Abnormal Uterine Bleeding
Recurrent Miscarriages
Termination of Pregnancy

- **Benoni CPD Conference**
- **27/08/2022**

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Lefapha la Disaense tša Maphelo

Abnormal Uterine Bleeding (AUB)

Definitions

- **Dysfunctional Uterine Bleeding (DUB):** Abnormal uterine bleeding not caused by any pathology
  - ✓ This is a diagnosis of exclusion

- **Abnormal Uterine bleeding(AUB):** Used synonymously with Dysfunctional Uterine bleeding(DUB)

- **Abnormal menses**
  - ✓ Anovulatory uterine bleeding
  - ✓ Intermenstrual bleeding
  - ✓ Postcoital bleeding
  - ✓ AUB - HMB
  - ✓ AUB - Decreased menses

Change in terminology:
Older classification/terminology

- **Dysfunctional Uterine Bleeding(DUB) =** preferred term now **Abnormal Uterine bleeding(AUB)**
- **Menorrhagia = H**eavy menstrual bleeding (>80 mL)
- **Metrorrhagia =** Acyclical, irregular bleeding between periods
- **Menometrorrhagia =** Increased flow during menstruation and between menstrual periods
- **Polymenorrhea =** bleeding that occurs more often than every 21 days (short cycle)
- **Oligomenorrhea =** bleeding that occurs at intervals longer than every 35 days (but decreased frequency)

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SPECIAL ARTICLE | Open Access

The FIGO ovulatory disorders classification system

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Early View
Online Version of Record before inclusion in an issue

Glossary of terms used in this paper

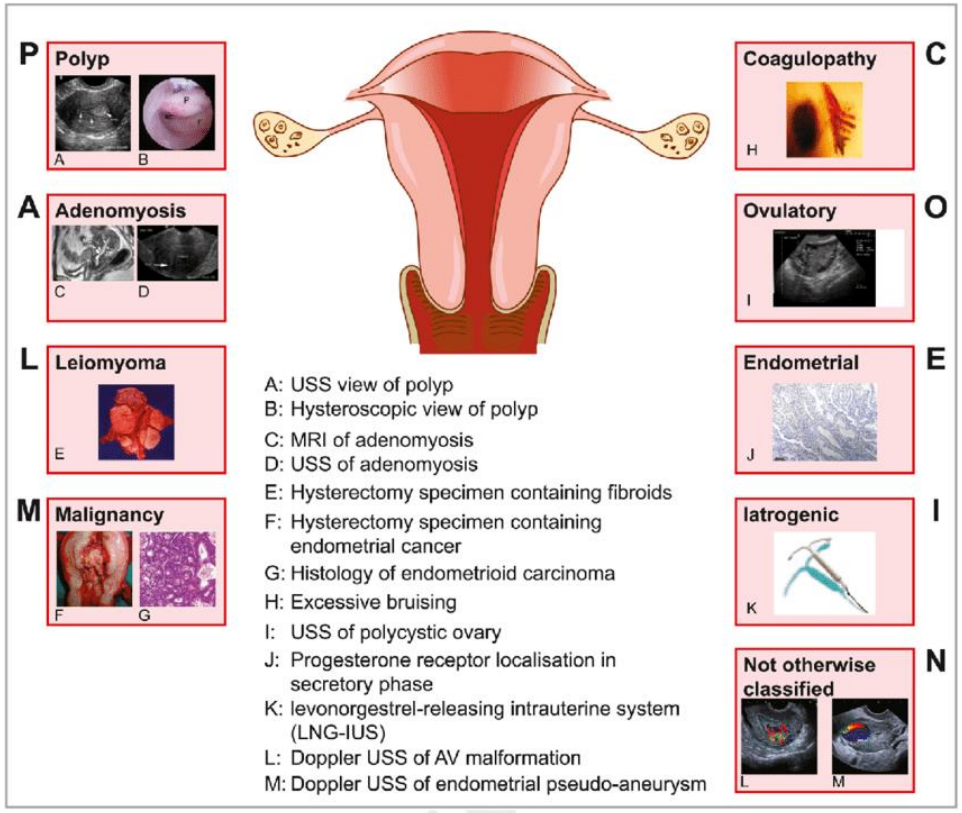
Abnormal uterine bleeding (AUB)	Implicitly, non-gestational and in the reproductive years. Any alteration in the normal frequency, regularity, duration, or volume of menstrual bleeding (including HMB) as well as intermenstrual bleeding and unscheduled bleeding with pharmaceutical agents designed to suppress menstrual function
Acute heavy menstrual bleeding	An episode of HMB of sufficient volume to require immediate therapy
Amenorrhea	A symptom – absence of menstrual bleeding in a girl or woman in the reproductive years
Anovulation	Failure to ovulate
Chronic abnormal uterine bleeding (AUB)	Symptoms of AUB for the majority of the past 6 months
Chronic ovulatory disorder	Evidence of an ovulatory disorder for the majority of the previous 6 months
Frequent menstruation	An AUB symptom – menstrual cycle of less than 24 days
Heavy menstrual bleeding (HMB)	An AUB symptom – excessive menstrual blood loss that interferes with a woman's physical, social, emotional, and/or material quality of life
Infrequent menstruation	An AUB symptom – menstrual cycle length of more than 38 days
Intermenstrual bleeding	An AUB symptom – uterine bleeding between regular menstrual periods
Irregular menstruation	An AUB symptom – menstrual cycle lengths that vary by more than 7 (ages of 18–25 and 42–45 years) to 9 days (ages of 26–41 years)

Change in terminology: New Classification/terminology

- FIGO in 2011 eliminated misleading terms (Cape Town, SA)
- Recommend discontinuing use of the term DUB
- Adoption of term AUB: FIGO CLASSIFICATION PALM-COEIN

PALM
Polyp
Adenomyosis
Leiomyoma
Malignancy & hyperplasia

COEIN
Coagulopathy
Ovulatory dysfunction
Endometrial
Iatrogenic
Not otherwise classified



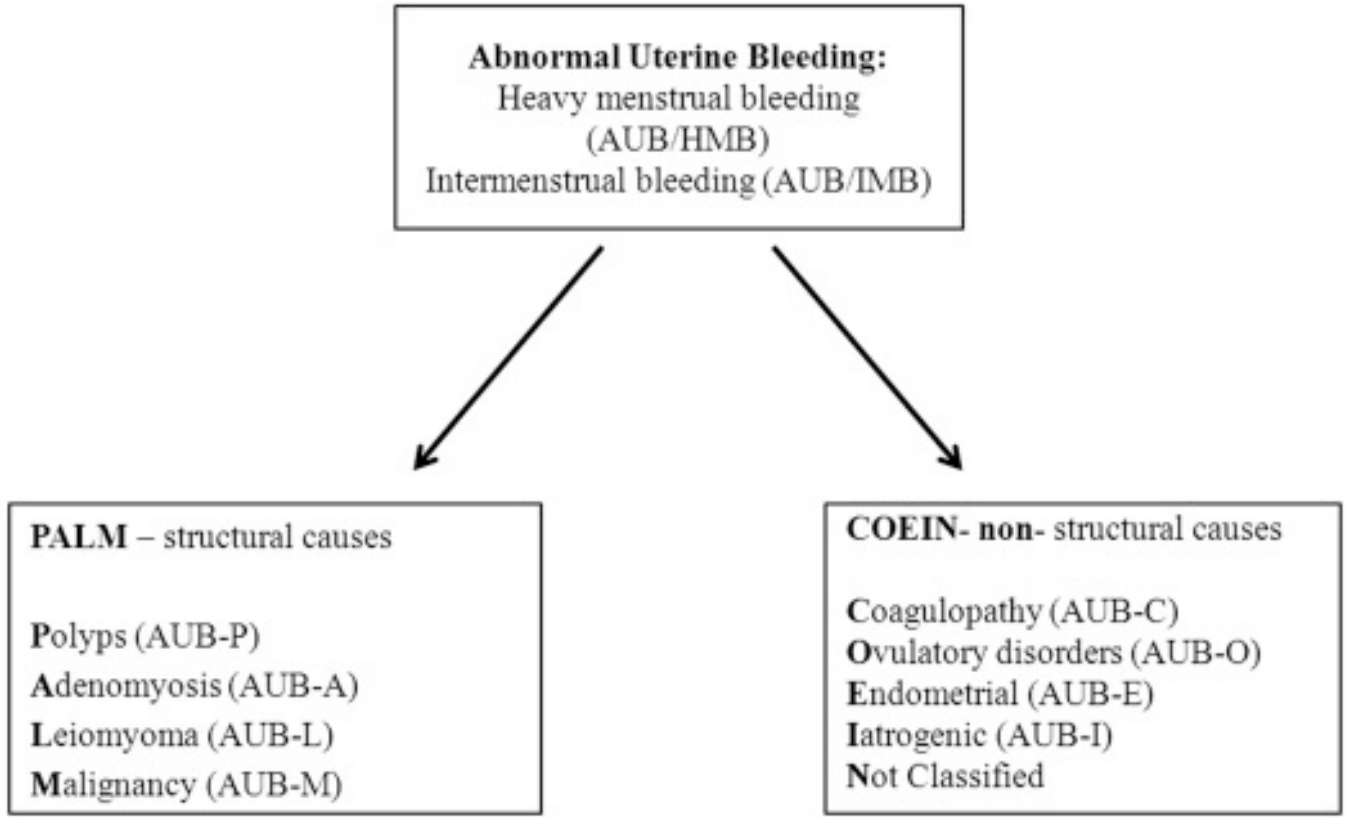
Approach to AUB

- **Differential diagnosis/Aetiology**

✓ Exclude pregnancy states

✓ Exclude trauma

✓ Then apply PALM-COEIN system



Common Causes of AUB by Age Group

Pre-Pubertal

- Precocious Puberty
- Foreign body
- Tumours
- Urethral prolapse
- Iatrogenic
- Coagulopathy

13 -18 years

- Anovulation
- Immature HPO Axis
- Iatrogenic-Contraceptives
- Coagulopathy
- Pelvic Infections

19 - 39 years

- Pregnancy states
- Myomas/Polyps
- Anovulation – PCOS
- Endometrial Hyperplasia

40 - Menopause

- Endometrial hyperplasia
- Endometrial cancer
- Cervical cancers
- Vaginal atrophy
- Leiomyomas
- Polyps

Management of AUB

- **Management of Acute heavy bleeding**

  - ✓ Stabilise patient
  - ✓ Anaemia – Blood transfusion
  - ✓ Stop the bleeding –
    - 1st line – Oestrogen
      - IV conjugated Estrogen 25mg 4-6hrly
    - 2nd line - Ovral (50ug EE) – 2 tablets 6hrly for 48hrs
    - 3rd line – Tranexamic acid 1g IV stat the 500mg 8hrly
    - 4th line – Provera 10-20mg (max 80mg/day) – in thick endometrium
  - ✓ Once stabilized, transition to a COC

