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May 2, 2000

ADMINISTRATIVE ORDER
No. 45-B s. 2000

SUBJECT: Prevention and Management of Abortion and Its Complications (PMAC) Policy

I. Background/Rationale

The Philippine Reproductive Health (RH) Program, created through Adm. Order 1-A s, 1998 has ten elements, one of which is the Prevention and Management of Abortion and its Complications (PMAC). This element aims to address the health and medical care needs of the many Filipino women who have had abortion, regardless of cause. Statistical reports show that among DOH-retained hospitals, abortion and its complications has been consistently the number 3 leading cause of hospital discharge during the five-year period of 1994-1998. A University of the Philippines Population Institute (UPPI) study conducted in 1994 shows that some 300,000 to 500,000 induced abortions are done clandestinely a year, given that abortion is illegal in the country. This roughly translates to some 46 induced abortions done every hour in the country. Of the women who have induced abortions, one in every five women ends up being hospitalized due to complications. Women who have spontaneous abortion can also develop complications and end up being hospitalized. The problem of abortion and its complications thus exacts a heavy toll on the already limited health system resources and also on the general health and wellbeing of the woman, her family and the society as a whole.

The existing health services available for women who have had abortion are limited to the medical treatment of the abortion complications. These services do not include counseling and referrals to other available RH services, both of which are components of quality PMAC. A study conducted by the DOH-UNFPA in 1999 showed that there are no policies and guidelines on PMAC and that women who had induced abortion are discriminated against when they are hospitalized.

The PMAC element of the RH Theme is hereby established with the end view that women who have abortion are given quality and humane post-abortion care services by competent, compassionate, objective and non-judgmental service providers in a well-equipped institution, complemented by a supportive environment. In addition, women with threatened abortion are also given care to prevent them from progressing into a complete abortion. Likewise, preventive measures established will ensure that future pregnancies are properly timed, thereby excluding abortion.

II. Goal

To improve the quality of health care services for the prevention and management of abortion and its complications in the Philippines.

Signed A.O Received in
the Records Section on 7/5/00

Sa Sentrong Sigla Health Ang Una!

III. Objectives

To strengthen the capability of the country's health care system in the prevention and management of abortion and its complications.

To improve the accessibility of quality post-abortion care services to all women of reproductive age in the country.

IV. Coverage/Scope

For the first year of implementation, PMAC shall initially be implemented in four (4) pilot hospital sites, including two DOH-retained hospitals, one LGU hospital and one private hospital. By the end of the fifth year of implementation (end of 2004), 50 DOH-retained hospitals shall be providing quality PMAC services.

The activities to be implemented include the following:

a. Training of Service Providers on the prevention and management of abortion and its complications, including counselling

b. Upgrading of health facilities in terms of minor renovations and provision of needed equipment and instruments

c. Strengthening of linkages of appropriate services within the hospital facility with the aim of providing a holistic approach to quality care for PMAC

d. Establishment of an effective referral system to link the community with the appropriate health care facilities for PMAC service

e. Ensuring the availability of necessary supplies and drugs

f. Provision of PMAC services in the health facilities

V. Guidelines and Procedures

PMAC should provide comprehensive preventive and medical health care services. This should include the following three key elements:

1. Prevention and treatment of abortion and its complications;
2. Counseling
3. Linkages between PMAC and other RH services

1. Prevention and Treatment of abortion and its complications

Each level of the health care delivery system should provide services for the prevention and treatment of abortion and its complications.

The prevention of abortion is a major component of this element of the PMAC program. Abortions may be prevented if high-risk pregnancies are recognized early and this shall be done through early prenatal care. Patient education during prenatal care shall include information on the dangers of vaginal bleeding during pregnancy, its possible causes, and what the patient should do if she has vaginal bleeding while

pregnant. If a woman is identified in the prenatal visit to be a high-risk gravida, she should identify possible blood donors and their contact numbers/addresses. This is to ensure that blood is readily available should the need for blood transfusion arises. For all sites where PMAC will be implemented, coordination with the voluntary blood donation program will be done.

Proper infection prevention measures shall be adhered to strictly by the service providers and instituted in the facilities where treatment of abortion patients takes place. This will preclude the occurrence of iatrogenic infections among abortion patients.

While treatment of abortion complications often is offered at secondary and tertiary care centers in urban areas, poor transportation system in many areas place centralized services out of reach of most poor, rural women. These gaps in services make even spontaneous abortion life-threatening in many instances. Increasing the availability of PMAC services throughout the health system requires decentralizing treatment services and improving the quality and range of care at every level. These steps shall be backed up by establishing standardized protocols for service delivery and comprehensive, systematic training.

