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Comprehensive Abortion Care

Training and Service Delivery Guidelines

Second Edition

2018

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Ministry of Health and Family Welfare
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प्रीति सूदन
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स्वास्थ्य एवं परिवार कल्याण मंत्रालय
Government of India
Department of Health and Family Welfare
Ministry of Health & Family Welfare
Dated : 14th June, 2018



FOREWORD

Government of India is committed to bring down maternal mortality ratio and has envisaged a comprehensive approach under the National Health Mission for responding to the health needs. Comprehensive abortion care (CAC) is an integral component of maternal health interventions as part of the National Health Mission. Abortion is a cross cutting issue requiring interface with not just girls and women but across all age groups. There is a need to sensitize all stakeholders on their role for respectful care and addressing stigma and bias on abortion.

Efforts are underway in multiple spheres for strengthening access to safe abortion services and there is a need for consolidating these efforts. There is a need to ensure high quality training and monitoring of services in this direction. I am confident that this effort of the Maternal Health Division, Ministry of Health and Family Welfare to issue updated national training and service delivery guidelines shall strengthen the efforts for ensuring access to comprehensive abortion care. The Ministry has worked with a consultative approach involving experts from all levels of health system delivery to draft and review these important guidelines and I hope that this effort shall go a long way in improving quality of training and subsequent service delivery.

The Comprehensive Abortion Care Training and Service Delivery Guidelines is a dynamic document and has been updated recently in light of global recommendations and international best practices. We at the Ministry of Health and Family Welfare, Government of India believe that this initiative will help us keep pace with the changes in medical technology. These guidelines should be disseminated widely among all concerned state and district level officials for effective implementation of the comprehensive abortion care programme.

(Preeti Sudan)

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PREFACE

Induced abortion has been legal in India for a broad range of conditions since the passage of the Medical Termination of Pregnancy Act in 1971. When this law was passed, India was among the first 15 progressive countries to have a liberal abortion law. We have come a long way since then and have ensured incorporation of comprehensive abortion care as an integral agenda in the lifecycle approach envisioned under the RMNCH+A framework. Provisions for budgetary allocations have been ensured for training, operationalization, supply of drugs and commodities as well as for communication for abortion services under the National Health Mission. Technical and policy guidelines on the same were issued by the Ministry to support implementation.

The National Health Policy 2017 envisages the highest possible level of health and well-being for all through preventive and promotive orientation in policies and universal access to health care without financial hardship in availing the same. The Government has in place provisions for free drugs and diagnostics in all public health facilities and comprehensive abortion care should also be strengthened keeping this in mind.

I am confident that these guidelines which are in line with international standards shall assist programme managers as well as technical officers at the state and district level to strengthen the roll-out of comprehensive abortion care interventions and ensuring free of cost availability of these services at all levels of the public health system.

(Manoj Jhalani)

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PROLOGUE

There is a compelling need to address maternal mortality caused by unsafe abortion in the country. Unsafe abortion is still the third largest cause of maternal mortality in India. Induced abortion is a planned intervention in pregnancy and globally, it is considered to be a very safe medical procedure. We need to ensure that women do not experience death or disabilities due to lack of safe services.

The Maternal Health Division has ensured availability of creating a wide range of documents on comprehensive abortion care (CAC) clearly articulating the policy intent. The training and service delivery guidelines need to be used in conjunction with the national CAC training package, operational guidelines and the guidelines on medical methods of abortion. In the last eight years, along with global technical advancements, new initiatives have been taken by GoI, for strengthening women's access to contraceptive services and abortion services. In light of these technical and programmatic updates there is a need to provide increased clarity to programme officers at the state and district level as well as to service provider. This guideline for CAC will address such needs.

I would encourage state officials to ensure dissemination and roll-out of these guidelines with the intent of ensuring free of cost comprehensive abortion care services at facilities close to women. This will go a long way in reducing the cost of travel and preventing women from seeking services from untrained providers.

The purpose of these guidelines is:

- To assist service provider in achieving and maintaining optimum standards of care
- To assist in strengthening the current available abortion care services
- To promote the concept of woman-centric care in the provision of abortion services
- To be used for CAC training in conjunction with guidelines on other aspects of maternal health and family planning

I hope that these guidelines shall be disseminated widely and assist doctors and programme managers in effective delivery of CAC services.

(Vandana Gurnani)

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ACKNOWLEDGEMENT

Unsafe abortion with its associated complications remains a public health challenge in spite of legalisation of induced abortion through MTP Act, 1971. *Comprehensive Abortion Care Training and Service Delivery Guidelines* is an attempt to provide guidance on safe, quality and comprehensive care for abortion which has myriads of challenges, legal implications, confidentiality and privacy issues, socio-cultural constrains, safety issues, medical and psychological issues, issues on rights and women's status in society. Capacity building of service providers, introduction of new medical advances, logistics, documentation and reporting are also major areas of concern. This updated version consolidates guidance on addressing these issues and concerns based on review of the international and national best practices and global standards to guide the framework for implementation in India.

The Ministry of Health and Family Welfare (MoHFW) would like to thank all the national and international experts from the Ministry, state governments, medical colleges, non-government organizations, professional organizations and individuals who contributed to the development of these guidelines, a collaborative effort by The Maternal Health Division of MoHFW.

The main motivating force behind the initiative is Smt. Preeti Sudan, Secretary, Ministry of Health and Family Welfare, Government of India. With her vision for putting women's health issues at top of the priorities and promoting programmes responsive to their needs, she has reinforced the need for strengthening this initiative.

These guidelines would not have been possible without the direction from Additional Secretary and Mission Director, NHM, Mr. Manoj Jhalani who has constantly provided encouragement to ensure that updated technical and policy guidance are available for the public health system to provide high quality care to women.

Healthy Village, Healthy Nation

एड्स - जानकारी ही बचाव है
Talking about AIDS is taking care of each other

I thank Ms. Vandana Gurnani, Joint Secretary (RCH) whose commitment towards women's empowerment and vision for ensuring care within a continuum of care framework has prompted that all aspects of training and programming are comprehensively reviewed while drafting technical guidelines for effective programme implementation.

I take this opportunity to thank my colleague, Dr. Dinesh Baswal, Deputy Commissioner Maternal Health (I/c) for his continuous guidance in drafting the guidelines.

The effort taken by Dr. Veena Dhawan, Assistant Commissioner (Maternal Health), in inviting, collating and consolidating the inputs from all the experts in a timely manner and compiling it in a concise and comprehensive document is worthy of praise.

Ipas Development Foundation (IDF) team worked in close collaboration with MoHFW for drafting these reader friendly yet comprehensive high quality guidelines. Mr. Vinoj Manning, Executive Director, IDF provided his insight and guidance at all stages. The tireless efforts of Dr. Sangeeta Batra, Senior Director, Health System, IDF and Ms. Medha Gandhi, Director Policy, IDF deserve a special mention. I would also like to thank Ms. Deepti George and Ms. Nidhi Verma, Assistant Managers Health System, IDF. I would also like to acknowledge the efforts of Dr. Narender Goswami, Consultant CAC, Ms. Pooja Chitre and the consultants in the Maternal Health Division.



(Dr. Sumita Ghosh)

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INTRODUCTION TO THE SECOND EDITION OF THE GUIDELINES

The Medical Termination of Pregnancy Act 1971 provides the legal framework for making safe abortion services available in the country. MoHFW issued the Comprehensive Abortion Care Training and Service Delivery Guidelines in 2010 to translate the legal provisions and clearly articulate implementable programme for program officers. However gaps in implementation were being observed and in the last seven years technical advancements have taken place globally in the field of abortion care hence the need for providing updated information to program officers was felt.

This second edition of the CAC guidelines is in line with the global best practices and has been prepared after exhaustive review of the latest global recommendations and international best practices, by an expert group. The key changes in the revised guidelines are detailed below:

1. In light of global evidence, programmatic updates have been included in the guidelines. The importance of strengthening women's access to CAC services in India in light of the abortion scenario in the country has been detailed in the first chapter.

2. Revision of the chapter on medical abortion with the latest protocol for administration including routes for drug administration.

3. The chapter on post-abortion contraception has been updated following introduction of new methods of contraception in the national program. Information on injectables, progesterone only pills, centchroman with the post abortion administration schedule has been included. Inclusion of hands-on practice for post-abortion IUCD insertion for IUCD trained providers

4. The chapter on termination of pregnancy in the second trimester has also been updated with focus on new and safer available technologies.

5. Updated information on usage of drugs for CAC services including new antibiotics and their dosage, use of Misoprostol for management of incomplete abortions.

6. Information on implementing CAC services effectively with reference to other national guidelines like family planning, waste management etc. and other laws like PC&PNDT and POCSO.

7. Stressing on importance of supply chain management of commodities for CAC is added in the edition.

8. Information on available communication material on CAC and its effective use.

9. Detailed information on the importance of and documentation requirements for CAC service.

These comprehensive guidelines are designed with the purpose of providing clear and concise information for better implementation of the CAC interventions in our health facilities. I hope that these guidelines would be useful in further strengthening CAC services for women at all levels of service delivery.



(Dr. Veena Dhawan)

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Acronyms

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha & Homoeopathy
BCC	Behaviour Change Communication
CAC	Comprehensive Abortion Care
CHC	Community Health Center
CMO	Chief Medical Officer
COC	Combined Oral Contraceptive Pill
D&C	Dilatation and Curettage
D&E	Dilatation and Evacuation
DH	District Hospital
DLC	District Level Committee
DV	Double Valve
EC	Emergency Contraception
EmOC	Emergency Obstetric Care
EVA	Electric Vacuum Aspiration
FIGO	International Federation of Gynaecology and Obstetrics
FRU	First Referral Unit
GoI	Government of India
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
HMIS	Health Management Information System
IEC	Information Education and Communication
IFA	Iron Folic Acid
IUCD	Intrauterine Contraceptive Device
I/M	Intramuscular
IMEP	Infection Management and Environmental Plan
I/V	Intravenous
LMP	Last Menstrual Period
MCG	Microgram
MG	Miligram
MMA	Medical Methods of Abortion
MMR	Maternal Mortality Ratio
MO	Medical Officer
MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
MBBS	Bachelor of Medicine and Bachelor of Surgery

MD/DGO	Masters/Diploma in Gynaecology and Obstetrics
MoHFW	Ministry of Health and Family Welfare
MPA	Medroxyprogesterone Acetate
NGO	Non-Governmental Organization
NPP	National Population Policy
NHM	National Health Mission
NSAID	Non Steroidal Anti Inflammatory Drug
OT	Operation Theatre
P/V	Per Vaginum
PCPNDT	Pre-Conception Pre-Natal Diagnostic Techniques
PHC	Primary Health Center
PID	Pelvic Inflammatory Disease
PIP	Program Implementation Plan
POC	Products of Conception
POP	Progesterone only Pills
PGE1	Prostaglandin E1
PGF2	Prostaglandin F2
PRI	Panchayati Raj Institution
QA	Quality Assurance
RCH	Reproductive and Child Health
RH	Referral Hospital
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
RMP	Registered Medical Practitioner
RTI/STI	Reproductive Tract Infection/Sexually Transmitted Infection
SDH	Sub District Hospital
SIHFW	State Institute of Health and Family Welfare
SRS	Sample Registration Survey
SV	Single Valve
TA/DA	Travel/Dearness Allowance
ToT	Training of Trainers
USG	Ultra Sonography
VA	Vacuum Aspiration
WHO	World Health Organization

CONTENTS

Foreword		iii
Preface		v
Prologue		vii
Acknowledgement		ix
Introduction		xi
Expert Group Members		xiii
Acronyms		xv
Chapter 1:	**Abortion Scenario**	**1**
	Annexure 1.1: IEC Materials	4
Chapter 2:	**Legal Aspects of Abortion Care**	**5**
	Annexure 2.1: Form C	8
	Annexure 2.2: Form I	9
	Annexure 2.3: Form II	10
	Annexure 2.4: Form III	11
Chapter 3:	**Counselling**	**13**
	Annexure 3.1: Post-abortion Contraceptive Methods	16
	Annexure 3.2: Challenging Situations during Counselling	19
Chapter 4:	**Clinical Assessment**	**21**
	Annexure 4.1**:** MTP in Women with Various Medical Conditions	24
Chapter 5:	**Infection Prevention**	**25**
Chapter 6:	**Vacuum Aspiration Techniques in the First Trimester**	**29**
Chapter 7:	**Medical Methods of Abortion for Termination of Pregnancy in the First Trimester**	**45**
	Annexure 7.1: MMA Ready Reckoner	56
	Annexure 7.2: MMA Card	57
Chapter 8:	**Termination of Second Trimester Pregnancies**	**59**
	Annexure 8.1: Medical Methods for Second Trimester Termination	66
Chapter 9:	**Health System Requirements for Provision of CAC Services**	**67**
Chapter 10:	**Operationalizing MTP/CAC Trainings**	**73**
	Annexure 10.1: Suggestive Agenda of Planning and Orientation Workshop	79
	Annexure 10.2: Suggested Sessions and Plan for Training-of-Trainer's Workshop	80
	Annexure 10.3 (a): Suggested Didactic Sessions for MTP/CAC Certification Course	82
	Annexure 10.3 (b): Suggested Session Plan for MTP/CAC Certification Course	83
	Annexure 10.4: Skills Checklist: Uterine Evacuation Procedure with MVA	84
	Annexure 10.5: Sample Certificate for MTP/CAC Certification Training	85
	Annexure 10.6: Suggested Didactic Sessions and Session Plan for MTP/CAC Training of Certified Providers	86

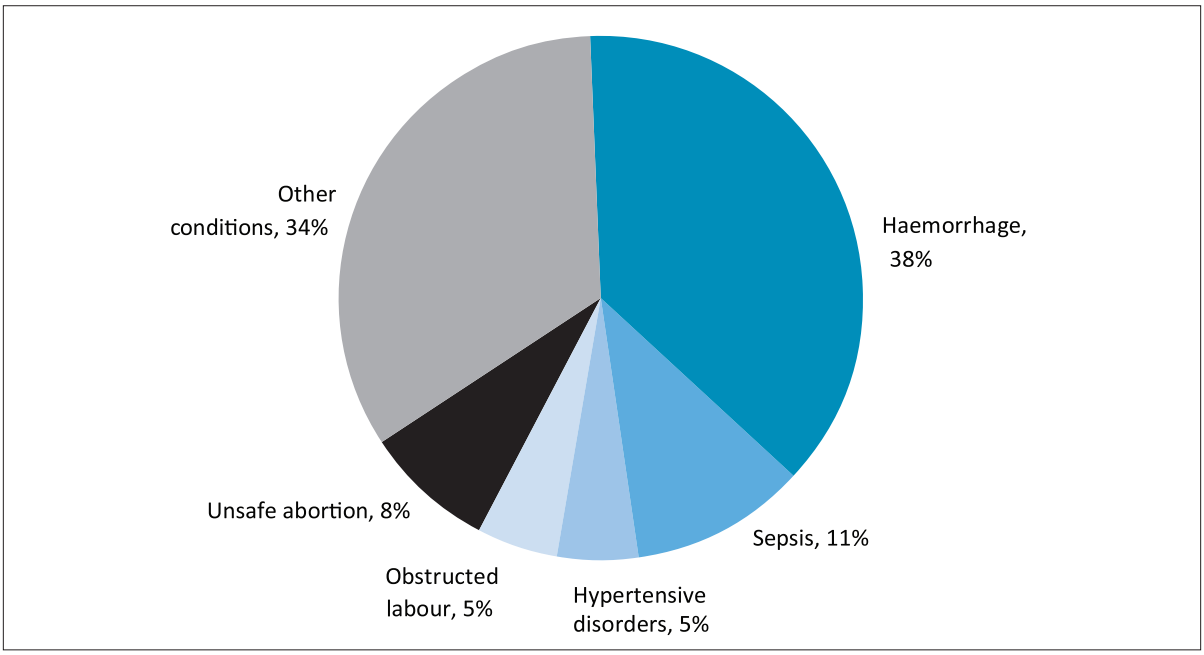
Abortion Scenario

Unsafe abortion is a significant yet preventable cause of maternal deaths. Though Medical Termination of Pregnancy (MTP) has been legalised in India since 1971, the access to services is still a challenge, especially in the rural and remote regions of the country. While there is a desire for small families among married couples, this has not translated into contraception usage. Further, no contraceptive is 100% effective and therefore, safe abortion services would always be a necessary component of reproductive healthcare. Ensuring Comprehensive Abortion Care (CAC) services is now an integral component of the efforts made by the Government of India to bring down maternal mortality and morbidity in the country.

I. Abortion Scenario in the Country

The Maternal Mortality Ratio (MMR) for India is 130/100,000 live births (RGI-SRS: 2014-16) and unsafe abortions account for 8% of the MMR. Many of those who survive these clandestine procedures often suffer from chronic, debilitating diseases that have a bearing on the future reproductive health of the woman.