Management of AUB

- **Management of chronic bleeding**

✓ Correct the underlying cause

✓ Correct anaemia

✓ If Ovulatory dysfunction then- 1st line: Hormonal management

✓ LNG-IUS

Therapy	Route	Dose	Frequency	Counseling
Combined OC	Oral	10–50-microgram ethinyl E2 tablets	Daily	Requires compliance. Lowest dose options at 10 micrograms have a higher amenorrhea rate. Breakthrough bleeding rates may be higher with lower dose options. May be administered cyclicly or continuously.
POP	Oral	35 micrograms norethindrone 5–15 mg norethindrone acetate	Daily	Requires compliance. No placebo week.
Combined patch	Transdermal	150 micrograms norelgestromin/35 micrograms ethinyl E2/d	Weekly	May be administered cyclicly or continuously.
Combined ring	Vaginal	0.12 mg etonogestrel/15 micrograms ethinyl E2/d	Monthly	At lower dose, breakthrough bleeding rates may be higher. May be administered cyclicly or continuously.
Injectable	IM or SC	150 mg or 104 mg DMPA	Every 3 mo	High rates of amenorrhea. Can be administered more frequently (monthly) for a few doses to achieve amenorrhea earlier.
Implant	SC	68 mg etonogestrel	Every 3 y	Gradual cessation of bleeding. High rates of breakthrough bleeding. Studies beginning to demonstrate use may be effective for up to 5 y.
IUD	Intrauterine	Levonorgestrel IUD (13.5–52 mg-formulations)	3–5 y	Gradual cessation of bleeding. Heavy bleeding episodes may predispose to expulsion of IUD. Lowest dose formulations have higher rates of breakthrough bleeding. Studies beginning to demonstrate that, for highest dose formulations, use may be effective for up to 7 y.

Management of AUB

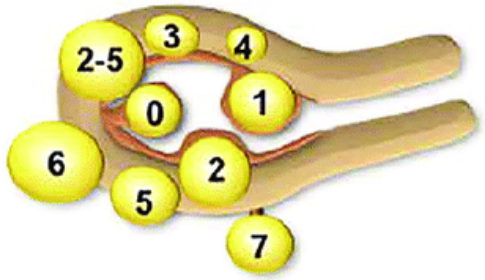
✓ **Non-hormonal/surgical options**

- If hormonal options fail
- Uterine tamponade (Bakri Balloon/folley's catheter)
- No place for endometrial ablation in teenagers (destruction of endometrium)
- Hysterectomy in life threatening bleeding where medical treatment is ineffective

Fibroids

- Fibroids are benign tumours of the smooth muscle of the uterus
- The aetiology is unknown
- Fibroids are found in 20–50% of women in reproductive age group
- Incidence of fibroids in women with infertility is 5-10%
- Malignant transformation is rare. The risk is estimated at less than 0.1%.
- May be asymptomatic or may cause infertility, non-infertility problems or obstetric problems

Leiomyoma Subclassification System

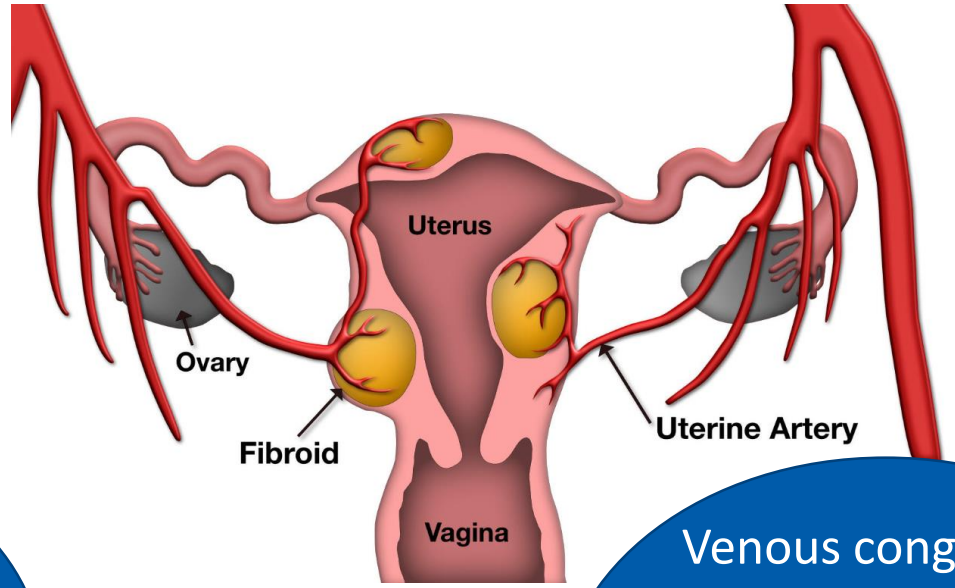


S – Submusosal	0	Pedunculated intracavitary
	1	< 50% intramural
	2	≥ 50% intramural
O – Other	3	Contacts endometrium; 100% intramural
	4	Intramural
	5	Subserosal ≥ 50% intramural
	6	Subserosal < 50% intramural
	7	Subserosal pedunculated
	8	Other (specify e.g. cervical, parasitic)

Hybrid leiomyomas (impact both endometrium and serosa)	Two numbers are listed separated by a hyphen. By convention, the first refers to the relationship with the endometrium while the second refers to the relationship to the serosa. One example is below	
	2-5	Submusocal and subserosal, each with less than half the diameter in the endometrial and peritoneal cavities, respectively.

Mechanism of causing bleeding

Increased vascularity of the uterus



Endometrial ulceration over the myomas

Interference with normal uterine contractility

Venous congestion due to compression of venous plexus in the myometrium and endometrium

Management of Fibroids

Medical options

For symptomatic bleeding and pain:

- Combined oral contraceptives
- Progesterone only contraceptives
  Pill, LNG-IUS
- NSAIDS
- Tranexamic acid

For decrease in fibroid size and symptoms:

- GnRHa - Zoladex
- sPRMs – Ulipristal acetate

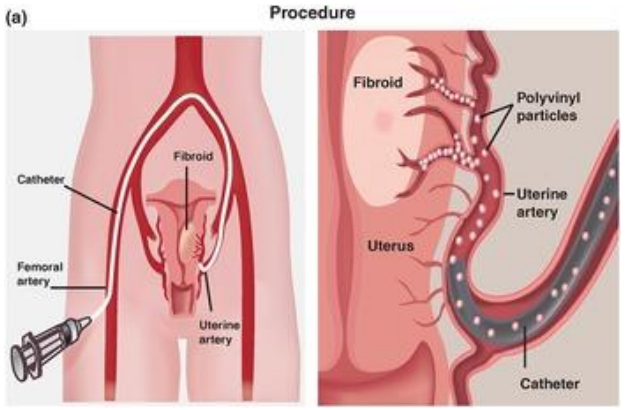
Surgical Options

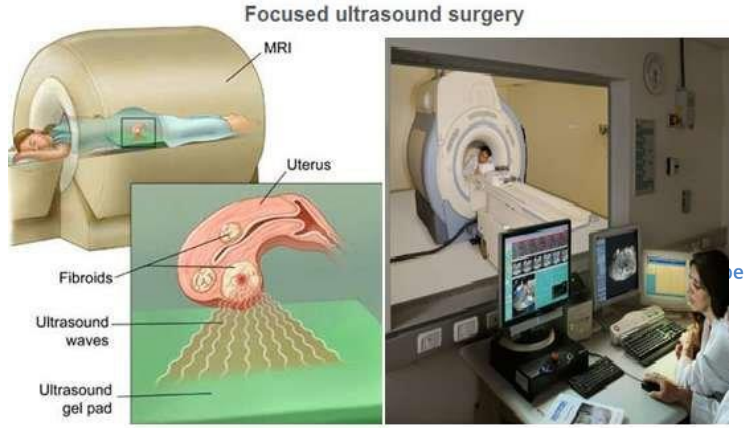
1. Myomectomy
   - Hysteroscopic
   - Laparoscopic
   - Laparotomy

2. Hysterectomy
   - Not for fertility

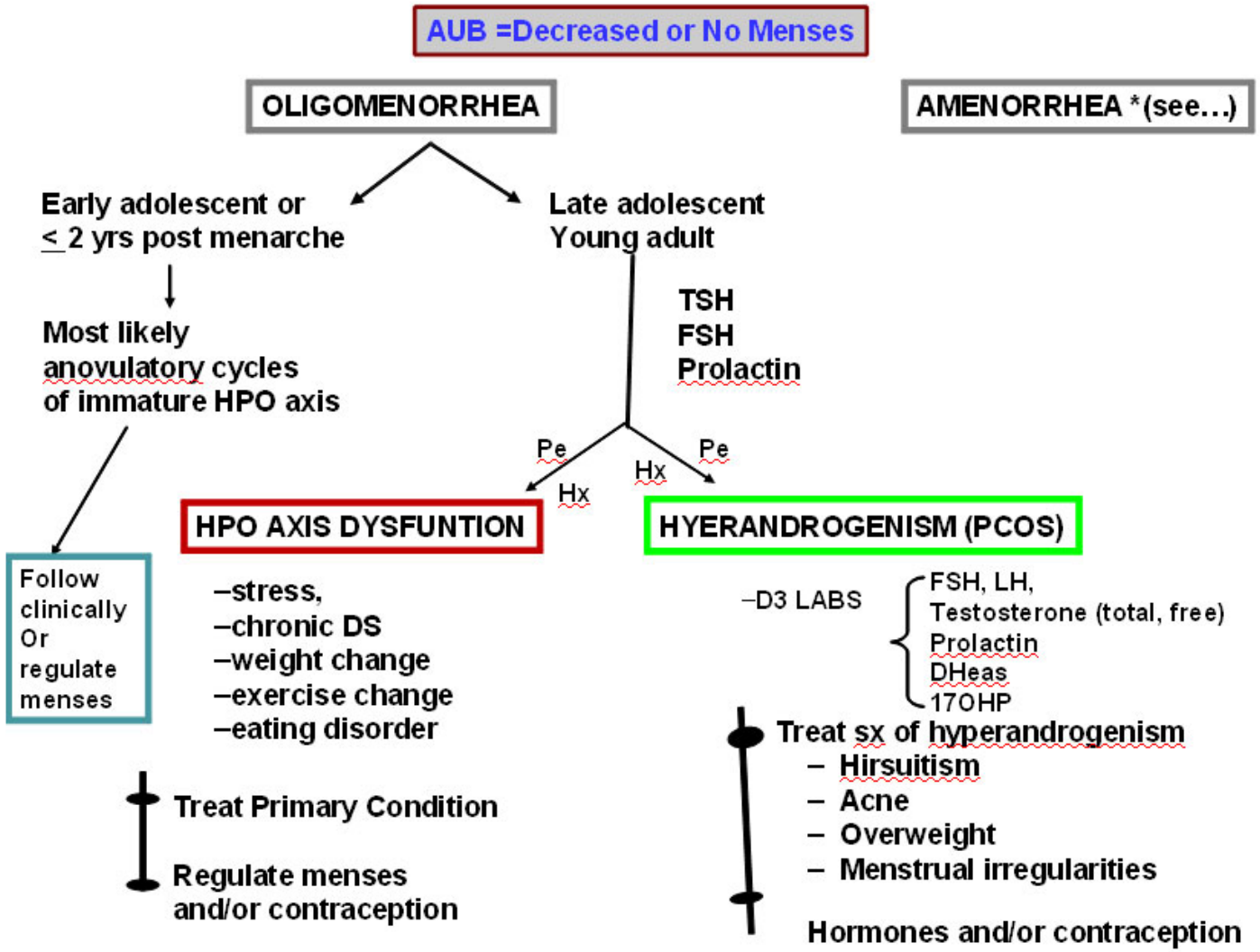
Other options

- Uterine Artery Embolisation (UAE)
- MRI guided focused ultrasound (MRgFUS/HIFU)