Management for abortion complications shall include:

- An initial assessment to confirm the presence of complications
- Medical evaluation (brief history, limited physical and pelvic examinations)
- Talking with the patient regarding her medical condition and the treatment plan
- Prompt referral and transfer if the patient requires treatment beyond the capability of the facility where initial assessment/evaluation was conducted
- Stabilization of emergency conditions and treatment of any complications (both complications present before treatment and complications that occur during or after the treatment procedure)
- Conduct of appropriate procedures, specifically uterine evacuation to remove products of conception(POC)
- Health education

The efficient prevention and management of abortion complications is dependent on care being integrated throughout the health care system, from the first point of contact to the most sophisticated tertiary level hospital. Whether it is health information, medical assessment, stabilized care for the referral, uterine evacuation or specialized care for the most serious complications, at least some components of PMAC should be available at every service delivery site in the health care system (Table 1). Table 2 summarizes the key steps for the management of abortion and its complications.

The abortion patient's family and the community have an important role in providing support to the abortion patient. IEC shall be undertaken to make community members aware of the health risks and complications of abortion, and what to do to help women who have an abortion or abortion complications access the health services they need. They shall also be made aware that patients who induced their abortion should be assisted in obtaining family planning counseling and services that allow them to avoid unintended pregnancy and consequently, abortion.

2. Counseling

Abortion patients have varied needs and concerns that can be addressed through counseling. Health service providers shall thus be trained on counseling to enable them to use communication and counseling skills to perform tasks such as the following:

1. Assess and acknowledge the abortion patient's needs and concerns;
2. Answer the patient's questions and give her information about her condition, treatment procedures to be done, what to expect during her stay in the health facility, post-procedure care and warning signs she has to look out for; and
3. Help the patient make decisions about family planning, sexually transmitted diseases (STD) prevention, and other reproductive health services.

Counseling in the context of post-abortion care shall be provided for the patient *before, during and after* the procedure for definitive treatment, which is uterine evacuation by the appropriate method. For the woman who has a threatened abortion, counseling shall focus on answering the informational needs of the patient such as questions regarding progression of her condition to a completed abortion and future fertility, and addressing emotional concerns.

Counseling includes addressing the emotional concerns such as grief, fear, anger, guilt, depression and other emotional issues that a woman who had an abortion, or is having a threatened abortion, may experience. At times, the emotional issues may also involve the woman's partner/husband. In these instances, counseling shall also be provided to the partner/husband. Joint counseling for the woman and her partner may be done, if the woman indicates that she wants him to be involved in the counseling process.

In the country's current health setting, women treated for abortion complications are not routinely provided with appropriate counseling services to prevent subsequent unwanted pregnancies. The providers of post-abortion care typically do not view the provision of contraceptive services as part of their tasks. In addition, post-abortion care services and family planning services are not always coordinated because of some administrative divisions within the facility/hospital.

Since ovulation returns rapidly following an abortion, with the subsequent risk of repeat pregnancy, post-abortion family planning services shall be initiated immediately. Post-abortion family planning shall include all the essential components of good family planning care, and shall be based on an individual assessment of every woman's situation. All modern methods of contraception are appropriate for use after abortion as long as the provider screens the woman for the standard precautions for a method and gives adequate counseling.

Some post-abortion patients who want to postpone another pregnancy may be unable to make a decision at the time of post-abortion care. The program shall undertake measures to ensure that they can return for follow-up or that they are referred appropriately to a nearby facility. They shall likewise be counseled before they are referred to another facility for appropriate care.

3. *Linking PMAC services to Other Reproductive Health Services*

Linking PMAC services with other reproductive health services is essential and logical, yet these services have remained separate in most of the country's health delivery outlets. This separation has resulted to abortion patients having no access to other reproductive health services.

It is important to identify the reproductive health services that each of the abortion patient may need and offer her as wide a range of services as possible. For example, providers need to be alert to symptoms of

reproductive tract infections (RTIs) to include sexually transmitted diseases (e.g., trichomoniasis or mucopurulent cervicitis) and provide the appropriate treatment for them. Also, for women over age 30, it may be possible to offer cervical cancer screening at the time of treatment or to provide referral to a facility where screening is available. Finally, women treated for spontaneous abortion may have special reproductive health care needs, such as special follow-up for management of recurrent spontaneous abortion (infertility) or advice before attempting to become pregnant again or about prenatal care. The staff at the different levels of health care facilities must be able to identify high-risk patients/clients and provide instructions for reproductive health care

VI. Implementing Mechanism

A. National Level

The overall responsibility for policy development, standard setting and coordination & integration of PMAC activities shall rest with the Center for Family Health (CFH). The CFH is likewise tasked to ensure that PMAC services are given funding and technical support.

