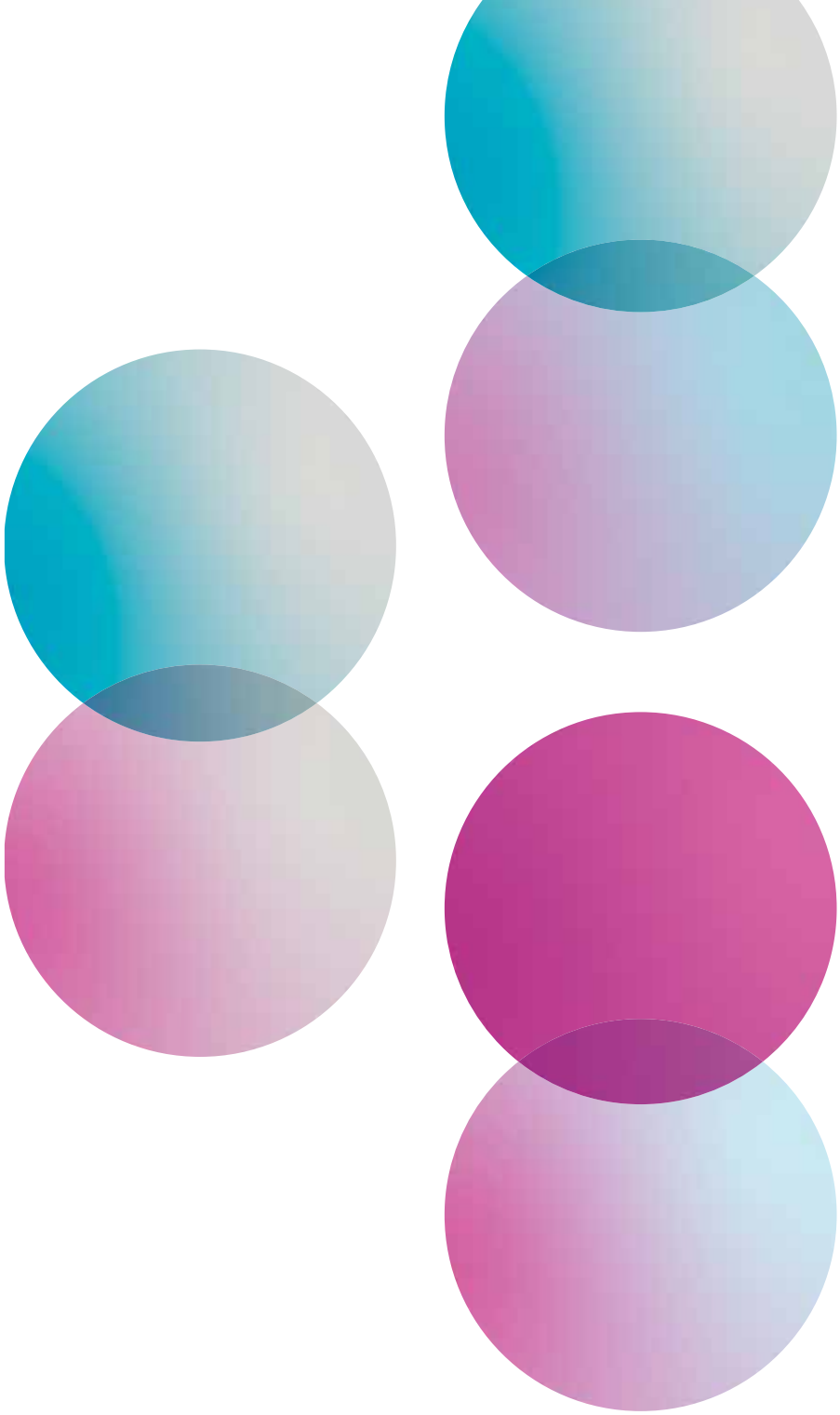
No surgical instruments are required for this method; however, inpatient monitoring is necessary throughout the process. In some cases, surgical aspiration with plastic cannulas may be required if the uterus is not completely evacuated.

Expected effects and common side effects of medical induction include cramping or pain, heavier-than-menstrual bleeding, fever, which may be related to misoprostol use and not necessarily infection

Risks associated with induced abortion methods

COMMON (up to 1 in 100 procedures): cervical injury, infection (risk reduced with prophylactic antibiotics)

UNCOMMON: hemorrhage (1 to 4 per 1,000), uterine perforation** (1 per 1,000), uterine rupture** (3 per 1,000 – more common in individuals with prior uterine surgery)



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