EXECUTIVE SUMMARY

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

SERIES **Times of abortion**

Document Nº 5

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CONSORCIO LATINOAMERICANO CONTRA EL ABORTO INSEGURO

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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.

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

Good practice guidance (GPg): Recommendation elaborated to assist the healthcare 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.

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.

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

Medication abortion: Induced abortion using pharmacological agents.

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

Products of pregnancy: Refers to the fetus and placenta.

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).

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; 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.

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.

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.

Scope and objectives

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.

Section 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?

- 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?

- 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?

- 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 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).

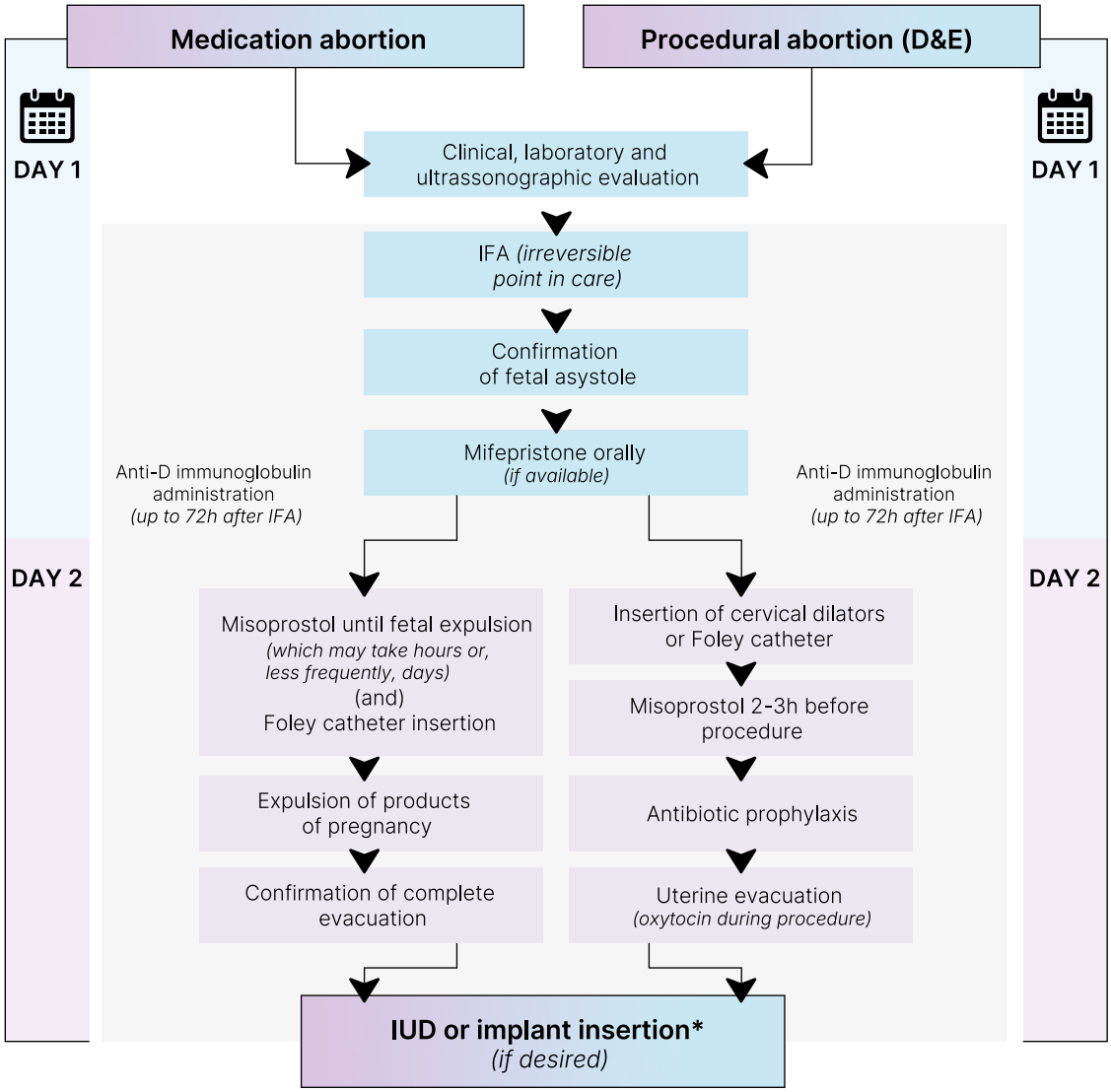
1.1.5: Who provides accompaniment?