Major Causes of Maternal Mortality



Source: RGI-SRS, 2001-03

II. Factors Contributing to Unsafe Abortions Include:

- **Social factors**
  - Lack of awareness that abortion is legal and is available in the health facilities
  - Belief of killing a life is woven around abortion and there is social stigma related to abortions
  - Gender discrimination and the low status of women in society

- The safety of a woman is further jeopardised by the involvement of multiple decision makers around her
- Ignorance about contraception and the lack of male participation in preventing unintended pregnancy
- Women do not go to male providers

- **Policy factors**

Policies are basic strategies that guide the Government to formulate a roadmap for further action on any programme. The policy factors impacting access to safe abortion services are:

- Scarcity of qualified providers for safe abortion services
- Inadequate equipment and supplies essential to provide services
- Insisting on acceptance of a particular contraceptive method during abortion care
- Weak referral linkages

- **Economic factors**
  - Loss of wages affect the individual's decision to seek healthcare
  - Private providers charge high fees for services
- **Physical access factors**
  - Scarcity of trained providers in the under-served areas and the judgmental attitude of the providers
  - Sites providing safe services are not advertised

III. Policies for Safe Abortion Care

As unsafe and illegal abortions make a significant contribution to MMR, the Government of India policies and strategies are focused on enhancing access and availability of CAC services in both the public and private sector. The policies under the National Population Policy (NPP) 2000 and the Reproductive and Child Health-II (RCH), National Health Mission (NHM) programme, within the framework of the MTP Act, 1971, are broadly categorised as:

(A) Integrated strategic approach under the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)

(B) Establishing CAC service delivery

(C) Generating awareness

(A) Integrated strategic approach under RMNCH+A

A strategic approach has been formulated under RMNCH+A to integrate the early detection of pregnancy, safe abortion care services and contraception counselling/services to address unintended pregnancies and abortions.

(B) Establishing CAC service delivery

CAC: Woman-centred approach

Abortion care services should be transformed from being just a medical procedure into a woman-centred CAC approach. This implies providing safe and legal abortion services, taking into account different factors influencing a woman's physical and mental health needs, her personal circumstances and the ability to access abortion services. The three key elements of this approach, which would help the transition of abortion care to being woman-centred care, are:



- Choice: giving woman the options to choose from the methods for the termination of pregnancy and post-abortion contraception
- Access: making services available near her home
- Quality: care provided with all the standard norms followed as under high quality of care, some of which are:
  - Provision of adequate time for counselling
  - Maintenance of privacy and confidentiality
  - Use of internationally recommended technologies, such as MVA, EVA and MMA
  - Adherence to appropriate clinical standards and protocols for infection prevention, pain management, management of complications and other clinical components of care
  - Provision of post-abortion contraceptive services, including emergency contraception
  - Provision of reproductive and other health services, such as RTI/STIs and counselling on sexual behaviour

Important steps taken to establish CAC services are:

- Provision of funds to states/union territories for the operationalization of CAC services including drugs and equipment, at health facilities
- Capacity building of medical officers in safe MTP techniques
- Training ANMs, ASHAs to provide confidential counselling for CAC and promoting post-abortion care and contraception
- Certification of private and NGO sector facilities through District Level Committees (DLCs)
- Active monitoring of CAC services in the public and private facilities through Health Management Information System (HMIS) and the quarterly reporting

(C) Generating awareness (IEC/BCC)

Activities that may be undertaken to create awareness on safe abortion care:

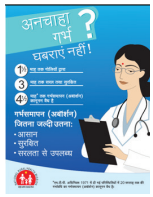
- Sensitization workshops on CAC for the state and the district officers in the states
- Standard IEC/BCC material on safe abortion developed at the central level and disseminated to the states (Annexure 1.1)
- Funds to states/union territories for the planning of IEC activities through state PIPs
- Orientation/training of ASHAs on skills to create awareness in the community. One-on-one communication with the women using the available IEC tools would help women in accessing services

CAC has also been integrated in comprehensive RCH BCC campaign.

Annexure 1.1

IEC Materials

Find below the various IEC materials that can be used for increasing awareness about safe abortion care, including by counsellors and healthcare workers:

Title	Material Brief	Key Messages	Intended Audience	Snapshot
Poster	The posters are developed to provide key information on specific safe abortion-related issues	• Information about various methods of safe abortion and the gestation period for which these methods can be used • Lesser the duration of pregnancy, safer the abortion	• General public • Community health workers • Community leaders	
Booklet	The booklet has been developed as reference material for community-based health workers	• Conditions in which abortion is safe/unsafe • Consequences of unsafe abortion • Conditions for which abortion is legally permitted in India • Danger signs to be monitored after abortion	• ASHA, ANM, AWW and supervisors	
Leaflet	Leaflet is designed to provide information on safe and legal abortion in a very simple and short messages format	• Conditions where abortion is safe • Post-abortion precautions • Conditions for which abortion is legally permitted in India	• Community women	
Flipbook	Flipbook has been developed as a communication tool to conduct small group meetings with the women in the community to sensitize them on safe abortion issues through story telling	• Contraception, its importance, pre- and post-abortion • Consequences of unsafe abortion • Conditions where abortion is safe • Approved facilities for safe abortion services	• Women • Community health workers	



Legal Aspects of Abortion Care

The Medical Termination of Pregnancy (MTP) Act, enacted in 1971, governs the provision of abortions in India. This Act allows the termination of a pregnancy up to 20 weeks, for a broad range of indications. It also offers protection to a practitioner if he/she adheres to and fulfils all the requirements of this Act.

The MTP Act was amended in December 2002 and the Rules, in June 2003.

An abortion is legal only when it fulfills the following conditions:

- It is performed by a registered medical practitioner, who is allowed to terminate the pregnancy, as defined by the MTP Act
- It is performed at a place that has been approved to terminate pregnancy under the MTP Act. For Medical Methods of Abortion (MMA), up to seven weeks gestation, drugs can be prescribed in outdoor clinics with an established referral linkage to an MTP approved site
- Other requirements of the Act such as gestation period, consent, opinion of registered medical practitioner,record keeping and reporting are fulfilled (Annexures 2.1 - 2.4)

The MTP Act details the following:

I. Who Can Terminate a Pregnancy?

A registered medical practitioner who possesses a recognised medical qualification as defined in the Indian Medical Council Act, 1956; whose name has been entered in a state medical register; and who has such experience or training in gynaecology and obstetrics as prescribed by the MTP Rules made under this Act.

Consent Requirement

Only the consent of the woman is required to terminate the pregnancy. However, in the case of a minor* or a mentally ill woman, the consent of the guardian*** is required.

The consent is to be obtained in Form C (Annexure 2.1).

***Reporting requirement for minors seeking termination of pregnancy under Protection of Children Against Sexual Offences Act, 2012**

Protection of Children Against Sexual Offences (POCSO) Act,** 2012 under Section 19 (1) requires anyone who knows that a sexual offence has been committed to report the case to the appropriate authorities (either the Local Police or Special Juvenile Police) or to the concerned authority in the Hospital responsible for medico-legal cases to report the same.

Medical practitioners must remember that while completing the reporting formalities, it is also important to ensure that services are offered to the client and all documentation is maintained as per the provisions of the law/s. The Special Juvenile Police Unit or Local Police have to further report the matter to the Child Welfare Committee in 24 hours. Medical practitioners are not obligated to file an FIR or to conduct the investigation; the provider's duty is to only inform the authorities when **providing services to a minor including abortion services under the existing provisions of MTP Act .** Legal proceedings, if any, can continue simultaneously and should not be a hindrance in provision of services.

** For more information on the POCSO Act please refer http://policewb.gov.in/wbp/misc/2013/22-11.pdf

*** According to the MTP Act, 'guardian' means a person who has the care and management of a minor or a mentally ill person. The MTP Act can be accessed at http://www.egazette.nic.in/WriteReadData/1971/E-1383-1971-0034-61647.pdf

The Rules further prescribe that only those with the following experience or training can perform MTPs:

Up to 12 weeks gestation

A practitioner who has assisted a registered medical practitioner in the performance of 25 cases of MTP, of which at least five have been done independently in a hospital that has been established or maintained by the Government or at a training institute approved for this purpose by the Government.

Up to 20 weeks gestation

- A practitioner who holds a post-graduate degree or diploma in obstetrics and gynaecology
- A practitioner who has completed six months of house surgency in obstetrics and gynaecology
- A practitioner who has at least one year experience in the practice of obstetrics and gynaecology at any hospital that has all facilities

II. When Can a Pregnancy be Terminated?

A pregnancy can be terminated by a registered medical practitioner (under the MTP Act) if:

- The continuation of pregnancy involves a risk to the life of the pregnant woman or causes grave injury to her physical or mental health

The anguish caused by the unwanted pregnancy in the following situations is presumed to cause grave injury to the mental health of the pregnant woman:

  - rape or incest
  - failure of any device or method used by a married woman or her husband for the purpose of limiting the number of children
- There is a substantial risk that, if the child was born, s/he would suffer from such physical or mental abnormalities as to be seriously handicapped

For the termination of a pregnancy that exceeds 12 weeks (but not 20 weeks) of gestation, the opinion of two registered medical practitioners is required in Form I – RMP Opinion Form (Annexure 2.2).

III. Where Can a Pregnancy be Terminated?

MTP can be performed at the following places:

- A hospital established or maintained by the Government
- A place approved by the Government or a District Level Committee (DLC) constituted by that Government with the Chief Medical Officer (CMO) as the Chairperson of the Committee

It should be noted that the DLC shall consist of not less than three and not more than five members, including the Chairperson, as the Government may specify from time to time.

Details of the composition and tenure of the DLC:

- One member of the DLC shall be a gynaecologist/surgeon/anaesthetist and the other members shall be from the local medical profession, Non-Governmental Organisations (NGOs) and the Panchayati Raj Institution (PRI) of the district



- One of the members of the DLC shall be a woman
- The tenure of the committee shall be for two calendar years and the tenure of the non-government members shall be of not more than two terms

Medical Methods of Abortion*

In case of the termination of an early pregnancy of up to seven weeks using mifepristone (RU486) and misoprostol, the registered medical practitioner, as defined by the MTP Act, can prescribe the drugs at his/her clinic provided he/she has access to a place approved for terminating pregnancies under the MTP Act. The clinic should display a certificate to this effect from the owner of the approved place. In other words, the clinic where medical abortion drugs are prescribed by an approved registered medical practitioner does not need approval as long as it has referral access to an MTP approved site.

IV. Documentation/Reporting of MTP Cases

It is mandatory to fill and record information for abortion cases, performed by any technique, in the following forms:

1. Form C – Consent Form
2. Form I – RMP Opinion Form
3. Form II – Monthly Reporting Form (to be sent to the district authorities)
4. Form III – Admission Register for case records

Maintenance of Admission Register

Every head of the hospital or owner of the approved place shall maintain a register in Form III for recording therein the details of the admissions or women for the termination of their pregnancies and keep such register for a period of five years from the end of the calendar year it relates to. Admission Register shall be a secret document and the information contained therein as to the name and other particulars of the pregnant woman shall not be disclosed to any person. Entries in the admission register shall be made by the serial number for each calendar year.

*also referred to as Medical Abortion

Form C

(See rule 9)

I.....daughter / wife of .....
aged about.....years of ..... (here state the permanent address) at present residing at.....
do hereby give my consent to the termination of my pregnancy at .....
..... (state the name of place where the pregnancy is to be terminated)

Place:
Date:

Signature

(To be filled in by guardian where the woman is a mentally ill person or minor)

I.....son/ daughter / wife of .....
aged about.....years of.....at
(Permanent address)
present residing at.....
do hereby give my consent to the termination of the pregnancy of my ward.....
who is a minor / mentally ill person at .....
(place of termination of pregnancy)

Place:
Date:

Signature

FORM I
[See Regulation 3]

I _____
(Name and qualifications of the Registered Medical Practitioner in block letters)

_____
(Full address of the Registered Medical Practitioner)

I _____
(Name and qualifications of the Registered Medical Practitioner in block letters)

_____
(Full address of the Registered Medical Practitioner)

hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of _____
(Full name of pregnant woman in block letters)

resident of _____
(Full address of pregnant woman in block letters)

for the reasons given below**.

* I/We hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the Serial No. _____ in the Admission Register of the hospital/approved place.

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioners

Place:

Date:

*Strike out whichever is not applicable.
**of the reasons specified items (i) to (v) write the one which is appropriate.

(i) in order to save the life of the pregnant woman,
(ii) in order to prevent grave injury to the physical and mental health of the pregnant woman,
(iii) in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,
(iv) as the pregnancy is alleged by pregnant woman to have been caused by rape,
(v) as the pregnancy has occurred as a result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children.

Note: Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place:

Date:

Signature of the Registered Medical Practitioner/Practitioners

FORM II
[See Regulation 4 (5)]

1. Name of the State

2. Name of the Hospital/approved place

3. Duration of pregnancy (give total No. only)
   (a) Up to 12 weeks
   (b) Between 12-20 weeks

4. Religion of woman
   (a) Hindu
   (b) Muslim
   (c) Christian
   (d) Others
   (e) Total

5. Termination with acceptance of contraception
   (a) Sterilisation.
   (b) I.U.D.

6. Reasons for termination :
   (give total number under each sub-head)
   (a) Danger to life of the pregnant woman.
   (b) Grave injury to the physical health of the pregnant woman.
   (c) Grave injury to the mental health of the pregnant woman.
   (d) Pregnancy caused by rape.
   (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
   (f) Failure of any contraceptive device or method.

Signature of the Officer In-charge
with Date

FORM III
[Refer Regulation 5]

Admission Register

Name of Facility _____ Month _____ Year _____

S. No.	Date of admission	Name of the patient	Wife/daughter of	Age (in years)	Religion	Address	Duration of pregnancy	Reasons for which pregnancy is terminated	Date of termination of pregnancy	Date of discharge of patient	Result & remarks	Name of Registered Medical Practitioner(s) by whom the opinion is formed	Name of Registered Medical Practitioner(s) by whom pregnancy is terminated
1	2	3	4	5	6	7	8	9	10	11	12	13	14

Counselling

'Counselling is a structured interaction in which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to open sharing of thoughts, feelings and perceptions.'

Every woman who seeks CAC services must be offered counselling. Providers, nursing staff/ paramedical staff and counsellors (where available) may be appropriately trained to offer abortion-related counselling services. Counselling is an integral part of comprehensive abortion services and is as important as performing the procedure correctly. The process of decision-making may be difficult for the woman and she may need help. Counselling is also important to help her decide whether to use a temporary or permanent method of contraception to avoid another unwanted pregnancy. Wherever possible, the spouse should also be counselled.

Care should be taken that women with complications of abortion are sensitively attended to at the facility without any prejudice.

Pre-procedure counselling

Pre-procedure counselling is important for the following reasons:

- It helps the woman to decide about the termination of pregnancy
- It helps the woman to choose the method of termination
- It ensures that the consent for the procedure is given after receiving complete information about the procedure and understanding its implications
- It helps the woman to adopt a contraceptive method after the procedure

I. Pre-procedure Counselling



Figure 1

- Ensure that privacy (visual and auditory) and confidentiality are maintained during counselling
- Be non-judgmental while interacting with the woman and be sensitive to her needs (Figure 1)
- Establish rapport with the woman and gain her confidence, as abortion is a very sensitive issue and she may be reluctant to discuss it. Building rapport is also critical for finding out whether there have been any attempts to terminate the present pregnancy; this is important for predicting likely problems and may affect their management
- Make the woman feel comfortable mentally as well as physically. The former is extremely important as she may have strange feelings about terminating the pregnancy
- Identify the reason for the termination of pregnancy by asking relevant questions related to her personal, social, family and medical history and the past use of contraceptive methods
- Use simple language and allow the woman to clarify her doubts
- If she has made up her mind for termination of her pregnancy, assess her for the CAC procedure

- If found eligible for MTP, explain to her, in simple language:
  - The range of available options of MTP techniques based on gestation
  - The MTP technique chosen by her. For instance, if she has opted for medical methods of abortion, then discuss her preference for the place of misoprostol use
  - The likely risks associated with the procedure
  - The care required after the procedure
  - That this will not affect her future fertility, if done under safe conditions
  - The immediate risk of pregnancy if no contraceptive method is used, as fertility can return as early as 10 days after the first trimester abortion and within four weeks after a second trimester abortion
  - She should wait for at least six months before trying to conceive again
  - Need and schedule for a follow-up
- Help the woman to sign the consent (Figure 2)
- Discuss various contraceptive methods (refer Annexure 3.1: Post-abortion Contraceptive Methods) including their advantages



Figure 2

- Help the woman to choose a contraceptive method and assess whether the method is appropriate (based on history and examination) for her

If the chosen method is not appropriate, explain the reason and help her choose another one.

If the method is appropriate, provide the method-specific information. In case the method is not available at the centre, provide information and other assistance for getting the appropriate service elsewhere.

If the woman is not willing to accept a contraceptive method:

- Do not refuse MTP, as she is likely to go elsewhere, probably to an illegal abortion provider, and suffer complications
- Assure the woman that she will not be refused MTP
- Wait for an opportunity to counsel her after the procedure. If she is still not willing to accept a contraceptive method, call her for follow-up in a week's time and counsel her again. Record the assessment findings, procedure, contraception or refusal to accept contraception and advice given (including referral)

MTP should not be denied irrespective of the woman's decision to refuse concurrent contraception.