AUB- Decreased Menses/Amenorrhoea



Recurrent Miscarriages

Definition

ASRM a committee opinion(2013)

- **2 or more** failed pregnancies
- Pregnancy is defined as clinical pregnancy documented by u/s or histopathologic exam

RCOG(Green-top Guideline 17, 2011)

- **3 or more** consecutive pregnancies
- Miscarriage is defined as the spontaneous loss of pregnancy before the fetus reaches viability
- all pregnancy losses from the time of conception - 24 weeks

ACOG 2001

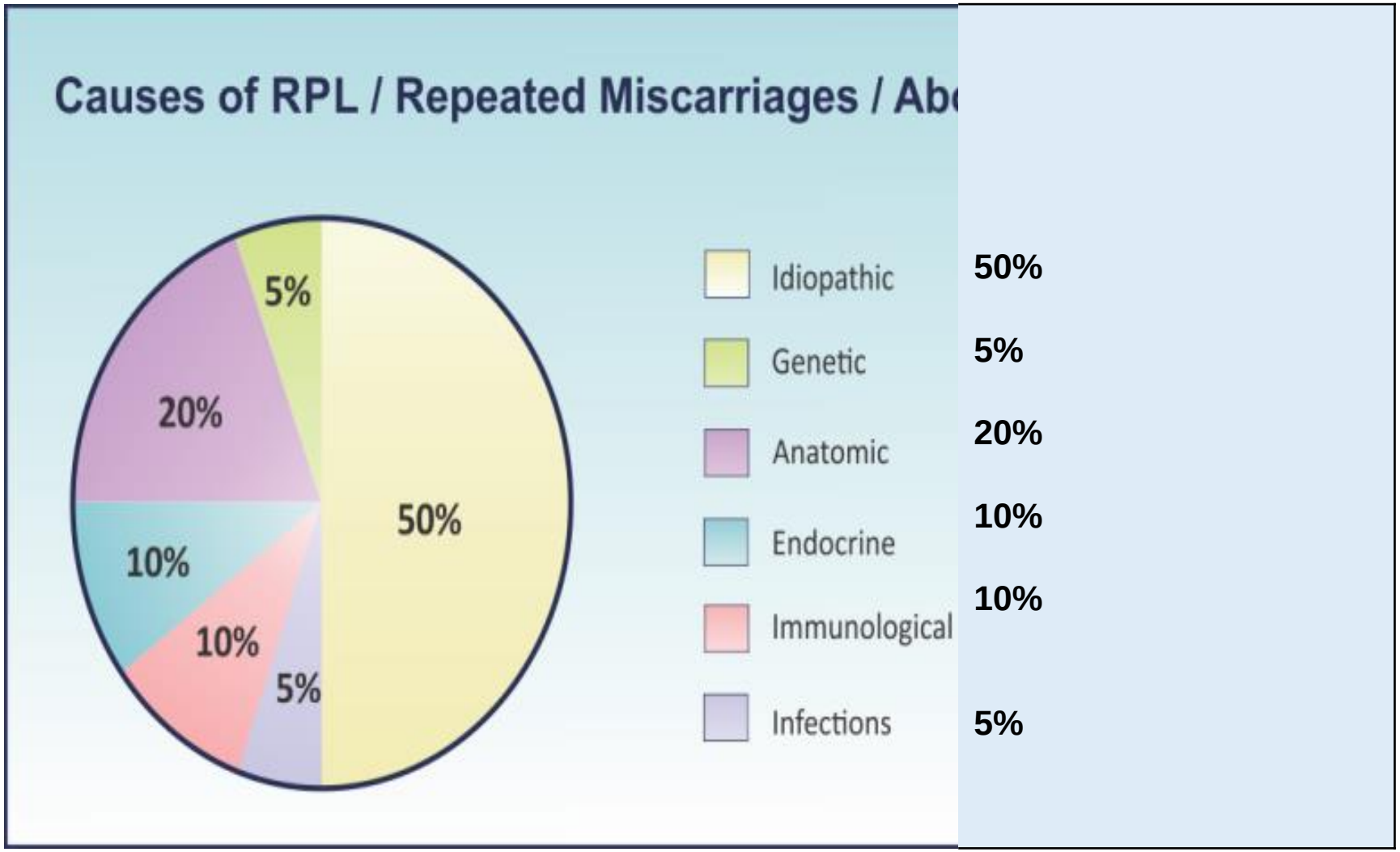
- **2 or 3 or more** consecutive pregnancy losses
- bulletin has been withdrawn & not been updated

ESHRE Guidelines 2017

- **2 or more** pregnancies

Lancet Series, 2021

- A definition of recurrent miscarriage that is based on individualised risk assessment
- Takes into account maternal age, reproductive history, and other clinical variables
- Likely to facilitate better stratification, targeted care, and research



50%

5%

20%

10%

10%

5%

Genetic causes

5%

Genetic evaluation of products of conception

Diagnostic evaluation:

- POC level D evidence
- Karyotype of partners level D evidence

Management

- Genetic counselling
- Preimplantation Genetic Testing (PGT) – and transfer of unaffected embryo
- Donor gametes

Anatomical causes

Congenital malformations	Acquired anomalies
•Septate uterus •Unicornis uterus •Uterus arcuatus •Uterine didelphi •Bicornuate uterus •Agenesis	•Myoma •Polyps •Intrauterine adhesions •Short cervix

Congenital uterine anomalies present in 15 to 20% of women with RPL versus 7% gen population

Pregnancy loss due to:

- impaired uterine distention
- abnormal implantation due to decreased vascularity in a septum
- The septate uterus - associated with the poorest reproductive outcome

  -most common uterine abnormality associated with RPL

  The longer the septum - the worse the prognosis

Anatomical causes

Evaluation

HSG

Hysteroscopy/Laparoscopy

Saline Infusion Sonohysterogram (SIS)

3D u/s + SIS

MRI

Management

Septum resection – hysteroscopically

RCOG - No RTC – observational studies showing benefit -insufficient evidence

ASRM – septate uterus, amenable to hysteroscopic resection

- no surgical corrective options for unicornuate ,bicornuate or didelphus

Acquired anomalies

- Evidence that polyps and intrauterine adhesion cause RPL is weak
- Intracavity myomas and myomas distorting cavity may contribute to RPL
- An association between pregnancy loss and intramural or subserous myomas is less clear
- General consensus = surgical correction of significant uterine cavity defects should be considered (ASRM)

Antiphospholipid syndrome (APLS)

International Consensus Classification criteria for APLS

- 1 clinical + 1 laboratory

Clinical Criteria	Laboratory criteria
• 3 or more consecutive loss < 10 weeks • 1 or more Fetal death > 10wks • 1 delivery < 34wks due to PET/Eclampsia • Vascular Thrombosis - venous - arterial	• Lupus anticoagulant 2 occasions 12 weeks apart • Anticardiolipin antibody >40 g/l • Anti β2 glycoprotein-1 2 occasions 12 weeks apart

APLS treatment

ASRM

Low dose aspirin + Heparin

- superior to aspirin alone
- 2x daily heparin + low dose aspirin confers benefit
- 50% reduction in pregnancy loss compared to prednisone or aspirin alone

Prednisone – does not improve pregnancy outcome

- increased risk of Gest DM and HT

IVIG – no benefit - Level A evidence

RCOG

Low dose aspirin + Heparin

Neither Prednisone nor IVIG improve outcome

Low dose aspirin – started preconceptually

Heparin – 1st detection of fetal heart

ACOG

- APLS + RPL + No thrombotic events = Asp + prophylactic dose heparin up to 6wks postpartum
- APLS + thrombotic event = therapeutic dose heparin + aspirin for life

Inherited Thrombophilias

- Protein C & S deficiency
- Antithrombin III deficiency
- Factor V Leiden
- Prothrombin mutation (G20210A)
- hyperhomocystenaemia

Justified if pt has personal history of venous thrombosis

- Routine testing not recommended (ACOG)
- Women with 2nd T miscarriage should be screened (level D)

Treatment

- Insufficient evidence to evaluate effects of heparin (RCOG)
- Some studies have shown that heparin may improve live birth rates

Infections

5% of causes

Infections do cause miscarriages

To cause RPL must be chronic pool of microorganisms

Infective cause in RPL is unclear

Infections associated with late complications

- TB
- BV
- Parvovirus B19
- Chlamydia
- Mycoplasma

No routine TORCH screen (RCOG/ASRM/ACOG)

Immune factors

10%

- No clear evidence to support causation
- No clear evidence that peripheral blood NK cells are related to RPL

- Testing not offered routinely

- Treatment

➢ paternal cell immunisation, third party donor leucocytes, trophoblast membranes, IVIG **do not** improve live birth rate

➢ Immune therapy should not be offered routinely

Endocrine

10-15%

- DM
- Thyroid ds
- PCOS

DM

Women with high HbA1c in 1st T are at risk of miscarriage and congenital abnormalities

Well- controlled DM not a risk factor for RPL

PCOS

Mechanism unclear

Assoc with obesity, IR, Hyperinsulinaemia, Hyperandrogenemia

Thyroid

Overt Hypothyroidism can cause infertility and RPL

Subclinical hypothyroidism : TSH > 4.5-5.0 mIU/l with normal T4

Anti thyroid antibodies linked to RPL

- TPO-Abs (Thyroid peroxidase)
- TgAb (Antithyroglobin antibodies)

Evidence that treatment with levothyroxine can attenuate risk

Unexplained RPL

50% of causes

- Excellent prognosis with TLC (85% vs 36%)