- 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?

- During counseling, it is important to emphasize that induction of fetal asystole (IFA) is a necessary step from 20 weeks of pregnancy to prevent fetal survival. 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. (See *Table 1* in Annexes)
- Beyond 25 weeks, medication abortion is the only option to be offered.

Figure 1



** Implants may be inserted on day 1*

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

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.

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.

1.2.2.1 **Considerations regarding the consent process**	1.2.2.2 **Considerations regarding documentation**
• 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.	• 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.

*****Samples of documents and guidelines for adapting the informed consent form for induced abortion from 20 weeks are provided in the Annexes section.*****

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.

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

- 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

- 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)

2.1.1: When should induction of fetal asystole (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 of the newborn.

2.1.2: Medications and techniques (see Table 2 in Annexes)

- Intracardiac potassium chloride (4-6 mEq) or 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

- 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)

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 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

- 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.

***** For more information on medication abortion and D&E, see Table 3 in Annexes.*****

2.4 Pain management

- 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 medication 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.

***** For more information on non-pharmacological and pharmacological pain management, see Tables 4, 4.1 and 4.2 *****

2.5 Confirmation of complete evacuation

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.

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.

2.6 Anti-D prophylaxis

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

Section 3: Care after expulsion of products of pregnancy

3.1 Lactation inhibition

- 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

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.

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

- 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

- 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: Management of abortion complications

4.1 Post-abortion hemorrhage

- 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. (*Table 5*)

- 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. (*Table 5*)

4.2 Uterine perforation or rupture

- 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

- 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 (*Table 6*).

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Annexes

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

Table 2.

Medications and techniques used for IFA

Medication	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)[1]	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)[2]	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

Source: WHO (2023)

[1] 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%.

[2] 298% 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.

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		
Mifepristone + 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]			

Source: prepared by authors

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

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[3]; provision of a private space, not shared with individuals in labor		
Oral analgesia	800 mg ibuprofen (PO) + 30 mg codeine (PO) or 10 mg morphine (PO)		
Oral analgesia			
Paracervical block	lidocaine 0.5%-1.0% or bupivacaine 0.25%[5]		
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†	
Regional block		0.1-0.2 mg/kg morphine (IV) + 50-100 mcg fentanyl (IV) (*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

[3]† 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[4].

[3] WHO, 2023a.

[4] Jackson and Kapp, 2020.

Table 4.1.

Moderate sedation medicines

	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

	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

Table 5.

Management of post-abortion hemorrhage according to etiology

Etiology	Relative frequency*	Treatment
Uterine atony	50%	Uterine massage. Tranexamic acid 1 g intravenously. 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.
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. Surgical repair with absorbable sutures.
Uterine perforation or rupture	7%	Laparoscopy (preferred) or laparotomy (preferred if hemodynamic instability). Tranexamic acid 1 g intravenously.
Coagulopathy	5%	Transfusion of coagulation factors (fibrinogen, red blood cells, fresh frozen plasma, cryoprecipitate, platelets). Tranexamic acid 1 g intravenously.

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

Table 6.

Suggested antimicrobial treatment regimens for post-abortion infection

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
IV: intravenously; PO: orally

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 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.

Annex I

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

_____
Signature
Full name

Healthcare Professional

_____
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 medication 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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