Important notes for the counsellor on post-abortion contraception

- Roughly 75% women ovulate and 6% conceive within two to six weeks after abortion, if they are not using contraception
- All modern contraceptive methods can be safely provided immediately after the first trimester abortions (caution to be taken for second trimester abortions)
- The continuation rate for post-abortion insertion of IUCD is good. Insertion of IUCD immediately after the first/second trimester abortions is not associated with a higher risk of expulsion, infection or bleeding
- Abdominal tubectomy can be safely performed concurrently with MTP. Laparoscopic ligation should be done only after the first trimester abortions

II. Post-procedure Counselling

Post-abortion counselling is an integral part of the post-procedure care. It is as important as the pre-abortion counselling for the following reasons:



- It ensures that the woman has understood the precautions and care needed during the post-abortion period and the actions that need to be taken in case of complications
- It provides an opportunity to counsel for contraception in cases where the woman is not sure about accepting a contraceptive method
- It reinforces the need for continuing the use of the contraceptive method chosen

Critical steps during post-procedure counselling:

- Continue to ensure privacy and confidentiality and an empathetic attitude
- Enquire from the woman how she is feeling and reassure her in case of any problems
- Inform her that she should avoid intercourse till bleeding stops or condoms should be used
- Repeat the information about post-procedure care and ensure that the woman understands it fully

Inform her that she should return to the hospital in case of:

- Severe abdominal pain
- Heavy vaginal bleeding
- Fever, fainting, abdominal distention or severe vomiting

Call the woman for a follow-up visit in a week's time and counsel her again if she had not accepted any form of contraception.

III. Information to a Woman Who is Being Referred to a Higher Level of Facility

It is important to explain the reason for the referral to the woman, spouse or relative accompanying the woman:

- Explain the reasons why she is being referred
- Explain which facility (referral site) they should go to and explain the procedure that will be done at the site
- Give a referral letter with details of history, physical examination, treatment given so far and the reason for the referral. Request for feedback
- Facilitate transport to the next level of facility. Emergency transport facilities (108) can be used for referral, if required
- Contact the provider at the referral site, if possible, giving information of the referral
- Instruct the woman to report for a follow-up either at the referral site or the facility from where she has been referred
- Record the referral
- Plan for a follow-up later for the woman to ensure her well-being

Possible reasons for referral are included as part of subsequent chapters.

IV. Counselling During a Follow-up Visit

Counselling during a follow-up visit provides an opportunity to:

- Ask the woman about problems after abortion, if any
- Ask her if she is comfortable with the contraceptive chosen
- Counsel for contraception in the case of a woman who had not accepted a contraceptive method. Here, the focus should be on the consequences of repeated abortions
- Find out about the procedure that was performed (in case the woman was referred) and if any contraceptive method was advised/given. If no contraceptive method was provided, counsel for contraception and help the woman to choose an appropriate method
- Record findings/advice

Annexure 3.1

Post-abortion Contraceptive Methods			
Method	**Timing After Abortion**		**Additional Information**
	First Trimester	**Second Trimester**	
A. Barrier Methods			
Condoms	As soon as sexual activity is resumed	As soon as sexual activity is resumed	• No hormonal side-effects • Can be used without consulting a health provider • Easily available • Prevention against STIs, including HIV • Enables men to take responsibility of contraception
B. Intrauterine Contraceptive Device			
Intrauterine Contraceptive Device (IUCD 380 A, IUCD 375)	Inserted immediately or up to 12 days after confirmation of a completed abortion using the surgical method With MMA, inserted around day 15 of the process, provided complete POC expulsion is confirmed and risk or presence of infection or any other contraindication is ruled out	Can be inserted immediately or up to 12 days after the procedure is complete and contraindications are ruled out	• Highly effective • Provides long term contraception for 5 years (IUCD 375) or 10 years (IUCD 380 A) • Can be provided by trained doctors (MBBS and above), ANMs/nurses after first trimester surgical abortions; by trained doctors (only) after MMA; and by PPIUCD trained doctors after second trimester abortions • No interference with sex • Immediate return to fertility on removal • No hormonal side-effects



Annexure 3.1 (contd.)

Post-abortion Contraceptive Methods			
Method	**Timing After Abortion**		**Additional Information**
	First Trimester	**Second Trimester**	
C. Hormonal Contraception			
Combined Oral Contraceptives (COCs)	Immediately or up to seven days after abortion using surgical method With MMA, it can be started on day 3 with the dose of misoprostol or within day 15 of the process, after confirmation of a completed abortion	Immediately or up to seven days after abortion	• Regulate menstrual cycles • Can be provided by all health workers after first screening by trained provider • No interference with sex • Offer protection against ectopic pregnancy, endometrial and ovarian carcinoma and benign breast diseases such as fibrocystic and fibroadenomatosis • Not suitable for women who are breast-feeding babies less than six months old
Long-term Injectables: MPA (Medroxy Progesterone Acetate)	Immediately or up to seven days after abortion, using surgical method With MMA, it can be started on day 3 with the dose of misoprostol	Immediately or up to seven days after abortion	• Highly effective • Confidentiality and privacy maintained • Can be provided by doctors (MBBS and above, AYUSH)/ANMs/Nurses after screening by the doctors (MBBS and above) for the first injection • No interference with sex • No effect on the quality and quantity of breast milk • No oestrogenic side effects • Offers protection against ectopic pregnancy, ovarian cancer, iron deficiency anaemia and uterine fibroids • Return of fertility takes 7-10 months from date of last injection
Progesterone-only Pills (POPs)	Immediately or up to seven days after abortion, using surgical method With MMA, it can be started on day 3 with the dose of misoprostol	Immediately or up to seven days after abortion	• Can be provided by doctors (MBBS and above, AYUSH)/ANMs/Nurses • Immediate return to fertility • Does not interfere with sexual activity • Can be used safely by breastfeeding women up to six months after delivery

Annexure 3.1 (contd.)

Post-abortion Contraceptive Methods			
Method	**Timing After Abortion**		**Additional Information**
	First Trimester	**Second Trimester**	
Centchroman	Immediately or up to seven days after abortion using surgical method With MMA, it can be started on day 3 with the dose of misoprostol	Immediately or up to seven days after abortion	• Safe for use by breastfeeding women • Immediate return to fertility • Can be provided by doctors (MBBS and above, AYUSH) • Cannot be given in women with polycystic ovarian disease, cervical hyperplasia, tuberculosis, renal disease, jaundice/liver disease and severe allergic state
D. Permanent Methods			
Female Sterilization	Can be performed after an abortion in the absence of any infection or severe blood loss, concurrently or up to seven days (both minilap and laparoscopic sterilization can be done) With MMA, it can be done only after the first menstrual cycle	Minilap sterilization can be performed concurrently or up to seven days after an abortion in the absence of any infection or severe blood loss (laparoscopic sterilization is not recommended)	• Permanent method of contraception • Highly effective • Effective immediately • No interference with sex • No effect on breast-feeding • No long-term side-effects • Offers protection against ovarian cancer
Vasectomy	Performed on males, independent of the timing and procedure of the abortion		• Very effective • Permanent method of contraception • No interference with sex • No long-term health risks • Couple must use another contraceptive method for at least three months or till there is azoospermia

IUCD, Combined Oral Contraceptive Pills and Injectables can be started beyond the stipulated period after ruling out pregnancy and with appropriate back-up method. However, that will not be classified as post-abortion.



Annexure 3.2

Challenging Situations during Counselling

Some of the challenging situations that counsellors may face during abortion counselling and suggestions on how to overcome them:

The woman is silent

- If the woman is silent at the start of the meeting, you could say, “I can see that it is difficult to talk. It’s often that way for some women. I wonder if you are feeling a little anxious.” Look at her and use body language that shows empathy and interest. Wait
- During discussion, silence can be okay. Sometimes the woman is thinking or wondering how to express her feelings or thoughts. Give her time to think

The woman cries

- A woman may cry for different reasons – to express sadness, get sympathy, or to stop further discussion. Do not assume why she is crying. Wait for a while and, if crying continues, say that it is all right to cry, it is a natural reaction. This permits her to express the reasons for crying. It is okay to ask the reasons gently

The counsellor cannot see a solution to the woman’s problem

- The counsellor, too, may feel anxious if he/she is not sure of what advice to give. The counsellor is a reproductive health expert but does not have to solve every problem for the woman. Express understanding; sometimes this is what she really wants. Also, suggest others who could help

The counsellor does not know the answer to a woman’s question

- Say honestly and openly that you do not know the answer, but you can try to find it for her. Check with a supervisor, a knowledgeable co-worker or reference materials, and give her the accurate answer

The counsellor makes a mistake

- Correct the mistake and say you are sorry. It is important to be accurate. It is not important to look perfect. Admitting a mistake shows respect for the woman. Be honest. The more honestly you express your own feelings when appropriate (without revealing your personal life), the easier it is for the woman to do the same

The counsellor and the woman already know each other

- Ensure confidentiality and privacy
- If the woman wishes, arrange for another counsellor

The woman asks a personal question

- In general, try not to talk about yourself. You do not have to answer personal questions. The relationship between a woman and a counsellor is professional, not social. It can sometimes help to talk about your own experience or describe what happened to someone else, without using names or identifying them. Sometimes the woman asks if the counsellor had the same problem. It is best not to say yes or no. Instead, say, “I’m familiar with this kind of situation. Please tell me more”

The woman wants the counsellor to make the decision

- This woman may actually be asking for help. You can ask questions such as, “You seem to be having trouble reaching a decision, perhaps you are not quite ready? Would you like to discuss this further? Do you need more information? Would you like to talk this over with someone else, perhaps your spouse or your parents?” You can say, “I can answer your questions and help you think about your choices, but you know your own life best. The best decisions will be the decisions you make yourself”



Clinical Assessment

Clinical assessment for suitability to undergo termination of pregnancy is critical to avoid complications while providing abortion services. The assessment helps to identify the woman who needs referral for the procedure at a higher level of facility, which is better equipped and can handle complications, if any.

Clinical assessment provides the following information:

- Confirmation of pregnancy
- Exact period of gestation
- Woman's general health condition
- Associated gynaecological disorders and infection
- Associated medical problems

I. Components of Clinical Assessment

(A) History taking

(B) Physical examination

(C) Pelvic examination

(D) Laboratory investigations

Note: The assessment should preferably be conducted in a place where the woman and the provider cannot be seen or heard by others.

(A) History taking

The following should be included in the history:

- Personal details: age, religion, address
- Menstrual history: length and duration of cycle, flow (excess or normal), last menstrual period (LMP)
- Obstetric history: parity, live births, abortions (induced and spontaneous), previous caesarean section (if any), last child birth/abortion
- History of any interference/drugs taken during this pregnancy to attempt termination
- Contraceptive history: type of contraceptive used, how long
- Status of tetanus immunisation: last dose received
- Psychosocial assessment to assess family support
- Sexual/domestic violence
- Medical history should include:
  - hypertension
  - heart disease
  - diabetes mellitus
  - epilepsy
  - asthma
  - drug allergies
  - bleeding disorders
  - renal disease
  - thyroid disease

(Refer: Annexure 4.1: MTP in women with various medical conditions)

(B) Physical examination

- General examination
  - Check pulse, blood pressure and temperature, if indicated
  - Look for pallor/icterus
- Systemic examination
  - Examine chest and cardiovascular system
  - Examine the abdomen for abdominal mass, scars and distension. Also check for rigidity and rebound tenderness

(C) Pelvic examination

Before starting the pelvic examination, inform the woman and take verbal consent from her. Also, ensure:

- Privacy is maintained
- Equipment is ready
- Woman has emptied her bladder

Examination of external genitalia

- Inspect the external genitalia: labia (majora, minora) and introitus for redness, ulcer, growth, warts, swelling and discharge

Speculum examination

- Inspect the vagina and cervix for ulcer, foul smelling discharge and bleeding
- If there is an erosion, cervix bleeds on touch, or a growth, investigate further or refer appropriately
- If there is any evidence of infection, perform the procedure under antibiotic cover

Bimanual examination (Figure 3)

This is one of the critical steps, helpful in comparing the size of the uterus to the period of amenorrhea. During bimanual examination:

- Feel the cervix for consistency and tenderness on movement. A soft cervix is indicative of pregnancy. Tenderness on cervical movement is indicative of ectopic pregnancy
- Feel the position of the uterus (whether anteverted or retroverted) and assess the size of the uterus. Also feel for shape, consistency and mobility of the uterus
- Feel through the fornices. Fullness or tenderness in the fornices is indicative of pelvic inflammatory disease (PID) or ectopic pregnancy



Figure 3

Calculating gestation age:

- LMP known: calculate the number of days since the last menstrual period and divide by 7. This will give the gestation age in weeks. For example: 49 days from LMP will mean 7 weeks gestation age
- LMP not known or conception in lactational amenorrhea: gestation age estimated by pelvic bimanual examination



Establishing the period of gestation may be difficult in cases where:

- The woman does not remember the date of her last menstrual period
- Conception occurred during lactational amenorrhea
- Wrong dates were provided intentionally by the woman
- Missed or incomplete abortions

Caution should be exercised in the following situations:

Uterine Size	Possible Conditions	Line of Action
Bigger than expected but has a smooth and soft surface	• Molar pregnancy • Multiple pregnancy • Wrong dates	USG, if available, or refer to an appropriate centre
Bigger than expected, irregular and firm	Presence of fibroids with pregnancy	USG, if available, or refer to an appropriate centre
Smaller than expected	• Wrong dates • Non pregnant uterus • Ectopic pregnancy • Products of conception (POCs) partially expelled as in a spontaneous/incomplete abortion	USG, if available, or refer to an appropriate centre

Role of ultrasound examination

An ultrasound may be helpful for accurate dating when there is a discrepancy in the size of the uterus by LMP and bimanual examination. However, this test is not a mandatory requirement for the provision of MTP. Where it is available, it can also be used to detect ectopic pregnancies along with quantitative βHCG measurements. Since it is an obstetric USG, it must be done in accordance with the Pre-Conception Pre-Natal Diagnostic Techniques (PCPNDT) Act.

(D) Laboratory investigations

- Haemoglobin
- Urine for albumin and sugar
- Blood group/Rh
- Urine for pregnancy test with Nischay kit (wherever required)

In case of existing infections, samples should be taken for culture for a final diagnosis of the type of infection.

Annexure 4.1

MTP in Women with Various Medical Conditions

None of the conditions mentioned below is a contraindication to the abortion procedure. However, precautions need to be taken while performing a procedure on women with these conditions. If the facilities to handle these cases are not available, refer to the next level of facility.

Condition	Comments
Anaemia	If very low haematocrit or haemoglobin, be prepared to treat appropriately. In cases of Hb < 7gm%, MTP should be done at a higher centre with appropriate facilities
Heart disease	Refer to an appropriate higher facility
Asthma	PGE1 analogues should be used in case of post-abortal atony, excessive bleeding or cervical priming The woman should be stable and not have an acute asthmatic attack prior to the procedure
Blood-clotting disorders	Refer a woman with clotting disorder to an appropriate higher facility with EmOC services, including blood transfusion
Diabetes	High blood-glucose levels are not dangerous, but ketoacidosis should be avoided The insulin dose will probably not be changed if the procedure is performed under local anaesthesia. The woman should take her usual dose of anti-diabetic medication on the day of the abortion procedure.
Hypertension	Give an injection of oxytocin 10 units I/M, if required, for excessive bleeding
Seizure disorder	The woman should take her usual dose of anti-seizure medication on the day of the abortion procedure
Thyroid disease	The woman should continue with her daily medication
Renal disease	Women with active renal disease should be referred to an appropriate health facility

Infection Prevention

The essentials of infection prevention in a CAC procedure are similar to those applied to any condition involving surgical intervention. They help to minimise infection due to micro-organisms and prevent the transmission of Hepatitis B and C, sexually transmitted infections (STIs) and HIV.

Universal precautions for infection prevention should be understood and applied by all medical and paramedical staff involved in providing CAC services. There should be frequent monitoring of staff for adherence to protocols related to infection prevention, both for their and the woman's protection.

I. Elements of Universal Precautions

All healthcare workers, regardless of their presumed infection status or diagnosis, should follow all the universal precautions.*

The basic elements of universal precautions are:

(A) Hand washing
(B) Personal protective barriers
(C) Aseptic technique
(D) Handling of sharp items
(E) Instrument processing
(F) Waste disposal

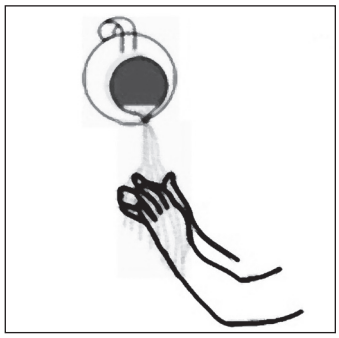


Figure 4: Hand Washing

(A) Hand washing (Figure 4)
Hands should be washed thoroughly with soap and running water before and after each contact with the woman, including when carrying out the procedure. While washing hands, you should:

- Rub both hands together and between fingers, nail beds and wrists to facilitate better cleaning
- Use running water through a washbasin and tap or a container/bucket with mug, to enable better cleaning of hands
- Air-dry hands

(B) Personal protective barriers
Personal protective barriers should be used to protect both yourself and the woman from the risks of cross-infection. This includes items such as gloves, plastic aprons, gowns, masks, head gears and eye covers (glasses). Gloves should be worn whenever there might be contact with blood and body fluids, mucous membranes or non-intact skin. They are not a substitute for hand washing. They should be put on immediately before the task to be performed, and then removed as soon as the procedure is completed. Hands must always be washed following their removal.