Stray-Padersen et al, 1984, 1988

- TLC
  - ✓ Psychological support
  - ✓ Weekly medical and u/s examination
  - ✓ Instruction to avoid work/travel/sexual activity
- Aspirin alone or with heparin, does not improve outcome (2RCT)

Unexplained RPL

2 Trials

1. The **PROMISE** (PROgesterone in recurrent MIScarriagE) trial – NEJM 2015

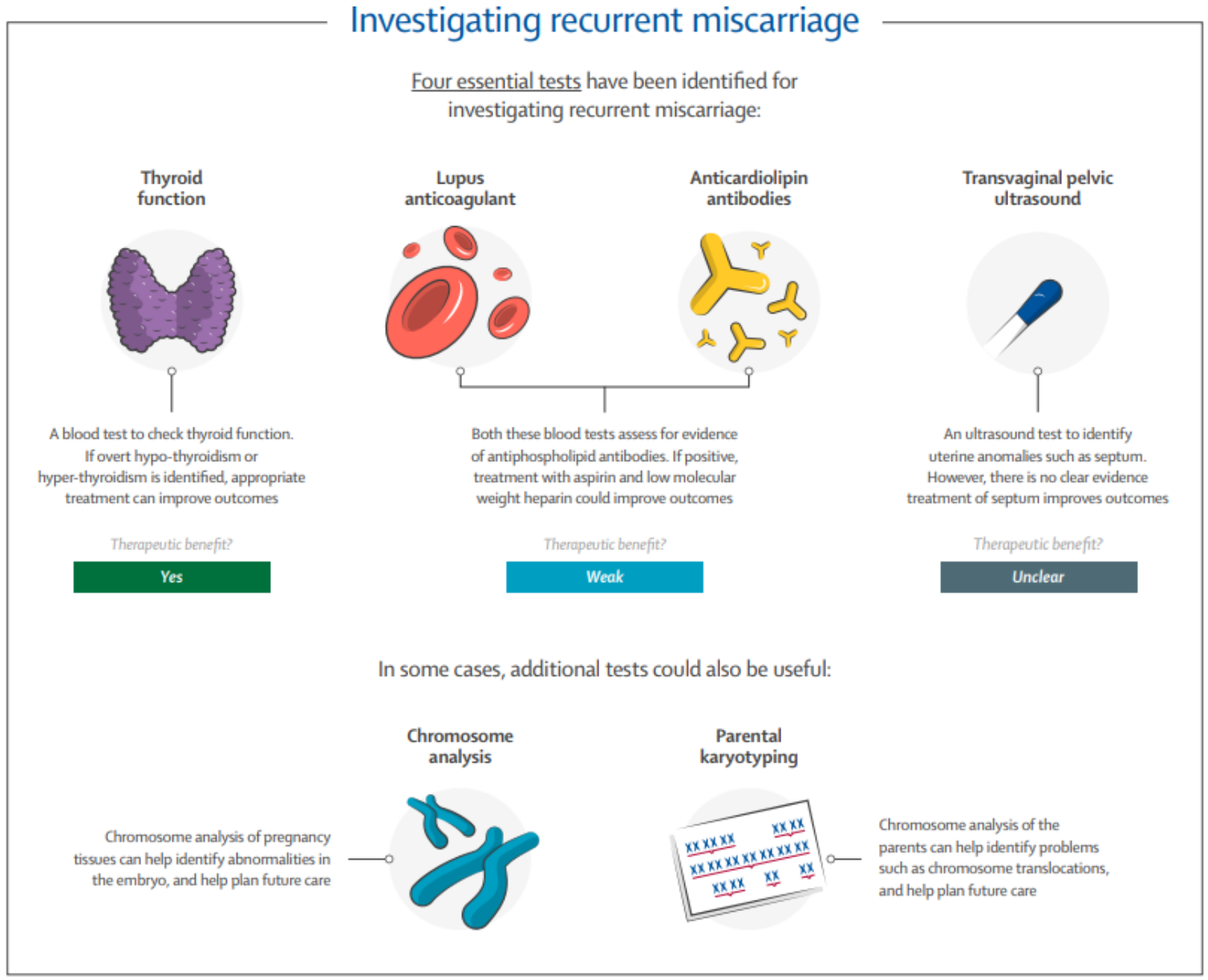
- 836 women with unexplained recurrent miscarriages
- Progesterone therapy in 1st trimester of pregnancy did not result in a statistically significant higher rate of live births in women with unexplained RPL
- a post-hoc subgroup analysis - greater benefit with 3 or more previous miscarriages

2. The **PRISM** (PRogesterone In Spontaneous Miscarriage) trial – Obstet Gynecol 2020

- 4153 women with early pregnancy bleeding
- Vaginal micronized progesterone 400 mg twice daily
- Women with a history of miscarriage who present with bleeding in early pregnancy may benefit from the use of vaginal micronized progesterone 400 mg 2x daily

Recurrent miscarriage: evidence to accelerate action

The Lancet, 2021



LANCET Series 2021

Prevention

There is no high-quality evidence that any treatment is useful in preventing miscarriages in women at high risk of miscarriage, but evidence suggests some treatments could help:

Progesterone
Progesterone can increase livebirth rates for women who experience recurrent miscarriage

Quality of evidence

Moderate

Levothyroxine
Levothyroxine may decrease the risk of miscarriage in women with subclinical hypothyroidism

Quality of evidence

Low

Aspirin and heparin
A combination of aspirin and heparin may increase livebirth rates in women who have antiphospholipid antibodies

Quality of evidence

Low

Termination of Pregnancy (TOP)

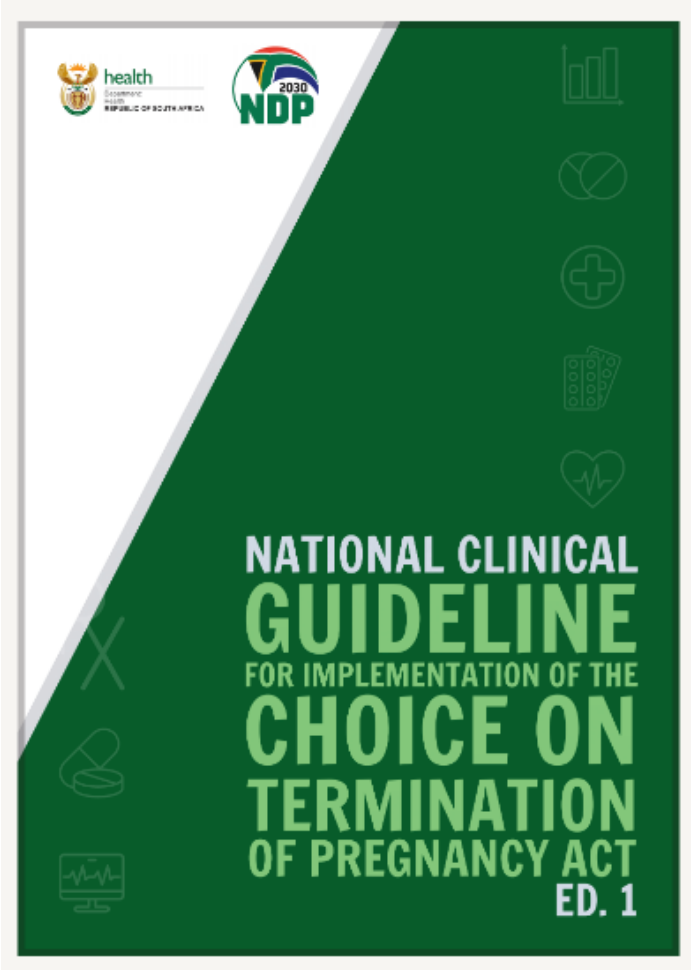
- CTOP Act 1996
  - Choice on Termination of Pregnancy Act 92 of 1996

- Amendments 2004 & 2008
  - Choice on Termination of Pregnancy Amendment Act 38 of 2004
  - Choice on Termination of Pregnancy Amendment Act 1 of 2008

  ✓ Expand access
  ✓ Expand trained HCP

- 50% abortions still occur in informal, illegal and unsafe providers

- Urgent need to address implementation of TOP services
  ✓ Ensure **access to the service** without undue delay
  ✓ Increase access to and **uptake of TOP services**
  ✓ Enable **informed decisions** and a **rights-based approach**
  ✓ Provide **standardised approach to TOP services**



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What does the Law Say? What is interpretation for practice

Circumstances in which and conditions under which pregnancy may be terminated

2. (1) A pregnancy may be terminated—

(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

(b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that—

(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy—

(i) would endanger the woman's life;

(ii) would result in a severe malformation of the fetus; or

(iii) would pose a risk of injury to the fetus.

Government Gazette , 1996

Table 1 / When, who, and under what condition a pregnancy can be terminated

IN WHAT GESTATION PERIOD?	WHO CAN TERMINATE THE PREGNANCY?	UNDER WHAT CONDITIONS?
UP TO 12 WEEKS + 6 DAYS (1ST TRIMESTER)	• a registered and trained medical practitioner • a registered and trained nurse • a registered and trained midwife	• upon request from the woman (no reason required)
BETWEEN 13 WEEKS + 0 DAYS TO 20 WEEKS + 6 DAYS	• a registered and trained medical practitione	• the continued pregnancy would pose a risk of injury to the woman's physical or mental health • there is a substantial risk that the foetus would suffer from a physical or mental abnormality • the pregnancy resulted from rape or incest • the continued pregnancy would significantly affect the social or economic circumstances of the woman
AFTER 20 WEEKS + 6 DAYS	• a registered and trained medical practitioner	The providing medical practitioner must consult with another registered medical practitioner, registered nurse, or registered midwife to be of the opinion that continuing the pregnancy would: • endanger the woman's life • result in severe malformation of the foetus • pose a risk of injury to the foetus

TOP Guidelines

Termination of Pregnancy Services

Pre-Abortion Care

- Counselling
- Informed consent
- Clinical assessment

Abortion Care

- Medical TOP (Mifepristone + Misoprostol regime)
- Surgical TOP (MVA + Evac in theater)
- Pain Management
- Infection prevention and control

Post Abortion Care

- Counselling
- Antibiotics
- Oxytocin
- Contraception

Medical TOP

FIRST TRIMESTER (≤12 WEEKS + 0 DAYS)

Table 6 / Combined Mifepristone and Misoprostol and Misoprostol-only protocol ≤12 weeks + 0 days gestation

GESTATIONAL AGE	MIFEPRISTONE DAY 1	MISOPROSTOL			
	ROUTE	DOSE	ROUTE	TIMING	DURATION
Combined regimen: **≤12 weeks + 0 days**	200 mg Oral Single-dose X	800 µg	Sublingual, vaginal, or buccal	1-2 days (after taking mifepristone) *The minimum recommended interval between mifepristone and misoprostol is at least 24 hours. Note: There is limited evidence to suggest that simultaneous dosing of mifepristone and misoprostol is efficacious.*	Single-dose (Repeat doses can be considered when needed to achieve the success of the medical TOP)
Misoprostol only regimen: **≤12 weeks + 0 days**	N/A	Same as outlined above			

Medical TOP

SECOND TRIMESTER (≥12 WEEKS + 1 DAY)

After 10 weeks + 0 days of gestation, medical TOP should be undertaken in a health facility only. Individuals should remain in-facility until the expulsion of pregnancy is complete.