B. PMAC Technical Working Group

The CFH shall convene a Technical Working Group (TWG) on PMAC to be composed of the following:

Chair:	Head, Center for Family Health
Members:	Representative, Maternal and Child Health Service
	Representative, Family Planning Service
	Representative, HOMS
	Representative, HMDTS
	Representative, PHIES
	Representative, POGS
	Representative, PNA
	Representative, IMAP
	Representative, PLOM
	Representative, Academe
	Representative, AVSC International
	Representative from a government and private hospital

The TWG is mainly tasked to prepare the policies and guidelines for the PMAC. It shall also be responsible for preparing the action plan to bring PMAC to scale in the country.

C. REGIONAL LEVEL

The Center for Health development (CHD) shall be tasked to monitor the implementation of PMAC services in the DOH retained hospitals, the Local Government Units (LGU) and coordinate with private hospitals in the area.

D. QUALITY ASSURANCE PROGRAM

The PMAC element, in all aspects of implementation, shall apply the standards and concepts set by the Sentrong Sigla to ensure quality health services. The PMAC TWG, shall therefore coordinate closely with the Sentrong Sigla Steering Committee and its 4 pillars to ensure that quality standards are developed and updated to conform with program structures and directions.

E. LINKAGES

All health facilities shall establish PMAC services as part of a network with other RH services. These RH services are, but not limited to, Maternal Care, Family Planning, Infertility services, RTIs, Violence Against Women, Adolescent RH, Men's RH Involvement, etc.

VII. EFFECTIVITY

This order takes effect fifteen (15) days upon publication in an official gazette.

ALBERTO G. ROMUALDEZ, JR., MD
Secretary of Health

Table 1 summarizes the recommended PMAC services appropriate at each level of health care facility.

Table 1: Provision of PMAC services by Level of Health Care Facility

Level of Health Care	Service Provider available	PMAC services available	Follow-up care
Community	• Barangay Health Workers • Traditional Birth Attendants	• Recognition of signs and symptoms of abortion and abortion complications • Referral to facilities where treatment is available • Provision of IEC	• Referral for counseling and possible use of FP methods
Primary • RHU • DHS • Private Clinics	• Nurses • Trained Midwives • General Practitioners	Above activities, plus: • Thorough History and PE to establish the diagnosis • Institute appropriate management, including counseling • Refer when necessary. • Provision of IEC	• Counseling • Provision of appropriate FP method
Primary Referral Level • District Hospital • Municipal Hospital	• Nurses • Trained midwives • General Practitioners • OB-Gynecologist	Above activities, plus: • Uterine evacuation as indicated for all incomplete abortions • Initial management of abortion patient before referral • Diagnosis and referral for severe complications (septicemia, peritonitis, renal failure) • Laparotomy & indicated surgery if available • Blood crossmatch & transfusion • Provision of IEC	• Counseling • Provision of appropriate Family Planning methods
Secondary Referral Level • Provincial Hospital Tertiary Referral Level • Regional Hospital or Medical Centers	• Nurses • Trained midwives • General practitioners • OB-Gynecologist	Above activities, plus : • Treatment of severe complications including bowel injury, sepsis, renal failure • Treatment of bleeding/clotting disorders • Provision of IEC	• All of the above activities

Adapted from: WHO, 1994a

Table 2: Key steps for the management of abortion and its complication

Type of Abortion	Presentation	History	Assessment of patient	Treatment
Threatened Abortion	Woman of reproductive age who: • Has history of delayed menses • Has vaginal bleeding • May or may not have cramping or lower abdominal pain	• Dates of LMP and previous normal menstrual period • Duration & amount of bleeding • Severity of cramping and location of abdominal pain • History of contraceptive use • History of drug intake • Abdominal/shoulder pain • Bleeding or clotting disorder • History or abdominal trauma or manipulation	• Stable vital signs • Examination of heart, lungs, abdomen & extremities • Vaginal bleeding • Uterine enlargement & tenderness • Closed cervix • Abdominal tenderness	Conservative management • Complete bed rest with sexual abstinence • Tocolytics Expectant management
Incomplete Abortion	Above presentation plus: • With or without unexplained fever & chills • Passage of meaty tissue/fetal parts per vagina	Above history plus: • History of uterine instrumentation • History of intake of abortifacients	• Cervix is open • Meaty tissue in the vaginal canal • Light to moderate vaginal bleeding • Profuse vaginal bleeding	• Stabilize the patient • Uterine evacuation by appropriate method

Type of Abortion	Presentation	History	Assessment of patient	Treatment
Abortion with complications			• Hypovolemic/septic shock: - rapid, weak pulse - low blood pressure - pallor & sweatiness - cold, clammy extremities - rapid breathing - anxiety, confusion or unconsciousness - temperature >38°C - abdominal tenderness (direct, rebound), muscle guarding - anuria, oliguria	• Stabilize the patient • Evacuate uterus if condition is stable • Continue appropriate fluid replacement • Blood transfusion as deemed necessary • Massive antibiotics • Give steroids • Close observation • If patient deteriorates do hysterectomy as necessary Note: • Determine tetanus immunization status and give tetanus immunization if warranted