(C) Aseptic technique
Strict asepsis must be observed during the operative procedure. Use an antiseptic solution such as Povidone Iodine to clean the cervix and external genitals (Figure 5).

*It is advisable that healthcare personnel refer to the National Guidelines on Infection Management and Environmental Plan (IMEP); and Notification, March 2016, by Ministry of Environment, Forest and Climate Change. These can be accessed at http://toxicslink.org/docs/rulesansregulation/imeppolicyframework.pdf and http://mohfw.nic.in/WriteReadData/l892s/9535223249GuidelinesandProtocolsorsexualviolence_MOHFWf.pdf respectively.

Use the 'No Touch Technique'. Ensure that any instrument/ part of the instrument that goes inside the cervical canal does not touch any non-sterile object/surface prior to insertion.

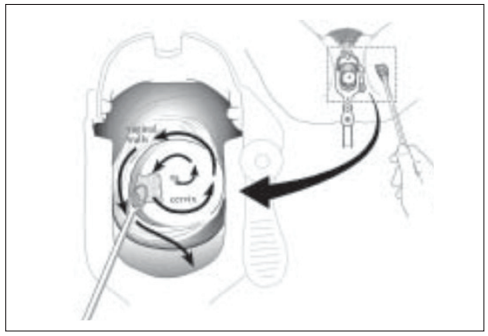


Figure 5: Cervical Antiseptic Preparation

(D) Handling of sharp items

It is vital that sharp items such as syringes, needles, scissors, etc. that are used during the procedure are handled with great care to avoid chances of injury by them. To ensure safety with sharp items:

- Avoid recapping or bending of needles after use
- Support staff should wear thick utility gloves while handling instruments, especially during the cleaning process and disposal
- Put all needles in a puncture-proof container after use

In spite of the best efforts, if accidentally exposed to needle pricks, cuts or blood/body fluids:

- Allow the exposed area of the skin to bleed briefly
- Immediately flush with clean running water
- Wash wound and skin thoroughly
- Give post-exposure prophylaxis within 72 hours of injury, if available

(E) Instrument processing

Ensure that the instruments/equipments used during the procedure are processed adequately for reuse.

For rubber gloves and metallic instruments:

Autoclave at 121 degree centigrade under a pressure of 15 lb./sq. inch for 20 minutes (unwrapped) or 30 minutes (wrapped).

Or

Boil in a covered container/boiler for 20 minutes. Ensure that the instruments are completely immersed in water.

After sterilization/HLD, store in covered trays, sterilized or high level disinfected.

(**Note:** The instrument processing steps for various technologies are discussed along with the procedures in different sections.)

(F) Waste disposal

After completing the procedure, waste material should be segregated for disposal. Different coloured bins/bags as given below, are used for different types of waste material:

- Yellow bin/bag for anatomical waste, e.g. placenta, POC, blood/body fluid soaked swabs/gauze/ bandage, blood bag
- Red bin/bag for plastics, e.g. plastic syringes and bottles, gloves, urine bag, etc.
- Puncture-proof container for sharps, e.g. needles, blades, etc.

- Blue bin for cut glass, e.g. ampules, slides, etc.
- Black bin/bag for general waste such as paper and glove covers, etc.

The colour of the bags/bins for waste segregation may differ as per the local protocols but the categories for segregation remain the same.



Disposal of waste can be done in one of the following ways:

- Waste in the yellow bin/bag is to be sent for incineration or disinfected with bleach solution and then sent for deep burial*
- Plastic waste in the red bin/bag is to be mutilated/shredded followed by disinfection with bleach solution and then disposed through the registered recyclers; it should never be sent to landfill sites
- Sharps in the puncture proof container are to be disinfected with a bleach solution and dumped in the sharps pit
- Cut glass in the blue bin is to be disinfected with bleach solution or sterilized and given for recycling

General, non-infectious waste can be disposed of in the municipality waste bins

*The deep burial pit should be two metres deep with the ground water table level six metres below the lower level of the pit. On each occasion when wastes are added to the pit, a layer of 10 cm of soil should be added on top of it. When it is half filled, cover it with lime within 50 cm of the surface before filling the rest of the pit with soil.



CHAPTER 6

Vacuum Aspiration Techniques in the First Trimester

I. Overview

This section provides an overview on terminating pregnancies during the first trimester using vacuum aspiration (VA) methods:

- Its indications and contraindications
- Provider, facility and equipment requirements
- Specific steps involved in conducting an MTP procedure using the two vacuum aspiration techniques – Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA)
- Possible complications and their management

II. Introduction to Vacuum Aspiration

Vacuum aspiration is a method by which the contents of the uterus are evacuated through a cannula that is attached to a vacuum source. The term 'vacuum aspiration' includes both Manual Vacuum Aspiration and Electric Vacuum Aspiration.

Gestation limit
Vacuum aspiration is a safe and simple technique for the termination of pregnancies up to 12 weeks of gestation/uterine size.

Safety and efficacy
Various studies have demonstrated that vacuum aspiration is a very safe and effective technique for first trimester abortion; it is successful in over 98% of cases.

Acknowledging the superior efficacy and safety of vacuum aspiration over conventional Dilatation and Curettage (D&C), a joint recommendation by the World Health Organization (WHO) and the International Federation of Gynaecology and Obstetrics (FIGO) states that properly equipped hospitals should abandon curettage and adopt manual/electric aspiration methods.

The practice of D&C is thus to be discouraged because the rates of major complications are two to three times higher than those with vacuum aspiration, as shown below:

	Vacuum Aspiration	Dilatation and Curettage
Incidence of excessive bleeding, cervical and vaginal injury, uterine perforation	Lesser	2-4 times higher than VA
Dilatation required for the procedure	Lesser	Greater
Pain control medication	Lower level	Higher level
Recovery period and hospital stay	Lesser	More
Post-procedure bleeding	Lesser	More

Provider's eligibility
Any provider who is recognised by the MTP Act 1971 as a registered medical practitioner entitled to terminate a pregnancy can use VA to perform the MTP procedure.

Provision of services at different levels of healthcare
Different levels of public sector health facilities (PHC and above) can use VA to provide CAC services for pregnancies up to 12 weeks. For private sector/NGO facilities, approval in accordance with the MTP Rules permits the use of VA up to 12 weeks.

III. Indications, Contraindications and Special Precautions

Indications for using vacuum aspiration

Vacuum aspiration can be used for:

- Induced abortion of up to 12 weeks gestation/uterine size

Vacuum aspiration can also be used for:

- Incomplete abortion of up to 12 weeks gestation/uterine size
- Missed abortion
- Hydatidiform Mole of up to 12 weeks gestation/uterine size
- Removal of decidua with surgical management of an ectopic pregnancy

Contraindications for vacuum aspiration

- Presence of acute cervical, vaginal or pelvic infection. The procedure should only be done under peri-operative antibiotic cover
- Suspicion of perforation (from a previous interference in the present pregnancy). Refer to the Table on 'Uterine Perforation', later in the chapter, for further management
- Suspicion of ectopic pregnancy

Special precautions
The conditions listed below are not contraindications for using vacuum aspiration. However, it is advisable to exercise precautions while performing VA in these cases. The procedure should be undertaken in facilities capable of managing potential complications.

- Adolescents
- Nulliparous
- Cervical stenosis
- Pregnancy with uterine fibroids
- History of caesarean section or uterine surgery
- Medical disorders such as:
  - Anaemia with haemoglobin below 8gm%
  - Bleeding disorders
  - Hypertension
  - Heart disease
  - Renal disease
  - Diabetes mellitus

Infrastructure required for VA procedure
Please refer to Chapter 9 on 'Health System Requirements for Provision of CAC Services'.

IV. Counselling for VA Procedure

Counselling is an integral part of the safe abortion services. In addition to the general counselling recommended for MTP procedures (refer Chapter 3 on 'Counselling'), the provider, before performing a VA procedure, needs to give the following additional information to a woman:

- The woman may be awake during the procedure, depending on the use of anaesthesia
- Pain relief will be given using oral analgesics and local anaesthesia. Sedation or general anaesthesia can be used selectively, when indicated
- The procedure will be completed in about 10 to 15 minutes
- The woman can leave the health facility when she feels fit (usually within half-an-hour to one hour) if done under local anaesthesia

V. Equipment for VA

Vacuum aspiration can be performed using either MVA or EVA. The primary difference between the two VA options is the source of the vacuum – MVA uses a handheld, portable aspirator (Figure 6), whereas EVA employs an electricity-operated device (Figure 8), which is referred to as the EVA or suction machine.

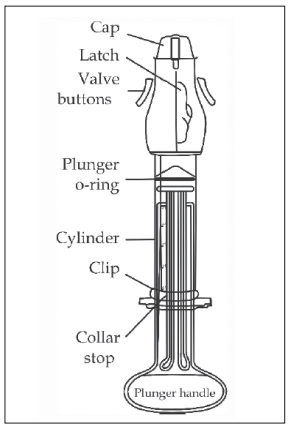


Figure 6: MVA Plus Aspirator

Manual Vacuum Aspiration
In an MVA procedure, a handheld plastic aspirator providing a vacuum source is attached to a cannula and hand-activated to suction out the uterine contents. MVA aspirators are essentially of two types: single-valve (also referred to as the menstrual regulation [MR] syringe) and double-valve aspirators (Figure 7).

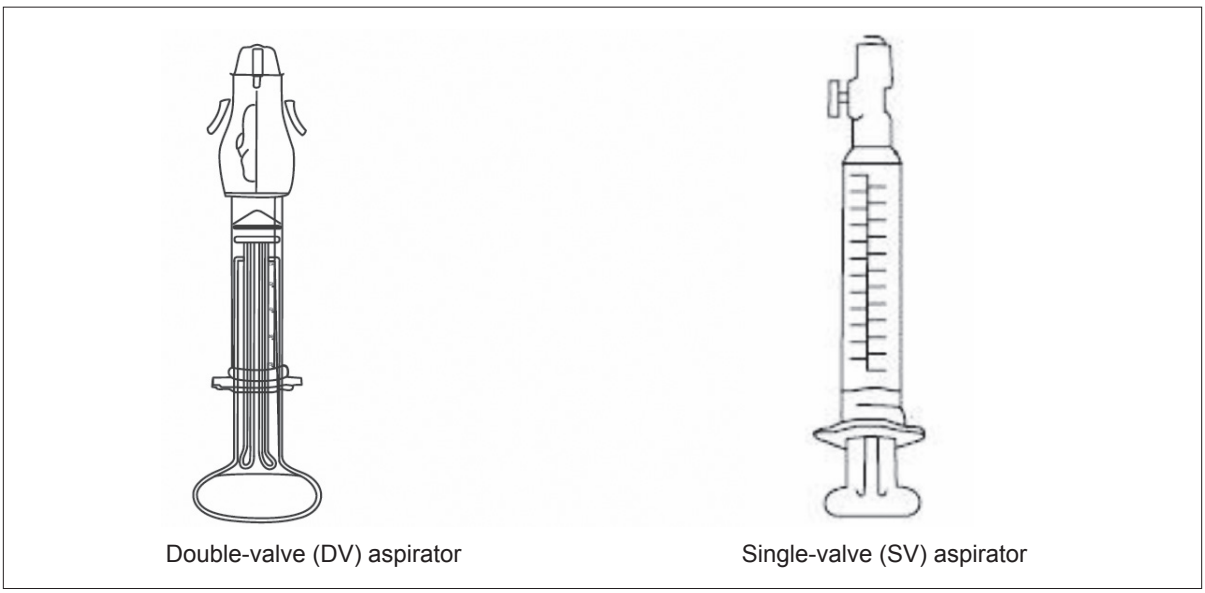


Figure 7: Two Types of MVA Equipment

Key Features of the Two Types of MVA Equipment

Features	DV Aspirator	SV Aspirator
Capacity	60 cc	50 cc
Negative pressure	26 in/660 mm of Hg	26 in/660 mm of Hg
Cannula size used	Up to 12mm	Up to 6mm
Vacuum maintained	Till 80% full	Till 50% full
Material used for valves	Silicone	Latex (exposed externally)
Sterilization option	Chemical sterilization Boiling Autoclaving	Chemical sterilization

Electric Vacuum Aspiration

EVA uses an electric pump or suction machine (Figure 8) attached to a cannula to evacuate uterine contents. EVA is typically used in centralised settings with higher caseloads.

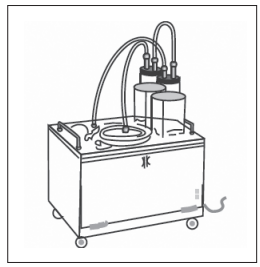


Figure 8: EVA Machine

Cannula (Figure 9)

The two varieties of plastic cannulae available for use with an MVA aspirator and EVA machine are:

- Disposable, single-use cannula (Karman)
- Autoclavable, reusable cannula (EasyGrip)

Depending on the type of raw material used in the manufacturing process, the processing options of cannulae from different manufacturers vary significantly.

The preferred size of the cannula as per the gestation age/uterine size are:

Uterine Size	Preferred Cannula Size
4-6 weeks LMP	4-6mm
7-9 weeks LMP	6-10mm
9-12 weeks LMP	8-12mm



Figure 9: Two Types of Cannulae

VI. Pre-procedure Care

Clinical assessment before the procedure and the investigations required are the same as for other techniques of pregnancy termination.

Counsel the woman and explain each step of the procedure.

Preparation for the procedure

- Shaving the perineum and vulva is not recommended. Perineum hair could be trimmed
- Obtain informed consent for the procedure in Form C (if not already obtained)
- Fulfill all the statutory and procedural requirements of the MTP Act and Rules
- A dose of oral analgesic/antispasmodic should be given an hour before the procedure

- Administer a single dose of prophylactic antibiotic such as oral Ampicillin/Azithromycin 1gm and Metronidazole 800mg. In non-lactating women, Doxycycline 100mg may be given in place of Ampicillin/Azithromycin. Doxycycline 100mg BD should be continued for seven days

Preliminary steps

- Ensure the availability and preparation of all instruments and drugs
- Ensure that emergency drugs and equipment are readily available

Pain control

Medication for pain management should always be offered. The purpose of pain control is to alleviate the woman's discomfort where mechanical dilatation is required for surgical abortion and to ensure that she suffers minimal anxiety, discomfort and risk to her health.

While the choice of the anaesthesia should be with the woman, local anaesthesia is a feasible, effective and safe method of providing pain relief during a VA procedure.

A combination of oral analgesic and/or local anaesthesia (paracervical block) should help to control the pain in the first trimester abortion. Young, very anxious women and cases of suspected cervical stenosis may require general anaesthesia.

VII. Procedure for Vacuum Aspiration

Manual Vacuum Aspiration

Step 1: Prepare instruments (Figure 10)

Charge aspirator

- Leave it charged for a few seconds
- Push buttons to release vacuum
- A rush of air indicates vacuum was retained

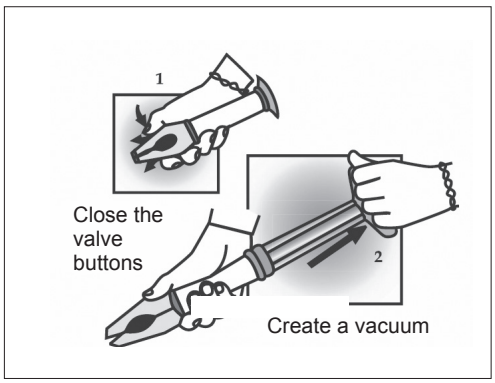


Figure 10: Preparing Instruments for MVA

Replace MVA aspirator when:

- Cylinder is cracked or brittle
- Mineral deposits inhibit plunger movement
- Valve is cracked, bent or broken
- Plunger arms do not lock
- Aspirator no longer holds vacuum

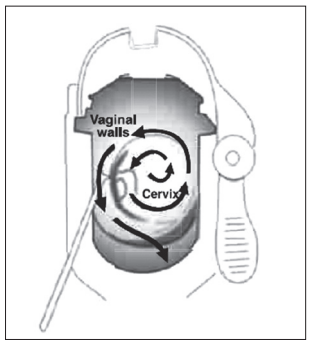


Figure 11: Antiseptic cervical preparation

Step 2: Prepare the woman

- Ensure pain control medication is given at the appropriate time
- Ask the woman to empty her bladder

Step 3: Perform cervical antiseptic preparation (Figure 11)

- Use an antiseptic such as Povidone Iodine to clean the cervix and vaginal walls
- Perform a bi-manual examination to confirm the assessment findings

Step 4: Administer paracervical block (Figure 12)

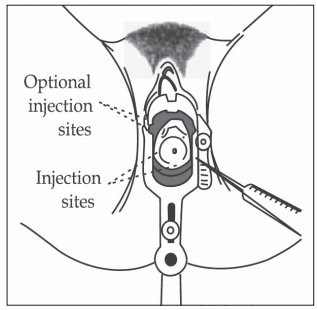


Figure 12: Paracervical Block

- Use Lignocaine one per cent (10ml; never more than 20ml). Give the paracervical block using a 22-24 gauge needle. There is increasing evidence to show that pre-testing before the administration of local anaesthesia need not be mandatory
- Apply slight traction with the volsellum/Allis forceps to identify the area between the smooth cervical epithelium and the vaginal tissue. Insert the needle just under the epithelium to a depth of 1.5-2cm at 4 and 8 o'clock positions and inject 2-4ml of Lignocaine at each site
- Proceed with MVA after allowing 2-4 minutes for the local anaesthesia to be effective

It is vital to aspirate before injecting the Lignocaine to ensure that the needle is not in the blood vessel.