Table 7 / Combined Mifepristone and Misoprostol and Misoprostol-only protocol ≥12 weeks + 1-day gestation

GESTATIONAL AGE	MIFEPRISTONE DAY 1	MISOPROSTOL			
	ROUTE	DOSE	ROUTE	TIMING	DURATION
≥12 weeks + 1 day	200 mg Oral Single-dose X	400 µg	Sublingual, vaginal, or buccal	1-2 days (after taking mifepristone) *The minimum recommended interval between mifepristone and misoprostol is at least 24 hours.*	Every 3 hours until foetal and placental expulsion. *Note:* There is no maximum number of doses.
Misoprostol only regimen: **≥12 weeks + 1 day**	N/A	Same as outlined above			

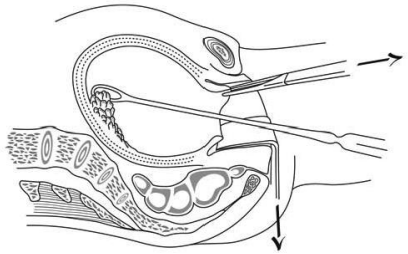
Surgical TOP

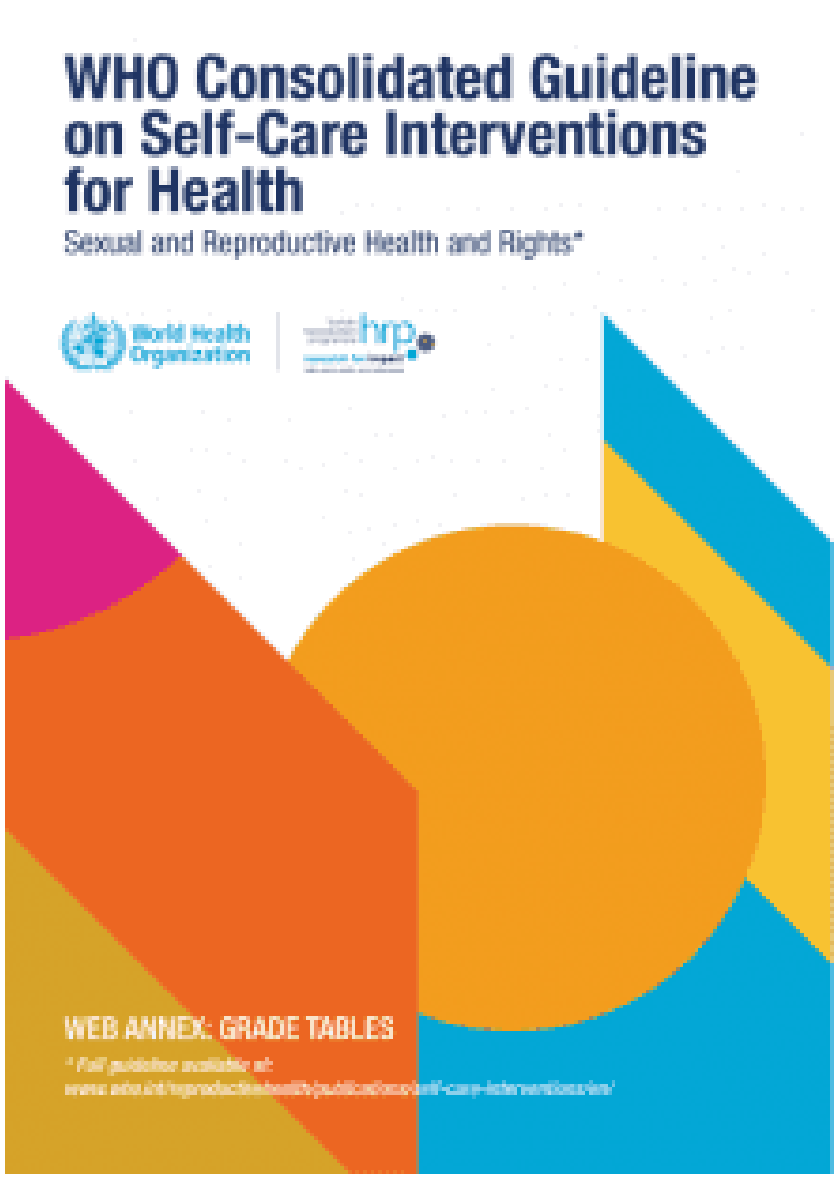
VACUUM ASPIRATION (≤14 WEEKS + 0 DAYS)

Vacuum aspiration is the recommended technique of surgical TOP for pregnancies of up to 14 weeks + 0 days of gestation. The procedure should not be completed by sharp curettage. Dilatation and sharp curettage (D&C) is not recommended and, if still practised, should be replaced by vacuum aspiration.

DILATATION AND EVACUATION (≥14 WEEKS + 1 DAY)

D&E is the recommended surgical method for TOP for gestation over or equal to 14 weeks + 1 day.




WHO Consolidated Guideline on Self-Care Interventions for Health
Sexual and Reproductive Health and Rights*
World Health Organization
hrp
WEB ANNEX: GRADE TABLES
* Full guideline available at:


World Health Organization
hrp
Abortion care guideline

Pregnancy self-testing	
Recommendation 21 (new)	WHO recommends making self-testing for pregnancy available as an additional option to health worker-led testing for pregnancy, for individuals seeking pregnancy testing. *(Strong recommendation; very low certainty evidence)*
Eliminating unsafe abortion	
Self-management of the medical abortion process in the first trimester	
Recommendation 22	Self-assessing eligibility for medical abortion is recommended within the context of rigorous research.

Interventions	Recommendations and key considerations[a]
Recommendation 23	Managing the mifepristone and misoprostol medication without the direct supervision of a health worker is recommended in specific circumstances. We recommend this option in circumstances where women have a source of accurate information and access to a health worker should they need or want it at any stage of the process.
Recommendation 24	Self-assessing the completeness of the abortion process using pregnancy tests and checklists is recommended in specific circumstances. We recommend this option in circumstances where both mifepristone and misoprostol are being used and where women have a source of accurate information and access to a health worker should they need or want it at any stage of the process.

Obstruction to Access

Obstruction to Justice

- Any person or act which prevents a client from accessing any part of a quality and lawful TOP service, in a timely manner
- Clinical and non-clinical staff
- Access to TOP under the CTOP Act is regarded a *constitutional right*

Refusal to Care

- Everyone has the right to freedom of conscience, religion, thought, belief and opinion. *(SA Constitution)*
- Refusal to provide TOP creates harm
- *A clinician's right to conscientious objection should* not be detrimental to the client seeking an abortion

Obligations

- Provide the person with information about where she can obtain an abortion
- Limits the right to refuse treatment or care when there is a medical emergency and maternal life or health is in serious danger
- TOP provider who refuses to care based on personal beliefs must refer the individual to a colleague or facility that is able to offer such services

Religion and abortion

CHRISTIANITY

- Christians believe that life begins at the instant of conception. Therefore, abortion is murder and is prohibited by the Ten Commandments.

ISLAM

- notable verse from the Qur‘an reads: —Do not kill your children for fear of poverty: we shall provide sustenance for them as well as for you. Verily the killing of them is a great sin‖ (17:31).For a woman carrying an illegitimate child from extramarital sex or rape, the consensus is that she should give birth, however, if the scar of rape is too heavy, then the decision is hers. However, All schools of Muslim law accept that abortion is permitted only if continuing the pregnancy would put the mothers life in real danger.

HINDUISM

- Classical Hindu texts strongly opposed abortion: one compares abortion to the killing of a priest, one considers abortion a greater sin than killing of one‘s parents and another says that a woman who aborts her child will lose her caste.

When is a fetus a baby

- **Pro-Life** -This is defined as the responsibility or obligation of the government to preserve all human life regardless of intent, viability or quality of life concerns

- **Pro-Choice** -This is the belief that women have the right to choose to abort the baby. (A pro-choice view is that a baby does not have the human rights)

Rights of fetus vs. Rights of a Woman

The moral status of the fetus

- Is the fetus a person? At what stage in its development does it becomes a person? Conception? 1st trimester? Birth?

The rights of the pregnant woman

- Does the pregnant woman have the right to decide if she is going to carry the baby to term or not?

Rights of fetus

- Much of the debate in regard to abortion has centered around the first premise, whether the fetus is a person or not
- If the fetus is a person, then it has the rights that belong to persons, including the right to life
- The concept of personhood, is the bridge that connects the fetus with the right to life
- It is morally wrong to end the life of an innocent person
- Therefore, it is morally wrong to end the life of a fetus.

The Rights of the Pregnant Woman

What right does a woman possess that would entitle her to choose an abortion?

- Right to privacy
- Right to ownership of one's own body
- Right to equal treatment
- Right to self-determination
  - ✓ Women have the right to decide about their own futures.
  - ✓ It is morally repellent to force a woman to bear a child against her will.

Conscientious Objection

- **No person should be held under legal duty to participate** in any part of a termination of pregnancy when he is said to hold a conscientious objection.

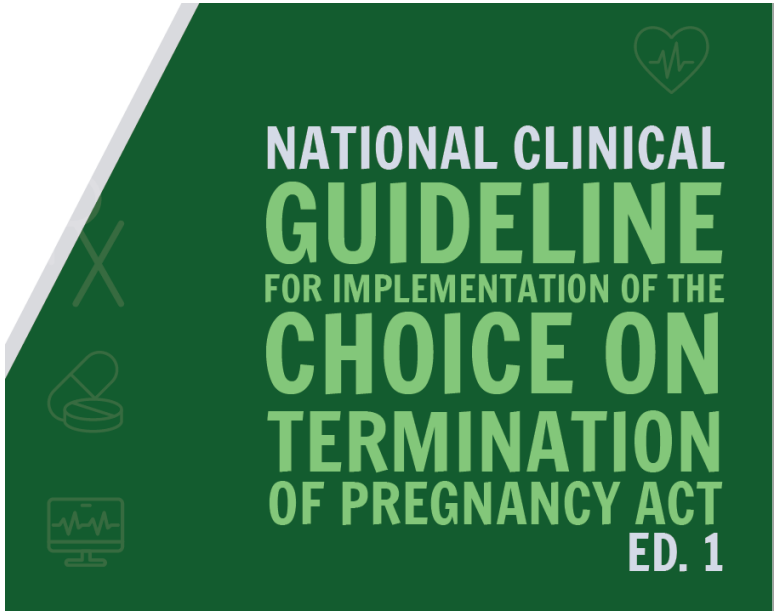
- Conscientious objection to participate in the treatment may be discharged by **a statement on oath or affirmation to the effect.**

- Nothing should affect the duty of a person to participate in the treatment for termination of a pregnancy where **the immediate treatment is necessary to save the life** of the patient or prevent grave permanent injury.