Step 5: Dilate the cervix

- Use a plastic cannula instead of a dilator to dilate the cervix
- Use a progressively larger plastic cannula till it fits snugly in the os to hold the vacuum

Cervical priming

It is not mandatory to perform pre-procedure priming for all women. However, it should be done in women with high risk of cervical injury or uterine perforation.

In pregnancies of more than nine weeks gestation (particularly in nulliparous women and women under 18 years of age), cervical priming may be administered. This will soften the cervix so that it is easily dilatable up to the desired size with a reduced risk of immediate complications.

The commonly used methods for cervical priming are:

- Tablet misoprostol 400 mcg administered sublingual 2-3 hours or vaginally 3-4 hours before the procedure
- Injection 15 Methyl F2 Alpha Prostaglandin 250mcg intramuscularly 45 minutes before the procedure. This should be an option when there is less time available for cervical preparation before the procedure and misoprostol cannot be used

Step 6: Insert cannula (Figure 13)

Gently apply traction to the cervix. Rotate the cannula while applying pressure for easy insertion.

Step 7: Suction of uterine contents (Figures 14-16)

- Attach charged aspirator to cannula
- Release buttons to start suction
- Use a gentle rotatory and in and out motion to aspirate contents
- Do not withdraw the cannula opening beyond the external os till all the POCs are aspirated
- Take care to avoid holding a charged aspirator by the plunger arms

Steps of MVA Procedure

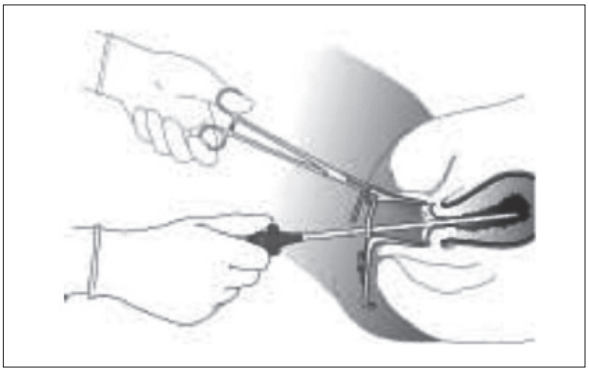


Figure 13

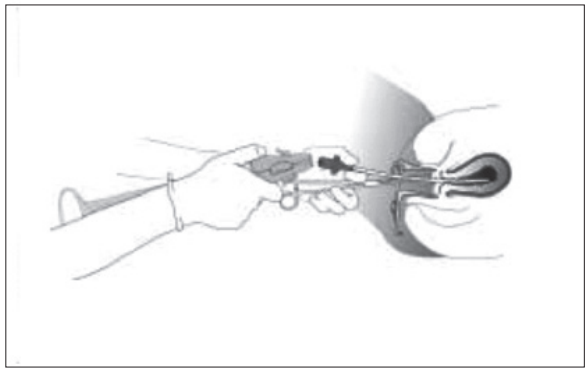


Figure 14

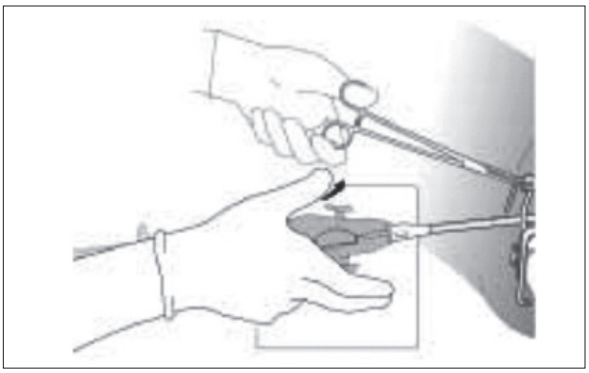


Figure 15

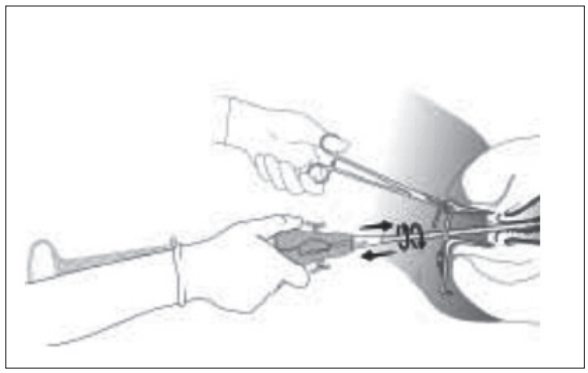


Figure 16

Signs that the uterus is empty

- Red or pink foam without the tissue passing through the cannula
- Gritty sensation over the surface of the uterus
- Cervix gripping over the cannula
- Uterus contracting around the cannula
- Increased uterine cramping

Check curette: Generally vacuum aspiration procedures can be safely completed without intrauterine use of curette or other instruments. No data suggest that the use of curettage after VA decreases the risk of the retained products.

When the procedure is complete

- Push buttons down and forward to close the valve
- Disconnect the cannula from the aspirator or remove the cannula from the uterus without disconnecting, depending on the completeness of the procedure
- May evacuate again after inspecting the products of conception, if needed

Step 8: Inspect tissue (Figure 17)

- Empty the contents of the aspirator into a container
- Inspect the POC to identify villi and decidua

If the aspirate does not contain the expected POC, ectopic pregnancy should be suspected and evaluated. If the contents do not conform to the estimated duration of pregnancy, incomplete abortion should be considered and managed.

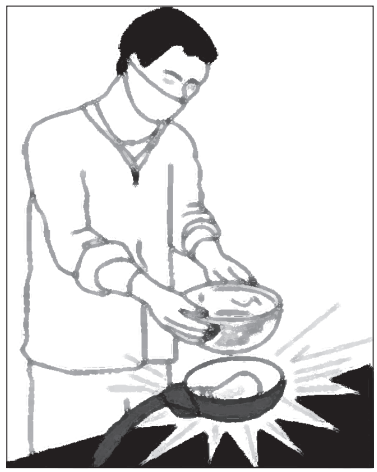


Figure 17: Inspect Tissue

Step 9: Concurrent procedures

When the procedure is apparently complete, wipe the cervix with a swab to assess bleeding.

Proceed with contraception methods such as sterilization, IUCD insertion.

Step 10: Instrument processing

Proper processing of instruments entails four steps:

(A) Instrument soak

The use of instrument soak in chlorine solution (0.5%) assists disinfection and helps remove tissue and body fluids. This also makes cleaning easier by keeping the instruments wet.

The used cannulae should be flushed before soaking them.

Chlorine solution (0.5%) for instrument soak in a plastic container is made by dissolving three levelled teaspoons (15gm) of bleaching powder in one litre of water. An appropriate quantity of the solution can be increased in the same proportion. Soak the instruments in disassembled form for 10 minutes.



Figure 18: Instrument Processing

(B) Cleaning (Figure 18)

To clean the instruments, wash all the surfaces of the instruments in warm water and detergent. Soap is not recommended as it tends to leave a residue.

(C) Sterilization/High Level Disinfection

Processing of MVA instruments can be done by any one of these options:

Method	Agent	Time
Sterilization	Steam autoclave (SV and some DV aspirators cannot be autoclaved)	Sterility is achieved at 121°C (250°F) for 30 minutes with pressure of 106 kPa (15 lbs/in^2)
	2% Glutaraldehyde (Cidex)*	10 hours
High Level Disinfection	Boiling water	20 minutes
	2% Glutaraldehyde (Cidex)*	20 minutes

*Instruments must be rinsed with sterile/HLD water before use.



Skin antiseptics that **cannot** be used for instrument processing are:

- Cetavlon
- Savlon
- Hibitane
- Eusol
- Lysol
- Phenol

(D) Storage

Following sterilization/HLD, the MVA instrument may be stored in a sealed, sterile/HLD container for later use. The container should be marked by the date of instrument processing for sterilization/ HLD and used within one week/24 hours, respectively. If not utilised within one week of autoclaving or 24 hours of HLD, the instruments should be re-cleaned and put through sterilization or HLD, as appropriate.

MVA Procedure Checklist

Prepare the instruments • Check the vacuum retention of the aspirator
Prepare the woman • Ensure informed consent; ask the woman to empty her bladder
Perform cervical antiseptic preparation • Follow a no-touch technique • Perform a pelvic examination to confirm the assessment findings
Administer the paracervical block • Inject 2-4ml lignocaine at 4 and 8 o'clock positions, after aspirating • Use positive, respectful, supportive reassurance
Dilate the cervix • Gently dilate the cervix until the cannula fits snugly
Insert the cannula and attach the aspirator
Suction of uterine contents • Rotate the cannula in each direction and use an in and out motion
Inspect the tissue • Empty the aspirator into the container and look for the POC
Complete the concurrent procedures • Assess the bleeding • Provide contraception
Instrument processing

Electric Vacuum Aspiration

The basic steps of performing a CAC procedure with EVA are very similar to MVA. However, there are differences in the equipment-specific steps, which are enumerated here:

Step 1: Prepare the instruments

Check whether the suction machine is in working condition and is maintaining an effective vacuum.

Step 2: Prepare the woman

Same as for MVA (Refer Section VII, Step 2).

Step 3: Perform cervical antiseptic preparation

Same as for MVA (Refer Section VII, Step 3).

Step 4: Pain management

If metal dilators are used, a higher level of pain medication may be required. This could be done by intramuscular sedation 15-20 minutes before the procedure; intravenous sedation 3-5 minutes before the procedure. Paracervical block with analgesia as in MVA is also a feasible option. (Refer Section VII, Step 4).

Step 5: Dilate the cervix

Dilate the cervix with a dilator/plastic cannula, as appropriate. (For cervical priming, refer to Section VII, Step 5).

Step 6: Insert the cannula

Insert the cannula and attach it to the tubing of the suction machine.

Step 7: Suction of uterine contents

The suction of uterine contents is done by gradually increasing the level of negative pressure up to approximately 25-26 inches/600-660mm of mercury (Hg) in the machine. It provides a constant level of vacuum after it has reached the desired level for sucking out the contents. On creation of adequate vacuum, rotate the cannula gently and move it back and forth until all the POC are evacuated through the hose into a glass container at the end of the tubing.

For the use of the curette at the end of the procedure, refer to Section VII, Step 7.

Step 8: Inspect tissue

- Empty the contents of the glass container
- Look for POC: villi and decidua should be visible

When the procedure is apparently complete, wipe the cervix with a swab to assess the bleeding.

Step 9: Concurrent procedures

Proceed with the contraceptive chosen/procedures such as sterilization or IUCD insertion.

Step 10: Instrument processing

The cannula is processed as enumerated in Section VII, Step 10.

Comparative Features of the Vacuum Aspiration Techniques

Comparative features of the two VA techniques – MVA and EVA:

S.No.	Feature	MVA	EVA
A. Similarities			
1.	Effectiveness	98-100%	98-100%
2.	Time taken for the procedure	5-15 minutes	5-15 minutes
3.	Pain relief with oral analgesic and local anaesthesia	Adequate	Adequate
4.	Injury to cervix and vagina	Rare	Rare
5.	Congenital anomaly in method failure	None	None
B. Differences			
1.	POC check	Possible and easy	Difficult and cumbersome
2.	Electric supply	Not required	Essential
3.	Regular maintenance	Less	More intensive
4.	Equipment noise during the procedure	None	Present. Sometimes disturbing for the woman
5.	Cost-effectiveness	Less resources required	More resources required. Higher maintenance

VIII. Post-procedure Care Immediately Following the Procedure

- Check the woman's vital signs
- Evaluate abdominal pain
- Observe bleeding per vaginum, which should decrease over time
- Vomiting/nausea

Before discharge

Following the VA procedure, the woman may leave the healthcare facility as soon as she feels well and her vitals are normal, even as early as 30 minutes when local anaesthesia is used. Longer recovery periods are generally required when sedation or general anaesthesia is used.

The following tasks should be undertaken before the woman is discharged from the facility:

- Assess and document the woman's vital signs at discharge
- Contraceptive counselling with contraceptive provision when requested
- Address other reproductive health issues: anaemia, reproductive tract infections (RTIs), HIV, domestic violence, cancer screening
- Provide medications and instructions as listed below:
  - Pain management with analgesics, NSAIDs (for example, Ibuprofen)
  - Antibiotic therapy, as appropriate
  - Injection Anti-D (50mcg) to Rh negative women
  - Sanitary napkin – two packets to be provided
  - Haematinic (IFA tablets) for at least three months

- To resume normal diet on the same day
- To restrict activity for the next three days
- To avoid vaginal douching
- To preferably avoid intercourse until a week or till bleeding stops. However, after an uncomplicated abortion, the woman may have intercourse as soon as she desires
- Caution on possibility of getting pregnant almost immediately if no contraceptive used
- Advise the woman on contraceptive methods, including barrier contraceptives as well as emergency contraception
- Follow-up visit within one or two weeks

- **Explain signs of normal recovery:**
  - Some spotting or bleeding is normal, though it usually does not exceed that of a normal menstrual period
  - Nausea and vomiting related to pregnancy generally subside within 24 hours
  - Uterine cramping may occur over the next few days, similar to that of a normal menstrual period. Discomfort from cramping may be eased by mild analgesics and warm compress
  - Explain warning signs such as excessive bleeding, severe abdominal pain, vomiting and fever
  - A normal menstrual period should begin within the next three to six weeks

Conditions that require immediate attention and treatment

- Significant decline in physical condition as reflected in vital signs
- Dizziness, shortness of breath or fainting, which may be caused by internal or external blood loss
- Fainting, which may be due to anxiety or transient vagal reaction
- Severe vaginal bleeding: While some post-procedure bleeding is expected, the amount of bleeding should decrease over time. Excessive bleeding may be a sign of retained POC, lack of normal uterine tone, cervical laceration or other complications
- Severe abdominal pain or prolonged cramping may be a sign of uterine perforation or post-abortal hematometra

IX. Follow-up Care

After a vacuum aspiration procedure, schedule the follow-up visit within one to two weeks, because it is during this period that problems are most likely to occur.

During the follow-up visit:

- Assess the physical status and vital signs
- Assess bleeding per vaginum
- Inquire about fever, pelvic or abdominal pain or cramps
- Determine whether symptoms of pregnancy, such as nausea and breast tenderness, have decreased or continued, in order to rule out continuing pregnancy
- Talk about contraceptive choices if not already chosen by the woman



X. Complications and Management

While complications with vacuum aspiration are rare, awareness of their possibility and prompt attention and management when they do occur are vital.