Conscientious Objection & Penalties

Penalties

- Inadequate Record Keeping
- Any individual or approved institution deliberately refuse TOP
- Document misleading information of the patient or
- completely fails to maintain medical records concerning termination
- Breach of Confidentiality Should any medical practitioner, approved institution or person employed or working in this institution with lawful access to records and shares this information with any member of the general public or other parties
- That person or the owner or manager of that institution will be held responsible or liable and can be fined along with 6 months of imprisonment.



OBSTRUCTION TO ACCESS

Obstruction to access refers to **any person or act which prevents an individual from accessing any part of a quality and lawful TOP service, in a timely manner.** This includes any person in or around a health facility, clinical or non-clinical, ranging from facility support personnel to illegal providers.

In line with the CTOP Act (Section 10, Offences and penalties), obstruction to access refers to all of the following:

1. Any provider who is not a registered medical practitioner, registered midwife, or registered nurse and has completed the prescribed training course and who performs the termination of a pregnancy (as per Chapter 5)
2. Any person or act preventing a lawful termination of pregnancy or obstructing access to a facility for the lawful termination of pregnancy (see "Refusal to care" below)
3. When the TOP takes place at a facility not approved to provide TOP services (as per Chapter 2.2)

As per the CTOP Act (Section 10, Offences and penalties), any person who obstructs access to TOP, as outlined above, shall be found guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding 10 years.

Roe v. Wade, 410 U.S. 113 (1973), was a landmark decision of the US Supreme Court in which the Court ruled that the Constitution of the United States conferred the right to have an abortion

Provides a fundamental "right to privacy", which protects a pregnant woman's right to an abortion. The Court also held that the right to abortion is not absolute and must be balanced against the government's interests in protecting women's health and prenatal life.

After the Supreme Court overturned *Roe* on June 24, 2022

Penalties by state

14 states, starting on June 24, 2022, have criminal penalties for performing abortions.[115] The penalties in states that have made abortion illegal vary, as outlined below.

State	Sentence	
	Abortion providers	Women aborting
Alabama	Performing an abortion is a Class A felony punishable by imprisonment for at least 10 years up to 99 years or life. Attempting to perform an abortion is a Class C felony punishable by imprisonment for at least 1 year and 1 day up to 10 years.[116]	None.[117]
Arkansas	Performing or attempting to perform an abortion is an unclassified felony punishable by imprisonment not to exceed 10 years and/or a maximum fine of $100,000.[118]	None.[119]
Kentucky	Intentional termination of life of an unborn human being is a class D felony punishable by imprisonment for not less than 1 and not more than 5 years.[120]	None.[121]
Louisiana	Committing an abortion is punishable by imprisonment for not less than one year and not more than ten years and/or a fine of not less than $10,000 or more than $100,000.[122]	None.[123]
Missouri	Performing an abortion is a class B felony punishable by imprisonment for at least five years and no more than fifteen years.[124]	None.[125]
Oklahoma	Performing or attempting to perform an abortion is a felony punishable by imprisonment for a term not to exceed ten years and/or a maximum fine of $100,000.[126]	None.[127]
South Dakota	Procurement of abortion is a class 6 felony punishable by up to two years imprisonment and/or a fine of $4,000.[128]	
Texas	Performing or attempting to perform an abortion is a first-degree felony if an unborn child ("an individual living member of the homo sapiens species from fertilization until birth, including the entire embryonic and fetal stages of development") dies as a result of the offense punishable by imprisonment of not less than 5 years and not more than 99 years and a maximum fine of $10,000; or a second-degree felony otherwise punishable by imprisonment of not less than 2 years and not more than 20 years and a maximum fine of $10,000.[129]	None.[130]
Utah	Killing an unborn child (not defined in the statute) is a second-degree felony punishable by imprisonment for not less than 1 and not more than	
Idaho	Performing an abortion is a felony punishable by imprisonment for not less than 2 and not more than 5 years and/or a maximum fine of $5,000.[132]	Purposely terminating a pregnancy other than by live bi imprisonment for not less than 1 and not more than 5 y $5,000.[133]
Tennessee	Performing or attempting to perform an abortion is a class C felony punishable by imprisonment for not less than 3 years and not more than 15 years.[134]	None.[135]
Mississippi	Performing or attempting to perform an abortion is punishable by imprisonment for not less than 1 year and not more than 10 years.[136]	None.[137]
North Dakota	Performing an abortion is a class C felony punishable by imprisonment for a maximum of five years and/or a fine of $10,000.[138]	None.[139]
Wyoming	Violation of abortion restrictions is a felony punishable by imprisonment for not more than 14 years.[140]	

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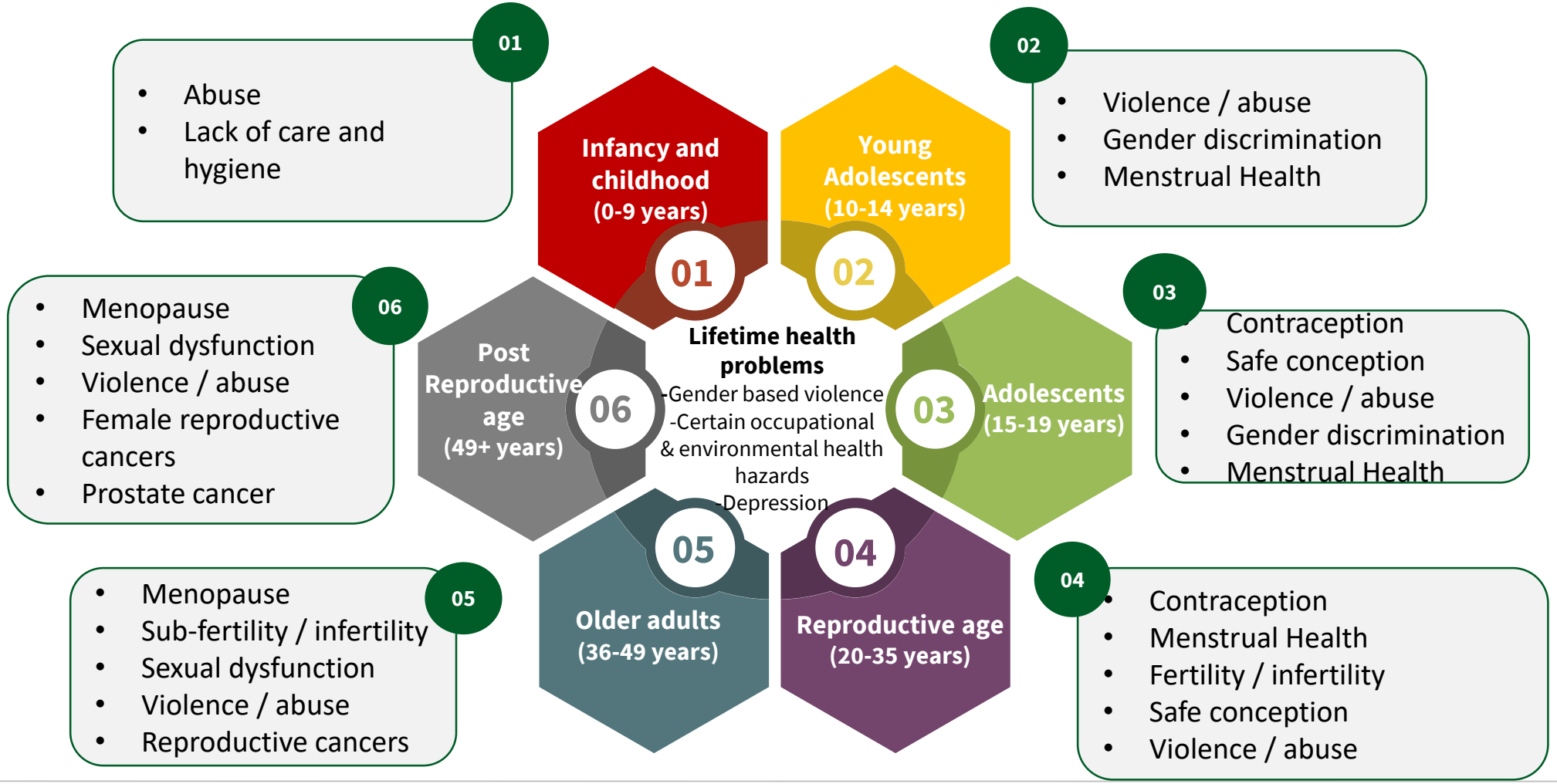
NATIONAL DEVELOPMENT PLAN 2030

SEXUAL REPRODUCTIVE HEALTH (SRHR) CURRICULUM: SOUTH AFRICA

Prof Zozo Nene
Head: Reproductive & Endocrine Unit
Steve Biko Academic Hospital
University of Pretoria

The Life Cycle Approach to SRH



The SRHR Training Package

MODULE 1
The SRHR policy framework and cross-cutting areas

MODULE 2
Adolescent sexual And reproductive health And Comprehensive Sexual Education (CSE)

MODULE 3
Sexual function and satisfaction

MODULE 4
Menstrual Hygiene Management (MHM)

MODULE 5
Modern contraceptives (family planning and counselling)

MODULE 6
Prevention and treatment of sub-fertility and infertility

MODULE 7
Safe abortion and post-abortion care

MODULE 8
Reproductive tract infections, sexually transmitted infections and HIV, HIV prevention, care and support and treatment

MODULE 9
Pre-natal care, safe delivery and post-natal care

MODULE 10
Genetics and SRHR

MODULE 11
Disability in SRHR

MODULE 12
Breast cancer and cancers of the reproductive system

MODULE 13
Gender-Based Violence (GBV)

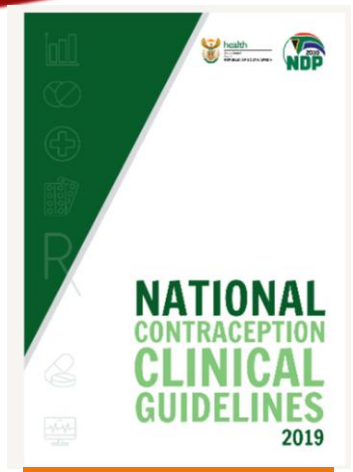
MODULE 14
Non-communicable and communicable diseases in relation to palliative care

PRIOR LEARNING/READING PREPARATIONS BEFORE ENROLLING FOR THIS MODULE

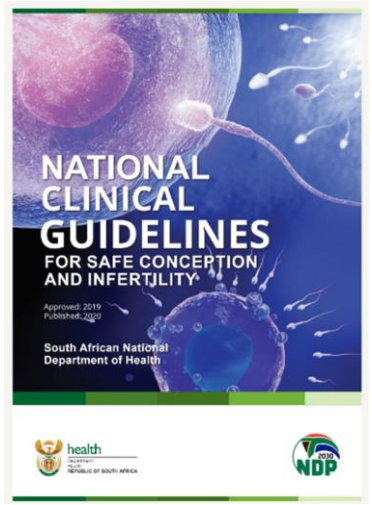
Click each file to access pre-reading material

- The National Integrated Sexual Reproductive Health and Rights Policy
- Strategy for Sexual and Reproductive Health and Rights in the SADC Region 2019 – 2030
- The Guttmacher–Lancet Commission on Sexual and Reproductive Health and Rights
- The 2030 Agenda for Sustainable Development

SRHR GUIDELINES



Updated Guideline Approved 2019



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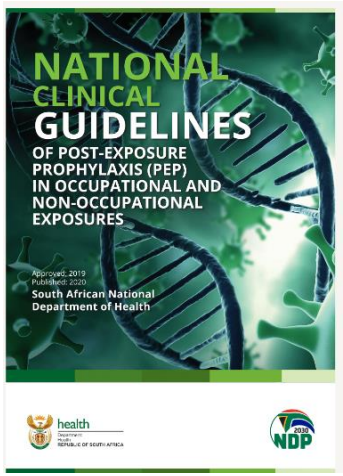

New Guideline Approved 2019

CLINICAL GUIDELINES FOR BREAST CANCER CONTROL AND MANAGEMENT

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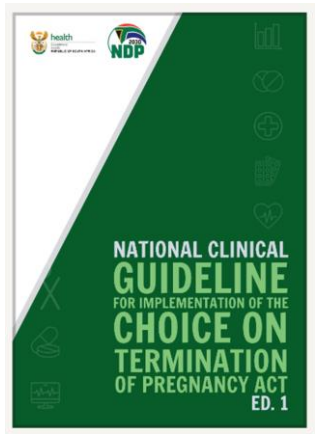

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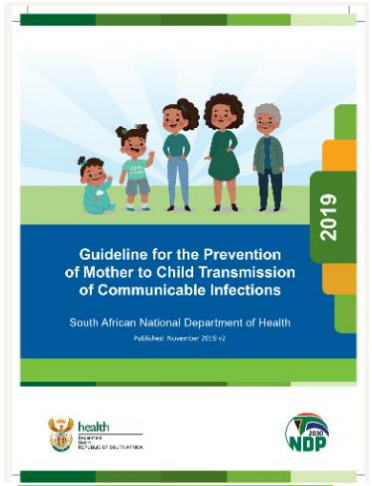

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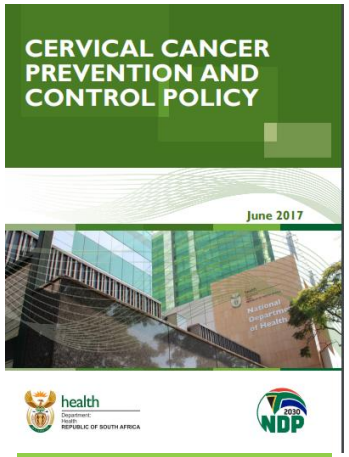

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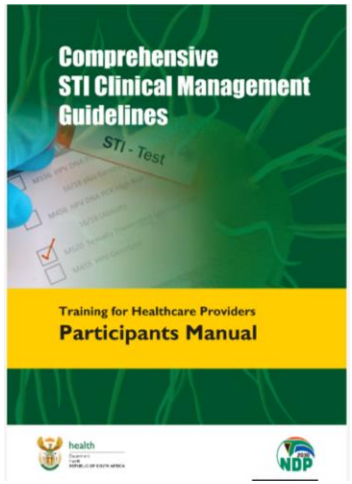

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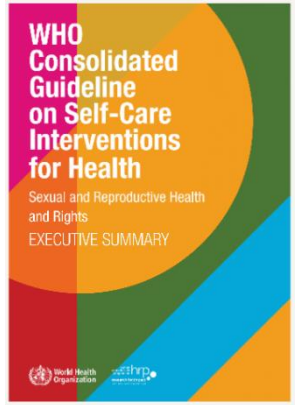


New Guideline Approved 2019

MODULE 1

THE SRHR POLICY FRAMEWORK AND CROSS-CUTTING AREAS

CPD Points = 13

Module structure / design

Module 1 is comprised of 10 learning sessions

1. Sexual Reproductive Health and Rights
2. Values Clarification and Attitude Transformation
3. Counselling in SRHR services
4. Self-Care Interventions
5. Service Delivery Platform
6. Quality of Care
7. Monitoring and Evaluation
8. Mentoring
9. Community engagement and orientation
10. Anatomy and Physiology

MODULE 2

Adolescent Sexual And Reproductive Health

And

Comprehensive Sexual Education (CSE)

CPD points = 8

Module structure / design

Module 2 is comprised of 8 learning sessions

1. Recap and application of cross-cutting components of SRHR
2. Assessing Current Health Issues Affecting Adolescents And Youth Introducing The National Adolescent Youth Health Policy (AYHP), 2017
3. Introduction Adolescent Youth Friendly Services (AYFS), Sexual Reproductive Health or Adolescents And Youth
4. Detailed Youth Clinic Interventions: Youth Zones, Ideal Clinic, Youth Clubs And The New B-wise Health Website
5. Individual application of Group Communication when working with Adolescents and Youth
6. Sexual Orientation and Gender Identity Expression
7. Adolescent Mental Health and Gender-based Violence
8. AYFS Implementation, Monitoring And Evaluation

MODULE 3

SEXUAL FUNCTION AND SATISFACTION

CPD Points = 6

Module structure / design

Module 3 is comprised of 8 learning sessions

0 Recap and application of cross-cutting components of SRHR

1 Sexual Pleasure, Sexual Health and Sexual Rights

2 Normal Sexual Response Cycle

3 Sexual Dysfunction

4 Evaluation of Sexual Dysfunction

6 Sexuality in People with disability & Palliative Care patients

7 Sexuality in the Menopause

8 Treatment of Sexual Dysfunction

MODULE 4

Menstrual Hygiene Management (MHM)

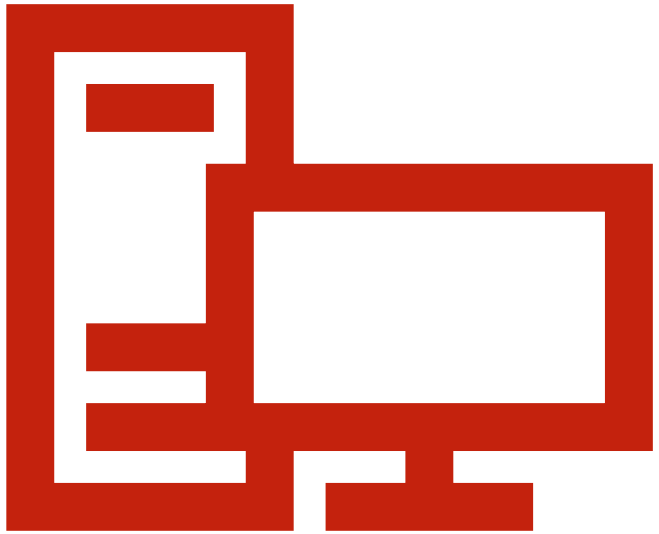
CPD Points = 7

Module structure / design

Module 4 is comprised of 7 learning sessions

1. Recap and application of cross-cutting components of SRHR to MHH
2. Menstrual health basics - life cycle approach (the first H in MHH)
3. Menstrual Hygiene Basics (MHH) (the second H in MHH)
4. Sanitary dignity as part of SRHR
5. Breaking The MHH Silence: De-education And Re-education
6. Menstrual hygiene service delivery
7. MHH monitoring and reporting

MODULE 5



Morden Contraceptives
(Family Planning And Counselling)

CPD Points = 13

MODULE STRUCTURE/DESIGN

Module 5 is comprised of 6 learning sessions

1. Recap and application of cross-cutting components of SRHR
2. Important clinical issues in contraception service provision
3. Method Provision
4. Post-partum, Post-Miscarriage, Post-Abortion-Contraception
5. Clients Requiring Special Consideration
6. Common Chronic Medical Disorders

LEARNING SESSION STRUCTURE/DESIGN

Learning Session 3 is comprised of 7 sub-sessions

1. Intrauterine Device
2. Progestogen –only Contraceptives
3. Combined Hormonal Contraceptives (CHCs)
4. Emergency Contraception
5. Barrier Methods
6. Voluntary sterilisation
7. Lactational Amenorrhoea Method

MODULE 6

Prevention and Treatment of Sub-fertility and Infertility

CPD Points = 6

Module structure / design

Module 6 is comprised of 10 learning sessions

1. Recap and application of cross-cutting components of SRHR
2. Definitions & Aetiology of Infertility
3. Approach to Basic evaluation of an Infertile Couple
4. Prevention of Infertility
5. Assisted Reproductive Technology (ART) & ART Procedures
6. Psychological care and Counselling of people with infertility
7. Safe Conception & Preconception Care
8. Safe Conception and Reproductive Options - Special Considerations
9. Early Pregnancy, Early Pregnancy failure & Genetics
10. Service Delivery Platform & Indicators for Infertility

MODULE 7

Safe Abortion and Post-Abortion Care

CPD Points = 10

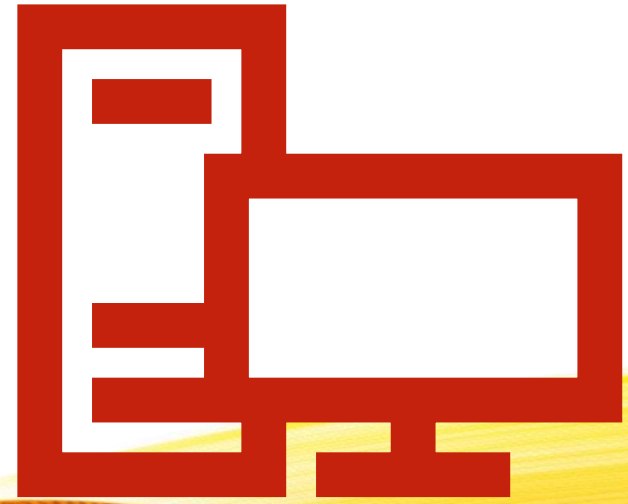
Module structure / design

Module 7 is comprised of 5 learning sessions

1. Recap And Application Of Cross-cutting Srhr Components
2. Clinical Care And Development Of Embryo And Foetus
3. Medical Termination Of Pregnancy
4. Surgical Termination Of Pregnancy
5. Public Health Perspective And Post Abortion Care

MODULE 8

Reproductive Tract Infections
Sexually Transmitted Infections
and
HIV: HIV Prevention, Care, Support and Treatment



CPD Points = 22

Module structure / design

Module 8 is comprised of 4 learning sessions

1. Recap And Application Of Cross-cutting Srhr Components
2. STI's Amongst Adolescents
3. HIV Prevention
4. PMTCT

MODULE 9

Pre-natal Care, Safe Delivery and Post-natal Care
(in development)

CPD Points = ??