(A) Complications due to local anaesthesia

Complications and side-effects are rare with the appropriate dose and when care is taken not to inject the drug into a blood vessel. However, mild side-effects such as the numbness of lips and tongue, a metallic taste in the mouth, dizziness and light-headedness, ringing in the ears, difficulty in focusing the eyes, itching and rashes, are occasionally encountered. They should be observed and must subside before the procedure is commenced. However, one should be alert for the following complications:

- Convulsions: injection diazepam 10mg I/V or phenytoin sodium 100mg I/V must be given slowly in such an emergency
- Systemic toxic reaction are very rare. If the woman shows signs of sleepiness, disorientation, muscle twitching and shivering, slurred speech and respiratory depression, manage her as follows:
  - Administer oxygen
  - Apply suction to the throat to maintain patent airway
  - Rapidly infuse fluids

(B) Complications during the procedure

- Refer to a higher facility when the woman is stabilized, for definitive management

(i) Haemorrhage	
Symptoms and Causes	**Management**
Signs/Symptoms: • Heavy, bright red vaginal bleeding with or without clots • Blood-soaked pads, towels or clothing • Pallor **Causes:** • Cervical injury, which may have been caused by the volsellum or difficult dilatation • Incomplete emptying of uterus • Uterine atony (soft and boggy uterus) • Perforation of uterus (instrument passed beyond the uterine wall)	**In case of cervical injury:** • Apply pressure with a sponge • Suture with chromic catgut or any other suitable absorbable suture 1-0 using a round body needle, if required **In case of bleeding from the uterine cavity:** • Give tablet misoprostol 400mcg sublingual/or 600mcg orally • Uterine massage • If the bleeding continues, start oxytocin infusion 10 units in 500ml RL or NS at 40-60 drops per minute • Vacuum aspiration may have to be done if evacuation is not complete or bleeding continues

(ii) Uterine Perforation	
Signs and Symptoms	**Management**
• Sudden loss of resistance with the instrument in utero • Dilator or cannula penetrates further than expected • Fat/omentum (yellow coloured) or bowel seen in the cannula or at the cervix • Difficulty in withdrawing the cannula • Rapid pulse and falling blood pressure (signs of shock) • Severe abdominal pain • Abdominal rigidity and distension • Shoulder pain	• Stop the procedure as soon as possible and remove the instruments • Trendlenberg position (elevate the foot end of the bed and lower the head end), if there is hypotension • Start intravenous fluids (RL or NS) • If the perforation is with a cannula/dilator of less than 8mm, either complete the procedure immediately under USG/laparoscopic guidance or after 48 hours, if she is stable. If she is unstable or continues bleeding or a bigger size cannula was in use, refer to the next higher level of care following protocols of referral • If intestine or omentum is seen on cannula, start an intravenous infusion and antibiotics. If properly equipped with complete laparotomy facilities, perform MTP in the facility itself under USG/laparoscopic guidance or refer to a higher level facility • During transport, a trained healthcare provider should accompany the woman: continue oxygen, IV therapy, keep the woman warm and keep her feet elevated
(iii) Fainting/Syncope	
Symptoms and Causes	**Management**
This occurs usually when the cervix is forcefully dilated. Severe pain is experienced and the woman faints due to a vaso-vagal attack causing marked bradycardia. This may last only for a few seconds to minutes, provided the pain is controlled.	• Stop the procedure immediately • Maintain an open airway • Avoid aspiration of vomitus by turning the woman's head and shoulder to one side • Trendlenberg position (elevate the foot end of the bed and lower the head end) • Administer injection atropine sulphate 0.6 mg I/V. Repeat after two minutes if response is inadequate • If recovery is not immediate, ventilate with an ambubag and administer oxygen • Start I/V fluids and monitor vital signs



(iv) Shock (either during the procedure or later)	
Symptoms and Causes	**Management**
• Fast, weak pulse (110 beats/minute or more) • Low blood pressure (diastolic less than 60, systolic less than 90) • Pallor • Rapid breathing (respiration 30 breaths/minute or more) • Anxious, confused or unconscious mental state • Profuse sweating or perspiration **Main Causes:** • Haemorrhage • Infection/sepsis	• Make sure the airway is open • Give oxygen at six to eight litres/minute (mask or nasal cannula) • Give I/V fluids (Ringer's lactate or isotonic solution) at one litre in 15-20 minutes using a large bore needle 16-18 gauge • Keep the woman warm • I/V antibiotics • Blood transfusion, if required • Evacuate the uterus with VA for retained POC if suspected

(C) Delayed complications

Women may present with delayed abortion complications, the treatment protocol for which is as below.

(i) Incomplete Abortion	
Symptoms and Causes	**Management**
• Pallor • Excessive or prolonged bleeding per vaginum • Fever or pain in the abdomen **Main Cause:** • Incompleteness of the procedure (It may be prevented by checking the quantity of evacuated POC in VA)	Depending on the general condition of the woman and the severity of bleeding: • Stabilise the woman first, if required, with the measures mentioned in the table above on 'Shock' • Give tablet misoprostol 400mcg sublingual/or 600mcg orally and observe her for decrease in the vaginal bleeding* or • Evacuate the uterus with VA for retained products of conception under antibiotic cover *May be administered by nursing personnel for management or before referral to next level of facility, if required
(ii) Infection/Sepsis	
Symptoms and Causes	**Management**
• Chills, fever • Foul smelling vaginal discharge • Abdominal pain or cramps • Distended abdomen • Rebound tenderness • Prolonged bleeding **Main Causes:** • Retained POCs • Asepsis not properly maintained	• Broad-spectrum antibiotics: Ampicillin/Azithromycin 1g and Metronidazole 400mg should be started • Injectable antibiotics and intravenous fluids may have to be used if signs of severe infection exist • Evacuate the uterus with VA for retained POCs Uterine evacuation performed on an infected uterus can more easily result in perforation, so it should be done with caution

(iii) Continuation of pregnancy
The pregnancy may continue due to various reasons. Continuation may be prevented by confirming the presence of chorionic villi in the evacuated POC. Women must also be counselled to report any delay in menstruation six weeks after the procedure.

This is managed by counselling and informing the woman of the condition. If she wants to get it terminated, the procedure should be repeated, if pregnancy is still within the first trimester. However, if the pregnancy has advanced to the second trimester, appropriate methods of termination should be used at an appropriate level of facility.

(D) Remote complications
The following complications are rare with VA and usually the result of trauma or infection. This underlines the importance of adopting a gentle and meticulous aseptic surgical technique.

(i) Menstrual disturbances
Amenorrhoea and hypomenorrhoea may result from varying degrees of intrauterine adhesions (Ashermann's syndrome).

Hysteroscopic adhesiolysis is now the management of choice for intrauterine adhesions.

(ii) Infertility
Infertility may result from tubal factor (closure or distortion) due to post-abortal infections or uterine factor due to endometrial trauma or infection.

(iii) Recurrent abortion
Late (mid-trimester) abortion can occur due to cervical incompetence as a result of injury from forceful dilatation to the cervix.

Cervical incompetence must be anticipated, diagnosed early and be managed by cerclage.

(iv) Ectopic pregnancy
Tubal distortion due to post-abortal infection may increase the risk of tubal ectopic pregnancy.

(v) Obstetric complications
Obstetric complications may rarely occur during future pregnancies.

Adherent placenta and uterine rupture may result from a previous undiagnosed perforation.

(vi) Psychosomatic conditions
Though uncommon, depression may be reported occasionally.

Psychosomatic symptoms are predisposed to by abortions carried out for medical reasons or foetal abnormality in an otherwise wanted pregnancy or when there is coercion or force by the spouse or family members. Sensitive and supportive counselling is the key to pre-empting and preventing most psychosomatic symptoms.



CHAPTER 7

Medical Methods of Abortion for Termination of Pregnancy in the First Trimester

I. Introduction

Medical methods of abortion (MMA) is a non-surgical termination of early pregnancy using a combination of drugs.

(A) Description
Medical methods of abortion include the use of mifepristone and misoprostol to induce and complete the abortion process.

(B) Mechanism of action
Mifepristone is a derivative of norethindrone with antiprogestin action. It binds to progesterone receptors in the endometrium and decidua, resulting in necrosis and detachment of POCs. It also softens the cervix and causes mild uterine contractions. Mifepristone sensitizes the uterus to the effect of prostaglandin. Misoprostol is a prostaglandin E1 analogue which binds to myometrial cells, causing strong myometrial contractions and cervical softening and dilatation. This leads to the expulsion of conceptus from the uterus. It is stable at room temperature and well absorbed from the gastro-intestinal tract and vaginal mucosa. Being selective for PGE1 receptors, there are no significant effects on bronchi and blood vessels, minimising its side-effects, as compared to other prostaglandins.

(C) Gestation limit
Use of mifepristone (in 2002) and misoprostol (in 2006) was approved for termination of pregnancy up to seven weeks (49 days) LMP.

A combipack of mifepristone and misoprostol (one tablet of mifepristone 200mg and four tablets of misoprostol 200mcg each) has been approved by the Central Drugs Standard Control Organisation, Directorate General of Health Services, for the medical termination of pregnancy up to nine weeks (63 days) LMP in December 2008.

If there is any doubt about the period of gestation on the basis of history or examination by the MO at the level of PHC/CHC, the woman should be referred to a gynaecologist at the FRU/DH for evaluation.

(D) Safety and efficacy
A combination of mifepristone and misoprostol has a success rate of 95-99% for early abortions. Mifepristone followed by misoprostol is a safe method to terminate pregnancy as long as the contraindications are not disregarded.

MMA failure cases can present as:

- Heavy bleeding
- Incomplete abortion
- Continuation of pregnancy

0.1-0.2% women may require blood transfusion following heavy bleeding.

(E) Provider's eligibility
Any provider who is recognised by the MTP Act as a registered medical practitioner, is eligible to terminate a first trimester pregnancy and can use MMA to perform the procedure.

(F) Site eligibility
Mifepristone with misoprostol for the termination of pregnancy can be prescribed by a registered medical practitioner at:

- Primary, secondary and tertiary levels of public sector healthcare sites
- Private sector facilities, which have been approved by the DLC as certified MTP sites under Section 4 of the MTP Act, 1971

For MMA up to seven weeks/49 days: It can be prescribed from outpatient facilities (clinics) that are not approved as MTP certified sites but have an established referral linkage to an MTP certified site. The clinic must display a certificate to the effect by the owner of the certified site.

II. Advantages and Limitations of MMA

Advantages of MMA

- Safe procedure with high percentage of success rate in early pregnancy
- Offers more privacy
- Feasible with minimum technical assistance
- Less overall complication rate. No risk of cervical or uterine injury
- No instrument and anaesthesia required, hence less invasive
- No effect on future fertility, if standard protocol followed

Limitations of MMA

- Generally three visits required (if misoprostol is administered at home, a minimum of two visits required)
- Whole process takes longer, duration of bleeding can be 8-13 days. However, the bleeding decreases as soon as the POC expulsion process is complete
- Drugs used for termination may have side-effects
- Potential risk of foetal malformation in cases where pregnancy continues due to the failure of MMA

III. Indications, Contraindications and Special Precautions

(A) Indications
All women with an intrauterine pregnancy, who wish to get their pregnancy terminated within seven weeks of LMP, and are:

- Willing to make three visits (two visits with home administration of misoprostol)
- Ready for surgical evacuation in case of failure of the method or excessive bleeding
- Within accessible limits of the appropriate healthcare facility providing emergency care

(B) Contraindications
Medical methods of abortion is contraindicated in women with:

- Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass, as mifepristone or misoprostol cannot treat ectopic pregnancy



- Anaemia (haemoglobin <8gm %)
- Uncontrolled hypertension with BP >160/100mm Hg
- Chronic adrenal failure
- Severe renal, liver or respiratory diseases
- Uncontrolled seizure disorder
- Inherited porphyria
- Glaucoma
- Allergy or intolerance to mifepristone/misoprostol or other prostaglandins

MMA should also not be given in case a woman does not have access to emergency care, if required during the MMA process.

Signs/symptoms during ectopic pregnancy could include:

- Lower abdominal pain, usually one-sided, that may be sudden and intense, persistent or cramping
- Irregular vaginal bleeding or spotting
- Fainting or dizziness that persists for more than a few seconds, possibly indicative of internal bleeding. Internal bleeding is not necessarily accompanied by vaginal bleeding
- Uterine size that is smaller than expected
- Palpable adnexal mass
- Tender cervical movements
- No POC after a vacuum aspiration procedure

When ectopic pregnancy is suspected, transfer the woman as soon as possible to a facility that can confirm diagnosis and begin treatment. Ectopic pregnancy can be diagnosed with a careful history, examination and USG.

(C) Special precautions

Drugs for MMA are to be used with caution in the following situations:

- Current long-term use of systemic corticosteroids (including those with severe uncontrolled asthma)
- Coagulopathy or on anticoagulant therapy
- Pre-existing heart disease or cardiovascular risk factors
- Pregnancy with in situ intrauterine contraceptive device (IUCD). IUCD has to be removed before giving drugs for abortion
- Pregnancy with fibroid. Women with symptomatic large fibroids encroaching on endometrial cavity can have heavy bleeding and fibroids may interfere with the uterine contractility
- Pregnancy with uterine scar. Caution should be exercised when MMA is offered to women with a previous history of caesarean section, hysterotomy or myomectomy
- Bronchial asthma. Misoprostol is a weak bronchodilator and, therefore, could be used in women with bronchial asthma. However, prostaglandins other than misoprostol should not be used
- Use of anti-tubercular drugs. These may decrease the efficacy of MMA drugs

IV. Counselling

Refer to Chapter 3 for details on general counselling on abortions. Here are some counselling points specifically for MMA.

Method-specific counselling

A woman undergoing termination of pregnancy with medical methods should know that:

- She will be required to make at least two visits to the hospital/clinic. Misoprostol may be given for home administration to her, on the provider's discretion. This is provided if she is within the accessible limits of an appropriate healthcare facility

Explain the symptoms that would be experienced by her, for example:

- Bleeding per vaginum is an essential part of the MMA process as it is similar to a miscarriage. Bleeding is usually heavier than what is experienced during a menstrual period and often lasts for 8 to 13 days. Soaking of two thick pads within one to two hours after taking misoprostol, but decreasing over time, is considered normal
- Abdominal pain is experienced as a part of the MMA process. It can be compared with severe menstrual cramps (refrain from describing cramping pain as similar to labour pains). Sometimes the pain begins after ingestion of tablet mifepristone, but most often it starts one to three hours after misoprostol administration and is heaviest during the actual abortion process, often lasting up to four hours. If the pain is persistent, the possibility of ectopic pregnancy should always be ruled out
- Nausea, vomiting, diarrhea, are minor side-effects of drugs, which are self-limiting

She would also need to be informed about:

- Contact details and address of the healthcare facility, within accessible limits, where she can reach quickly if there is an emergency
- The possibility of a surgical evacuation being performed in case of failure or excessive bleeding
- The possible delay of the next menstrual cycle by one or two weeks, but subsequent periods would come on time
- The use of a contraceptive method (such as condoms) if she has intercourse during treatment
- How failure to abort necessitates VA as continuation of pregnancy may result in congenital malformation in the foetus
- Appropriate time for use of different contraceptive methods with MMA

Note: A consent form is signed after being satisfied with all the information provided, and after getting satisfactory answers to any doubts that the woman may have.

Clinical assessment before the procedure and the investigations required are the same as for other techniques of pregnancy termination.

Role of ultrasonography (USG)

It is not mandatory to perform an ultrasonography for all women undergoing termination of pregnancy with medical methods. USG is indicated for the following conditions:

i. Pre-procedure:

- Women with a suspicion of ectopic pregnancy (symptoms such as irregular vaginal bleeding, pelvic pain, or adnexal mass or tenderness)



- Provider's uncertainty with examination, or inability to assess the uterine size due to obesity or pelvic discomfort
- Women unsure of LMP or have conceived during lactational amenorrhea; have irregular cycles; and have a discrepancy between the history and the clinical findings

ii. During the procedure:

- Women presenting with excessive vaginal bleeding
- Women presenting with severe pain in the abdomen, not relieved with analgesics

iii. At the end of the procedure:

- Clinical examination does not confirm the completion of the abortion process
- Continued vaginal bleeding, which is more than normal menstrual periods
- Suspicion of continuation of pregnancy

Since it is an obstetric USG, all the protocols under the PCPNDT Act should be followed.

V. Infrastructure Required for the Procedure

There is no infrastructure requirement for the outdoor clinic from where the drugs can be prescribed, up to seven weeks of gestation period. But, the clinic should have an established referral linkage with an MTP certified site and it should display a certificate to the effect. If prescribed from an 'MTP certified site', the infrastructure requirements are the same as for the surgical methods (vacuum aspiration).

VI. Procedure

After the woman is found suitable to undergo pregnancy termination with medical methods (refer Chapter 4: Clinical Assessment), counselled on the relevant aspects related to the procedure and has given consent for it, the clinical protocol given here is to be followed:

Day 1

Day of Mifepristone administration

- Mifepristone (200mg) is administered orally
- Anti-D (50µgm) is given to Rh negative woman

Before the woman leaves the facility:

- Instruct her to maintain a record of her symptoms in the MMA card given to her
- Provide her with the address and phone numbers of a back-up facility where she can go in case of an emergency
- Ask her to return to the clinic after 48 hours, if she has opted for clinic use of misoprostol
- Home administration of misoprostol may be allowed at the discretion of the provider. It can improve privacy, convenience and acceptability of the services, since safety is not being compromised. The woman should have access to 24-hour emergency services. She should also be instructed on how and when to use an additional dose of misoprostol

- Information on antiemetics and analgesics (Ibuprofen)

A small percentage of women (3%) may expel products of conception with mifepristone alone, but the total drug dosage schedule with misoprostol must be completed.

Day 3

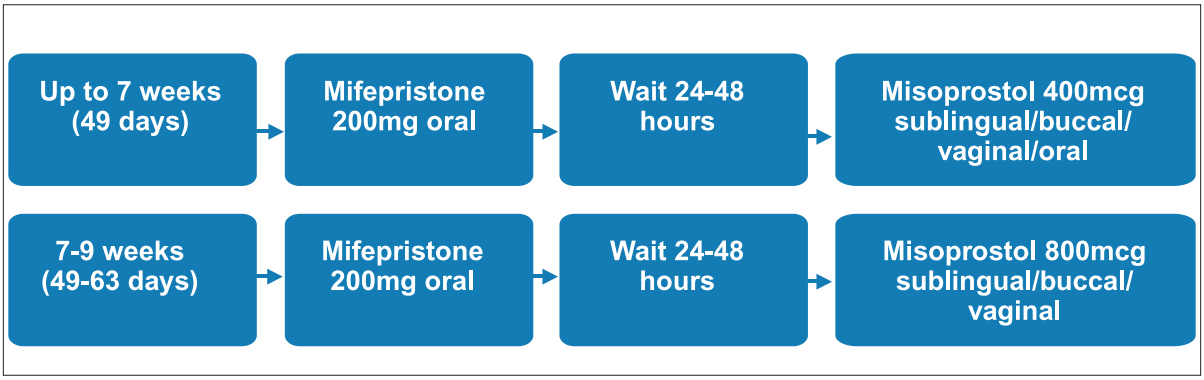
Day of Misoprostol administration

Note if there is any history of bleeding or other side-effects and proceed with the following:

- Administer misoprostol 400mcg sublingual/buccal/vaginal/oral route for gestation age up to seven weeks

OR

- 800mcg sublingual/buccal/vaginal for gestation age up to nine weeks



- Additional dose of misoprostol to be repeated in the conditions below:
  - The woman vomits within half-an-hour of the intake of oral misoprostol
  - There is no vaginal bleeding even after 24 hours of misoprostol administration (a woman reporting no bleeding or very light bleeding suggests that either there is a continuing pregnancy or that the treatment is not working)
  - She has excessive bleeding during the abortion process. If the bleeding does not get controlled even after the repeat dose of misoprostol, surgical evacuation may be considered

Table 1: Effectiveness of Misoprostol Administered by Different Routes

Route of administration	Onset of action	Duration of action	Preferred recommended route
Sublingual	Fastest	Highest plasma levels and prolonged action	Most recommended
Buccal	Quick	Prolonged action	Recommended
Vaginal	Quick	Prolonged action	Recommended
Oral	Quick	Least duration	Least recommended but still can be given



If the woman is in the facility:

- Observe the woman for four hours and monitor:
  - Pulse and blood pressure
  - Time of start of the bleeding and expulsion of products (if it occurs)
  - Side effects of the drugs
- Perform a pelvic examination before the woman leaves the clinic and if cervical os is open and products are partially expelled, remove them digitally
- Prescribe drugs for pain relief, if required. Non-narcotic and narcotic analgesics or ibuprofen should be provided. Non-steroidal anti-inflammatory drugs (NSAIDs) do not interfere with misoprostol
- Before the woman leaves the facility:
  - Instruct her to take adequate rest and avoid travelling
  - Tell her that she should report to the facility in case of excessive pain or bleeding (bleeding heavy enough to completely soak two pads an hour for two consecutive hours or more)
- Tell her to use a contraceptive method if she has intercourse
- Provide her with:
  - Analgesics
  - Antiemetics
  - Additional dose of misoprostol, to be repeated in the conditions mentioned above
  - Chosen contraceptive method
  - IFA tablets: 180 tablets
  - Two packets of sanitary napkins

Within Day 15

Day of follow-up

- A clinical history of the woman is taken and a pelvic examination is done to ensure the complete expulsion of the products of conception
- USG is required if the history and examination do not confirm expulsion of the POCs

Before the woman leaves the facility:

- Tell her that her next period may be delayed but she should come for a check-up if she does not menstruate in six weeks
- Provide her the chosen contraceptive method if she has not already started it

Protocols for Mifepristone and Misoprostol:

Day	Drugs used
Day 1: mifepristone administration	200mg mifepristone oral; Anti D 50mcg, if Rh negative
Day 3: misoprostol administration	Up to 7 weeks: 400mcg misoprostol (two tablets of 200mcg each) sublingual/buccal/vaginal/oral OR 7-9 weeks: 800mcg sublingual/buccal/vaginal In addition: • Analgesics (Ibuprofen) • Antiemetic • Offer contraception
Within Day 15: Follow-up day	• Confirm and ensure completion of procedure • Offer contraception, if not already done so

VII. Adjunct Medications

(A) Prophylactic antibiotics
The routine use of prophylactic antibiotics is not indicated except in cases of:

- Nulliparous women
- Women with the presence of vaginal infections

Recommended antibiotics are Doxycycline 100mg, twice a day for seven days for non-lactating women, and Azithromycin 500mg once a day for three days or Ampicillin 500mg TDS for five days for lactating women.

(B) Analgesics
Pain is an accompaniment with the process of abortion. Women counselled properly may tolerate pain better, thereby reducing the need for analgesics. The commonly used drug for pain management is Ibuprofen 400mg. Paracetamol is not effective for pain relief during the process of MMA.

Persistent pain, with failure to respond to these drugs for several hours, warrants evaluation for other causes, such as ectopic pregnancy, infection or incomplete abortion.

VIII. Expected Side-effects

The common side-effects of mifepristone with misoprostol for termination of early pregnancy are related to the abortion process, the pregnancy itself and the effects of drugs used. Common side-effects include:

- Nausea/vomiting/diarrhoea (gastrointestinal symptoms): Pre-abortion counselling helps and routine administration of antiemetic/antidiarrhoeal is not necessary
- Feeling of warmth and chills: It is usually short-lived and resolves spontaneously. Ibuprofen given for pain relief also takes care of fever, but if the temperature exceeds 100.4°F (38°C) or persists for several hours despite antipyretics, infection should be ruled out. Antipyretics such as Paracetamol can be given, if required
- Headache, dizziness and fatigue: Headache is treated with non-narcotic analgesics and mild dizziness of short duration is managed by hydration. Advise the woman to take plenty of fluids, rest and exercise caution while changing position



IX. Complications and Management

Proper case selection, adequate counselling and appropriate referral are the key to the success of medical methods of abortion. Also, the woman should be informed about the possible complications and where/whom to contact for emergency services.

(A) Heavy bleeding

Pre-abortion counselling should emphasise that bleeding is likely to be heavier than regular menses and comparable to that of a miscarriage. The woman should be told that soaking two pads per hour for two hours in a row is normal at the time of peak cramping. This is often the case during the expulsion of the products of conception. However, if this persists and/or the woman is dizzy, she should consult the doctor. Vacuum aspiration may have to be done to complete the process.

(B) Incomplete abortion

Women with incomplete abortion during the process of MMA generally present with excessive/ continued bleeding. If her condition is unstable, resuscitate and stabilize her first. Stabilization should be followed by an examination and further management.

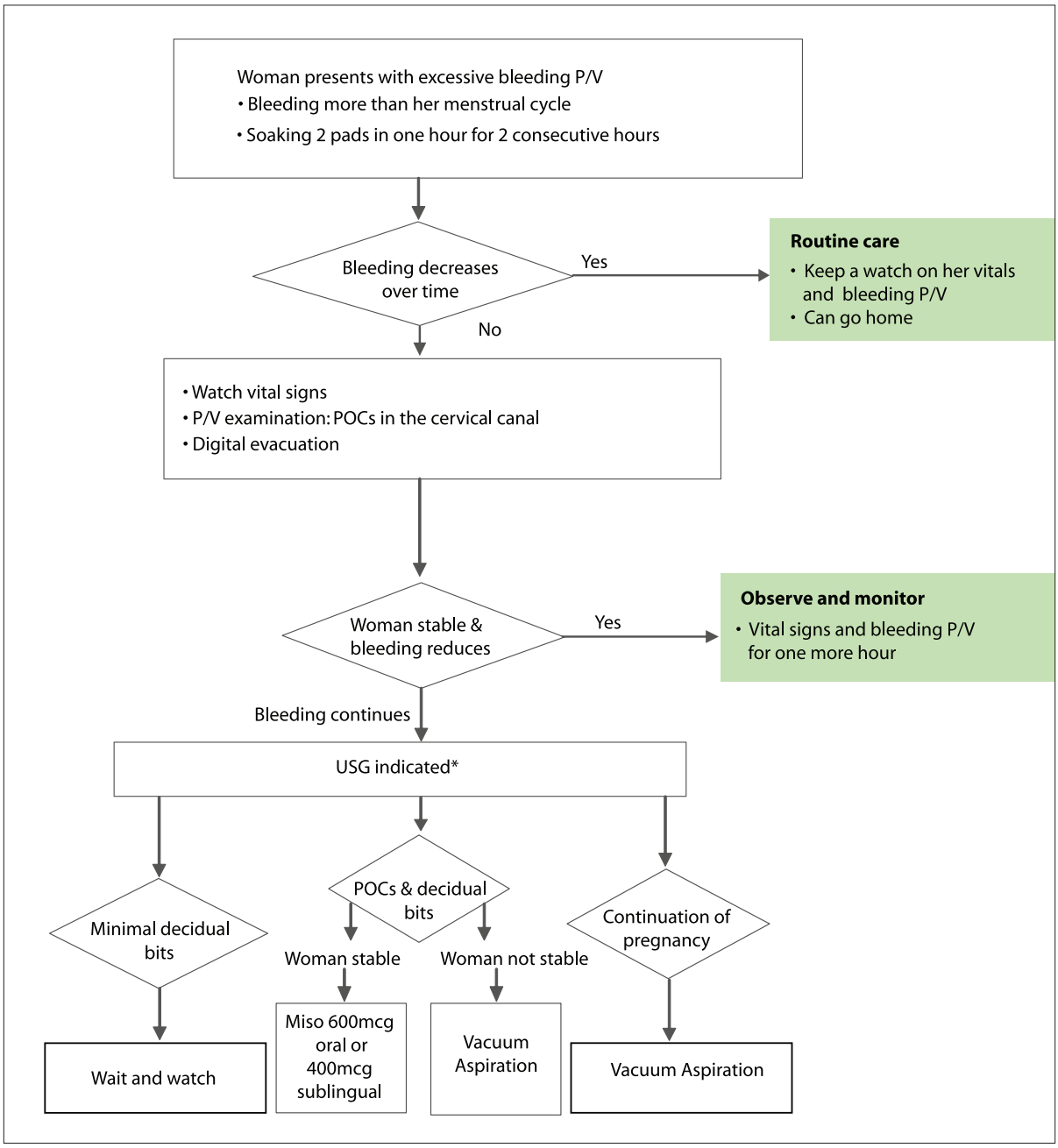
If her condition is stable, proceed with the examination:

- If POCs are felt at the os, manage with digital evacuation, followed by vacuum aspiration, if required
- If no POCs are felt at the os, decide the line of management, based on the clinical symptoms, pelvic examination and USG findings
  - (i) If the USG shows incomplete expulsion of POCs, then an additional dose of misoprostol (600mcg oral or 400mcg sublingual) may be offered to the woman. Wait for the pregnancy to be expelled with time. The woman should be counselled to return to the clinic after one week to ensure that the abortion is complete
    - If bleeding continues, even after an additional dose of misoprostol (as mentioned above), perform vacuum aspiration
  - (ii) If no gestation sac is visible on USG, but bleeding continues owing to decidua bits in the uterine cavity, manage conservatively, without any medication or intervention, as these are expelled spontaneously in most cases. An additional visit after seven days will have to be planned to ensure completion of the process
    - If bleeding is profuse at any time during this process, VA may have to be done
  - (iii) If USG shows continuation of the pregnancy despite use of MMA drugs, it should be terminated by vacuum aspiration

    If USG is not available, manage the woman based on her general condition, severity of bleeding and pelvic examination findings, similar to management under table on ‘Incomplete Abortion’ in Chapter 6: Vacuum Aspiration.

The table below summarizes the management plan for excessive bleeding during MMA:

Algorithm for Management of Excessive Bleeding during MMA Process



If there is excessive bleeding anytime during the MMA process, vacuum aspiration may be considered.

* If USG is not available, manage as in the table on 'Incomplete Abortion' in Chapter 6: Vacuum Aspiration.



(C) Continuation of pregnancy
It is advisable to terminate a pregnancy surgically if it continues after drugs for MMA have been taken, due to the risk of possible teratogenicity. A written statement, signed by the woman, must be kept on record if surgical termination is refused.

(D) Delay in onset of next menses
There might be a delay in the following menstrual period. The next menstruation can occur from 3-6 weeks after the abortion and is usually normal.

X. Follow-up and Post-abortion Contraception

Contraception should be offered to all women who are seeking abortion. The following contraceptive methods can be used after MMA:

- Hormonal pills can be started on Day Three with misoprostol or Day 15, if the abortion process appears to be complete
- Injectables and Centchroman can be started on Day Three of the MMA process
- IUCD can be inserted around Day 15 of the MMA process, after confirming the completion of the abortion process and ruling out contraindications
- Condoms should be used if the woman has intercourse any time during the process of MMA
- Women desiring concurrent tubal ligation should be counselled for surgical abortion so that the two procedures can be combined. Alternatively, tubal ligation can be done after the next cycle, if the woman so desires

The woman should also be given information on the use of emergency contraception.

XI. Documentation/Reporting of MMA Procedure

Since MMA comes under the purview of the MTP Act, the documentation is similar to that required for the VA procedure. It is mandatory to fill and record information for abortion cases, performed by MMA, in the following forms:

- Form C – Consent Form
- Form I – RMP Opinion Form
- Form II – Monthly Reporting Form (to be sent to the district authorities)
- Form III – Admission Register for case records

MMA Ready Reckoner



Medical Methods of Abortion (MMA)

Ready Reckoner for Provider

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

FIRST VISIT DAY 1

What to do

- Physical and pelvic examination
- Confirm eligibility **(upto 49 days / 7 weeks LMP)***
- Informed consent
- **Tablet Mifepristone 200 mg orally**
- Offer Anti-D 50 mcg to Rh negative women

Tell the woman

- Return for Misoprostol administration after two days
- Contact address and phone number of the facility / center where she can go in case of any emergency
- Record her experience of any side effect on the MMA card

3% women may expel completely with Mifepristone alone but Misoprostol schedule should be completed

SECOND VISIT DAY 3

- Give Misoprostol 400 mcg sublingual/ buccal/vaginal/oral
- Observe for 4 hours
- Analgesics: Ibuprofen 400 mg
- Contraceptive options: condoms, hormonal methods (oral, injectable)

- Mean period of bleeding is 8-13 days
- Possible side effects - nausea, vomiting, diarrhoea, headache, fever, dizziness
- Report in case of excessive bleeding, pain abdomen and fever
- Report if there is no bleeding 24 hrs after Misoprostol (consider giving additional dose of Misoprostol)

75% women abort within 4-6 hours after Misoprostol administration

THIRD VISIT DAY 15

- Pelvic examination to ensure the completion of abortion
- Contraception options:
  - Hormonal methods (oral)
  - Condoms
  - IUCD
  - Sterilization after one menstrual cycle

- About immediate return to fertility
- Report back if there are no periods within 6 weeks of completion of the abortion process

USG only if examination does not confirm the completion of procedure

V-2
Rp-7 / Mar 23, 2018

*Combipack (1 tab of Mifepristone 200 mg and 4 tab of Misoprostol 200 mcg each) has been approved by the Central Drugs Standard Control Organization, Director General Health Services, for termination of pregnancy upto 63 days / 9 weeks LMP in December 2008. Currently, MTP Rules permit medical abortion upto 49 days / 7 weeks only.

MMA Card

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

M.M.A CARD



Name of Health Centre: .....

.....

Name of Doctor : .....

Mobile Number : ..... Ph. No.: .....

	Day 1	Day 3	Day 15
Date			

In case of emergency, immediately contact

Name of Health Centre: .....

Phone Number: .....

Expected Symptoms:

During medical methods of abortion, you may experience one or more of the following symptoms which are self-limiting:

- More than normal menstrual bleeding
- Pain/cramps in the abdomen
- Fever/chills/ rigors
- Nausea or vomiting
- Diarrhoea
- Headache
- Dizziness

If you experience any of the following symptoms, immediately contact a doctor at the health centre:

Excessive bleeding – Soaking 2 or more thick pads per hour for 2 consecutive hours.



No bleeding within 24 hours after taking second drug.



Persistent fever and foul smelling vaginal discharge after taking second drug.



V-2
Rp-2 / Aug 08, 2016

This chart will help you to assess your health during the 15 days of medical abortion process.
Put a (✓) against the symptoms that you experience each day during these 15 days:

During the process ⟶	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Spotting															
Normal menstrual bleeding															
Excessive bleeding															
Nausea / vomiting															
Pain / cramps															
Fever / chills / rigors															

Note: Please visit the health centre for your scheduled day 3 and day 15 visit, or in case of any emergency situation. You may take support of an ASHA worker for visiting the health centre.



Termination of Second Trimester Pregnancies

Second trimester abortions are a small percentage of all abortions worldwide; only 9-11% of all induced abortions occur in the second trimester. However, these abortions are responsible for two-thirds of all major complications. To avoid these, it is essential that second trimester abortions are performed as per the criteria laid down in the MTP Act and Rules, following the appropriate method and taking all necessary precautions.

I. Overview

For various medical, socio-economical, logistical or psychological reasons, some women who decide to terminate a pregnancy will not do so in the first trimester. Thus, it is essential that second trimester abortion services are available and accessible.