MODULE 10

GENETICS

CPD Points = 15

Module structure / design

Module 10 is comprised of 7 learning sessions

1. Introduction to genetics
2. Genetic counselling
3. Genetic testing
4. Prenatal genetics
5. Teratogens and safe prescribing
6. Common genetic conditions
7. Inherited cancers in reproductive care

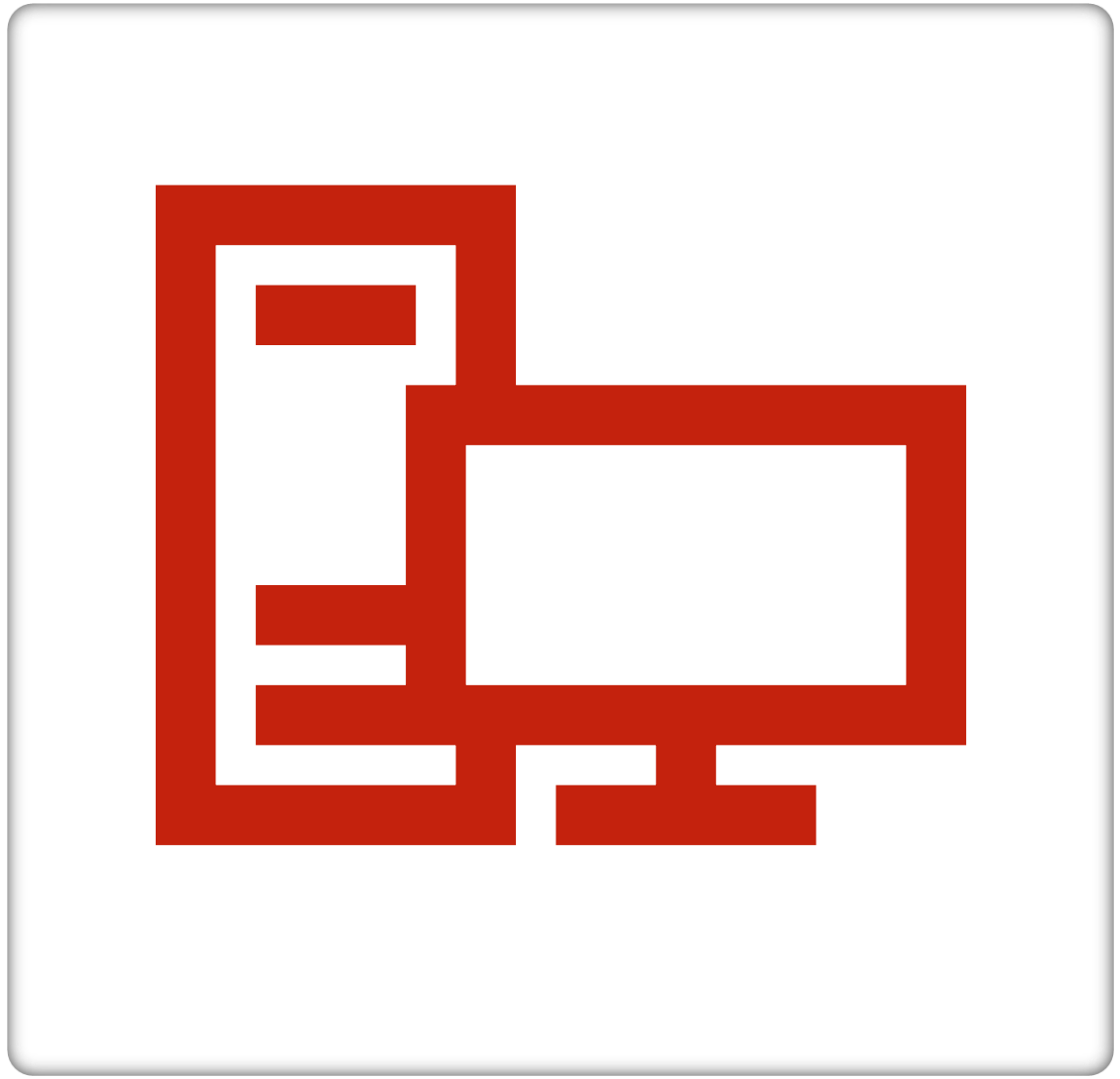
* Additional information, only for the interest of expert healthcare providers will be marked in the heading of the slide in red eg.

EXPERT:

MODULE 11

Disability & SRHR

CPD Points = 5



Module structure / design

Module 11 is comprised of 4 learning sessions

1. Recap And Application Of Cross-cutting SRHR Components
2. Disability Rights
3. Building a Disability Equitable State Machinery
4. Monitoring and Evaluation

MODULE 12

Breast Cancer and Cancers of the Reproductive System

CPD Points = 7

LEARNING SESSION STRUCTURE/DESIGN

Module 12 has 7 learning sessions

1. General Oncological Principles
2. Genetics
3. Breast Cancer
4. Cervical Cancer Prevention And Control Policy
5. Cancer Of The Male Reproductive Organs
6. Principles of Local Vs. Systemic Treatment, Prevention Of Cancer, Risk Factors And Myths
7. Referral Pathways

MODULE 13

Gender Based Violence

CPD Points = 11

Module structure / design

Module 13 is comprised of 8 learning sessions

1. Recap and application of cross-cutting components of SRHR
2. Strategic pillars for GBV response in South Africa
3. Understanding GBV
4. Consequences of GBV
5. Identifying GBV and providing referrals
6. Undertaking a medical examination and providing medical care
7. Documenting GBV
8. Trauma counselling for GBV

MODULE 14

Non-communicable and communicable diseases in relation to Palliative Care

CPD Points = 7

LEARNING SESSIONS

Module 14 is comprised of 8 learning sessions

1. Introduction to palliative care, contraception and End of life care
2. Palliation with safe, effective antenatal, childbirth, and postnatal care
3. Sexually transmitted infections, and GBV in palliative care
4. Spiritual Care
5. Pain and common symptoms management
6. Loss, Grief and Bereavement
7. Communication
8. Care for the care giver

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15 July 2021 - 08:00 am
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31 December 2022 - 11:00 am

Duration
8 Weeks

Time commitment
2 Hours

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Certificate of Achievement

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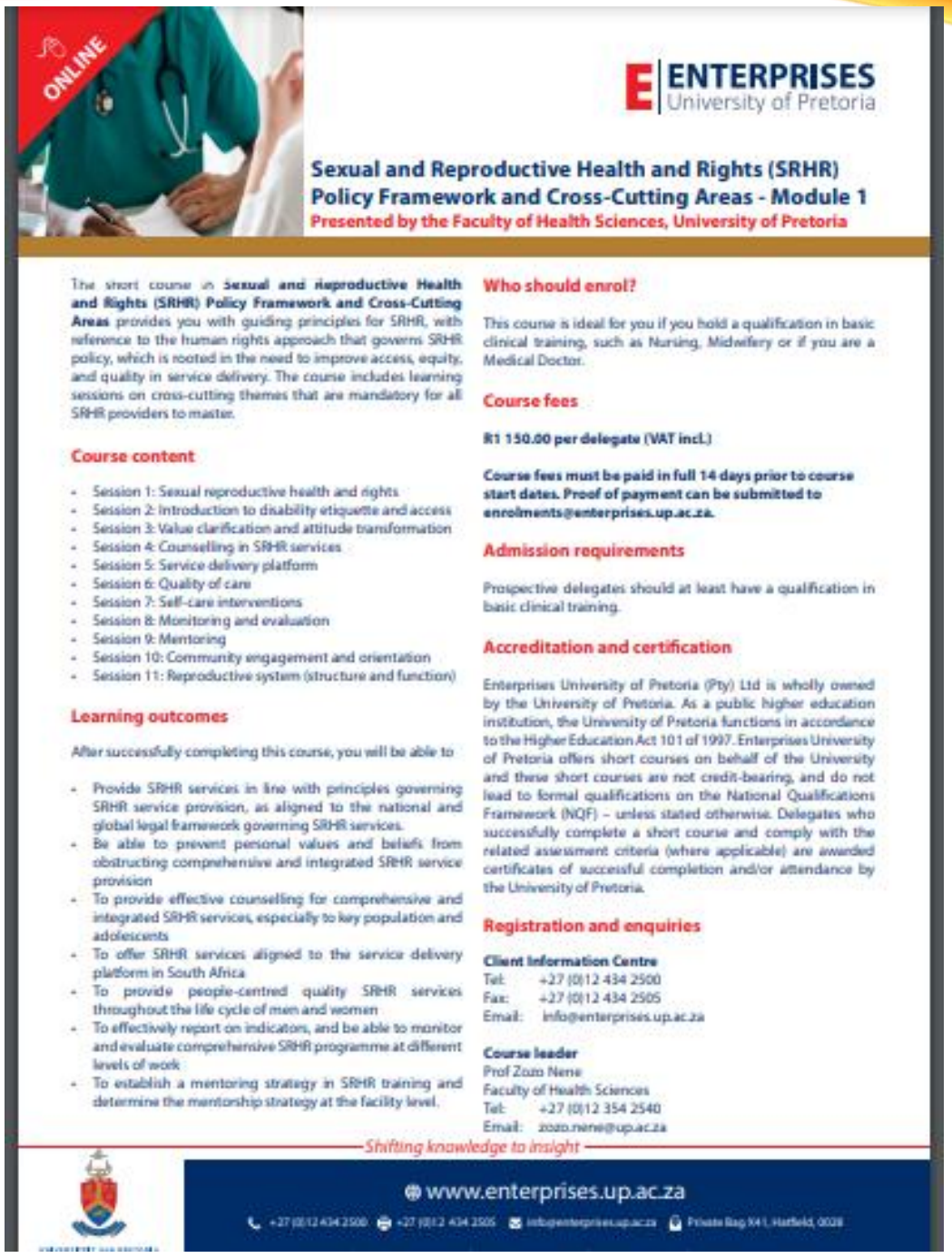


QUESTIONS