Provider's eligibility
A registered medical practitioner with qualifications as laid down in the MTP Act and Rules is entitled to terminate a second trimester pregnancy (Refer Chapter 2: Legal Aspects of Abortion Care – Who can terminate a pregnancy?)

Site eligibility
Provision of services at different levels of healthcare

- In the public sector, tertiary level healthcare centres (medical colleges) and secondary level healthcare centres (district hospitals and first referral units) that fulfil the criteria as per the MTP Rules can provide MTP services for pregnancies up to 20 weeks
- Primary health centres and non-designated (which do not fulfill the eligibility criteria) community health centres are not permitted to offer second trimester MTP services
- Private sector facilities are permitted to provide second trimester terminations after approval from the district level committees in accordance with the MTP Rules 2003

Indications

- The MTP Act allows the termination of a pregnancy between 13-20 weeks gestation only when opinion is formed by two registered medical practitioners
- The MTP Act allows the termination of a second trimester pregnancy as per indications in Section 3 of the MTP Act. (Refer to Chapter 2: Legal Aspects of Abortion Care – When can a pregnancy be terminated)

The provider should ascertain that MTP is not being sought following prenatal sex determination.

Infrastructure required
Refer Chapter 9: Health System Requirements for Provision of CAC Services.

II. Counselling

It is important to recognise that in second trimester services, some women will be aborting a wanted pregnancy for medical reasons (foetus with congenital anomalies) that requires a high level of sensitivity by the counsellor and the provider.

Appropriate pre- and post-procedure counselling, including contraceptive counselling, play an important role for these women. (For details, refer to Chapter 3: Counselling)

III. Clinical Assessment and Pre-procedure Care

Comprehensive care of women who require or request pregnancy termination in the second trimester must include careful assessment of medical and psychological conditions.

Pre-procedure assessment includes the following:

- History taking
- General physical examination
- Bimanual/pelvic/abdominal examination
- Informed consent (Refer Chapter 3: Counselling, Section I – Pre-procedure Counselling)
- Investigations – Hb, urine routine examination and blood group (ABO Rh) are essential (Refer Chapter 4: Clinical Assessment)

For pre-procedure preparation, refer to Pre-procedure Care under Chapter 6: Vacuum Aspiration.

In addition:

- All second trimester terminations to be done as indoor care
- Prophylactic antibiotics, as appropriate, should be given to all
- Injection Anti D (300 mcg) to be given to Rh negative women

IV. Different Methods of Second Trimester Pregnancy Termination

(A) Surgical methods

(B) Medical methods

(C) Miscellaneous

(A) Surgical methods

(i) Dilatation and Evacuation (D&E)

(ii) Hysterotomy

(A) Surgical Method

(Ai) Dilatation & Evacuation (D&E)

The D&E method involves preparing the cervix and evacuating the uterus with a combination of suction and forceps. It is a safe and effective surgical technique for abortions beyond 12–14 weeks where **skilled, experienced providers** are available. D&E requires preparing and dilating the cervix; and evacuating the uterus using vacuum aspiration and ovum/sponge-holding forceps.

D&E is not a commonly used method in India and requires special training.

Special precautions

A woman with the following conditions should be taken up for pregnancy termination by D&E with caution:

- Anaemia (Hb% less than 8gm)
- Hypertension



- Liver and renal disease
- Uterine fibroids and known congenital anomalies of the genital tract
- Previous LSCS
- Placenta praevia
- Cardiac disease

Pain management
The types of pain management medications appropriate for D&E procedure are:

- Non-narcotic analgesics, such as Ibuprofen, can be used to control pain during and after the procedure
- Anxiolytics, such as Diazepam, reduce anxiety and relax muscles. These are useful when the woman is anxious but is otherwise in a stable physical condition
- I/V sedation may be used with injection of Pentazocine 30mg and Promethazine 25mg
- General anaesthesia may be given, if required

Verbal support to the woman throughout the D&E procedure can help her stay relaxed, thereby reducing pain and anxiety, making it an important element of pain management.

For pregnancy termination between 16-20 weeks, surgical procedure should desirably be done under USG guidance.

D&E is a two-step process:

(i) Cervical preparation/dilatation

(ii) Evacuation

(i) Cervical preparation/dilatation: It is recommended for all women undergoing the termination of pregnancy over 12-14 weeks. It decreases the risk of cervical injury and uterine perforation.

The following medication/devices/instruments are used for cervical preparation and dilatation before the evacuation of the POCs:

- Misoprostol
- Osmotic dilators

Misoprostol
Misoprostol (400mcg) is used vaginally 3-4 hours or sublingually 2-3 hours before the procedure for cervical dilatation. One additional dose of 400mcg may be given if the dilatation is inadequate after four hours or dilators may be used.

Advantages of using misoprostol for dilatation:

- It is a highly effective drug for inducing cervical dilatation and uterine contractions
- The administration of misoprostol leads to the contraction of the uterus even before the actual procedure is initiated, thereby reducing the amount of blood loss, possibility of perforation and the time taken for the procedure

Disadvantages of using misoprostol for dilatation:

- It has GI side-effects, which can discomfort the woman

Osmotic dilators

Osmotic dilators can be used to dilate the cervix before performing uterine evacuation. These are made of hygroscopic materials, which swell up by absorbing cervical and vaginal secretions. They gradually dilate and soften the cervix and also stimulate uterine contractions. These require a minimum of four hours to be effective.

Advantages of using osmotic dilators:

- There are less incidents of cervical tears and haemorrhage since it induces gradual dilatation

Disadvantages of using osmotic dilators:

- Can lead to infection, particularly if introduced without proper aseptic care and left in the cervix for too long
- Not easily available

(ii) Evacuation

After achieving the desired level of cervical dilatation, proceed with the evacuation of uterine contents with 12-16mm cannula and forceps.

In the unlikely event that the foetus parts cannot be easily removed, administer additionally any one of the following uterotonic agents such as:

- 400-600mcg misoprostol orally or sublingually
- Injection of prostaglandin (PGF2 alpha) 250mcg IM
- Injection of oxytocin, 20 units in 500ml normal saline or lactated Ringer's solution run at 50ml/hour

(Aii) Hysterotomy

This is not a preferred method for pregnancy termination. It is helpful in the following conditions:

- Failure with the other methods
- Other associated gynaecological conditions

(B) Medical methods

(i) Mifepristone and misoprostol regime

(ii) Misoprostol alone regime

(B) Medical methods

Use of mifepristone and misoprostol for second trimester terminations is not yet approved in India. However, WHO and international evidences recommend the use of mifepristone and misoprostol as being a safe and effective method for second trimester terminations. The WHO recommended protocol is given as Annexure 8.1, for reference.

Medical methods in second trimester termination involve two steps during the process of pregnancy termination:

- Cervical priming
- Inducing uterine contraction

Advantages of medical methods

- Non-surgical technique
- Gradual dilatation of the cervix, hence less chances of damage to the cervix and sequelae such as cervical incompetence

Disadvantages of medical methods

- Continuous monitoring of the uterine contractions and vital signs of the woman
- GI side-effects that can discomfort the woman

(C) Miscellaneous

Few other agents are used to stimulate uterine contractions and induce abortions after 12 weeks but available data regarding their safety are limited. These agents include hypertonic saline, or hyperosmolar urea injected intra-amniotically; ethacridine administered intra- or extra-amniotically; prostaglandin analogues administered parenterally or intra- or extra-amniotically; and oxytocin injected intravenously or intramuscularly. These methods and routes of administration, however, are invasive and likely to be less safe. Further, the time to complete abortion is longer when compared to the use of methods such as combined mifepristone and misoprostol (WHO 2012).

Extra amniotic ethacridine instillation supplemented by oxytocin

This had been one of the commonly used methods. Ethacridine lactate, when instilled extra amniotically, has a direct oxytocic effect on the myometrium. It also causes the separation of membranes, which releases prostaglandins, leading to uterine contractions.

Ethacridine is currently not easily available in the country.

V. Post-procedure Care Following the Second Trimester Pregnancy Termination

Post-procedure care

After a second trimester abortion, a woman should remain in the healthcare facility for at least four hours so that the healthcare team can ensure that she is well enough to return home. The healthcare provider assigned to the recovery room should check the woman's pulse and blood pressure when she first arrives in the recovery room, and shortly thereafter, and again before she is discharged.

Conditions that require immediate attention and treatment:

- Significant physical deterioration, as reflected in vital signs
- Dizziness, shortness of breath or fainting, which may be caused by internal or external blood loss
- Fainting, which may be due to anxiety or to a transient vaso-vagal reaction
- Severe vaginal bleeding: While some post-procedure bleeding is expected, the amount of bleeding should decrease over time
- Severe abdominal pain or cramps: Severe, prolonged cramping may be a sign of uterine perforation or post-abortal haematometra

Post-procedure information

The recovery period is also an important opportunity to provide the woman with information, including follow-up instructions and contraception.

Every woman should know:

- She may experience some bleeding per vaginum for several days and that this is normal. Bleeding may be as heavy as a period for the first week. If her bleeding increases, rather than decreasing during the following week, she should contact the clinic/provider
- She may have some abdominal cramping and that this is normal. If her cramping increases rather than decreasing, or if she has fever or severe abdominal pain, she should contact the clinic/provider
- She can resume her normal diet on the same day
- She should restrict activities for one week
- She should avoid vaginal douching or tampons
- She can become pregnant again even before her menstrual cycle returns and that contraceptive options are available to help her to prevent an unwanted pregnancy
- It is recommended that she does not have sexual intercourse until any complications are resolved, the bleeding stops and her chosen contraceptive method becomes effective
- She should return for a follow-up examination within two weeks

The following tasks should be undertaken before the woman is discharged from the facility:

- Contraceptive counselling with contraceptive provision, when requested
- Address other health issues – anaemia, reproductive tract infections (RTIs), HIV, domestic violence, cancer screening
- Suppression of lactation with tablet Cabergoline 0.5mg stat
- Provide discharge instructions as listed earlier
- Pain management with analgesics, NSAIDs
- Provision of antibiotic therapy (tablet Doxycycline 100mg for eight days or as appropriate)

Follow-up care

- Every woman who has a second-trimester abortion should be scheduled for a follow-up medical visit within two weeks after the procedure. At the follow-up visit:
  - Review her medical record from the procedure
  - Perform a physical examination
  - Review her contraceptive decisions
  - Provide any related services indicated or desired by the woman, making sure to answer her questions
  - Record results of the follow-up visit in the woman's medical chart

VI. Complications and Management

Excessive haemorrhage during the procedure
Refer to Chapter 6: Vaccum Aspiration – Complication and Management.

Lacerations and perforation

Minor lacerations

With a D&E procedure, minor lacerations can occur during cervical dilation; cervical injury can occur during foetal passage in medical methods of abortion. If untreated, such injuries can bleed and may cause future problems such as cervical incompetence. They can also serve as the entry point for infection. The occurrence of lacerations can be reduced by proper preparation of the cervix.

For the management of cervical lacerations, refer to Chapter 6: Vaccum Aspiration – Complication and Management.

Uterine perforation

If a woman complains of upper abdominal pain during the procedure, it may mean that the bowel has been disturbed by uterine perforation.

For more information on management of uterine perforation, refer to Chapter 6: Vaccum Aspiration – Complication and Management.

Infection and sepsis
A woman can present with infection any time from several days to several weeks after an abortion. Infection may be limited locally (uterus or cervix) or may become generalised sepsis.

For more information on management of infection/sepsis, refer to Chapter 6: Vaccum Aspiration – Complication and Management.

Shock
With second-trimester abortion, shock most often results from haemorrhage or sepsis.

For more details on management of shock, refer to Chapter 6: Vaccum Aspiration – Complication and Management.

Anaesthetic complications
Rarely, a woman may have a reaction while in the recovery room due to the anaesthesia used during the procedure.

For more details on management of anaesthetic complications, refer to Chapter 6: Vaccum Aspiration – Complication and Management.

Annexure 8.1

Medical Methods for Second Trimester Termination

(I) Mifepristone and Misoprostol regime

It involves the use of a combination of drugs to initiate and complete the termination of pregnancy.
Cervical priming: Under this regime, cervical priming is done by mifepristone.

Inducing uterine contractions: Misoprostol serves to dilate the cervix and it also induces uterine contractions.

Contraindications

Medical methods are contraindicated in women with:

- Anaemia (haemoglobin <8gm %)
- Uncontrolled hypertension with BP >160/100mm Hg
- Cardio-vascular diseases such as angina, valvular disease and arrhythmia
- Coagulopathy or woman on anticoagulant therapy
- Chronic adrenal failure or current long-term use of systemic corticosteroids
- Severe renal, liver or respiratory diseases
- Uncontrolled seizure disorder
- Inherited porphyria
- Allergy or intolerance to mifepristone/misoprostol or other prostaglandins

Drug Protocol (WHO 2014)

- 200mg oral mifepristone followed 36-48 hours later by 400mcg misoprostol oral followed by 400mcg misoprostol vaginal or sublingual every three hours, up to five doses (including the first dose)

  OR
- 200mg oral mifepristone followed 36-48 hours later by 800mcg misoprostol vaginal followed by 400mcg misoprostol vaginal or sublingual every three hours, up to five doses (including the first dose)

Pain management during medical methods: Give Ibuprofen 400mg or an equivalent agent to all women undergoing the termination with medical methods with the first dose of misoprostol and then subsequently every six to eight hours. Paracetamol is not effective for pain relief during the process of MMA.

Pain medication is to be supplemented by verbal reassurance.

(II) Misoprostol alone regime

Here, misoprostol is used for cervical priming as well as inducing uterine contractions.

This regimen is less effective (75-90%) than the combined regimen (98%).

Drug Protocol

400mcg misoprostol, vaginal or sublingual, every three hours, up to five doses (WHO 2014).

During the MMA process, the placenta should be expelled within two hours of foetal expulsion. If the placenta remains in the uterus, one of the following options should be used:

- Sublingual/buccal/ rectal misoprostol, 400mcg
- High-dose oxytocin regimen for two hours, such as 20 units in 500 ml normal saline, run at 50 ml/hr IV



CHAPTER 9

Health System Requirements for Provision of CAC Services

I. Supply Chain Management for Strengthening CAC Services

CAC supply chain management refers to the healthcare commodities that will enable CAC services, mainly MMA drugs, MVA equipment and consumables, needed to deliver high quality CAC services to the women. Supply chain is an integral component of the public health system and has an implication on CAC service delivery as well. It is essential for programme managers at the state and district levels as well as concerned staff at health facilities to ensure that MMA drugs, MVA equipment and cannulae and related supplies, as detailed later in the chapter, are available at all facilities with CAC trained providers.

Healthcare supply chain management for CAC services broadly involves:

- Estimating the demand for MMA and MVA commodities (forecasting)
- Obtaining commodities – MMA drugs, MVA equipment, cannulae, contraceptive methods and consumables (procurement)
- Ensuring rational and demand-based distribution of these commodities (logistics)
- Their stocking at various levels – state, district and facility levels (storage)
- Providing these commodities for healthcare (for procedures)
- Documentation of utilisation of commodities for monitoring and planning re-order

To have an efficient supply chain management system, not only are the commodities (MVA equipment and MMA kits) needed at the right time at the right place and in the right quantity but it is equally important for the information from each level to flow back in the system. This ensures that it is sufficiently responsive to meet regular and unplanned needs that may emerge from time to time.

Programme managers need to ensure that these steps are followed effectively for ensuring seamless CAC services in the public health system.

II. Infrastructure Required for CAC Procedure

MTPs using VA can be performed in a setting defined and approved for first trimester MTP as per the MTP Act and Rules. These may be equivalent to a basic labour room or a major or minor operation theatre.

In addition to the essential equipment and supplies listed below, the facility must have clean running water and a toilet. It is preferable, though not mandatory, that the facility has a separate place with adequate privacy or a separate room for counselling.

(A) Essential equipment/drugs/supplies for VA procedure:

- Sim's and/or Cusco's speculum
- Anterior vaginal wall retractor
- Allis forceps or volsellum (small toothed)
- Sponge-holding forceps
- Cheatle's forceps

- Bowl for antiseptic solution
- Proper light source/torch
- MVA aspirator and/or electric suction machine
- Cannulae of required sizes
- Kidney tray or suitable receptacle for emptying the contents of the aspirator
- Bowl and strainer for tissues
- Plastic bucket for chlorine solution for keeping soiled instruments

Equipment for resuscitation

- Ambu bag
- Oral airway
- Oxygen cylinder

Equipment for infection prevention and sterilization

- Autoclave
- Boiler
- Cidex tray

Essential supplies

- Antiseptic solution: Povidone iodine solution
- Sterile cotton swabs
- Sterile gloves
- Clean perineal sheet (desirable)
- Syringe and needle for administration of paracervical block and other drugs
- Sterile saline or water for washing instruments that are chemically sterilized or high level disinfected, before use
- Chlorine solution/bleaching powder
- Utility gloves

Essential drugs

- Antibiotics: Doxycycline, Azithromycin, Ampicillin
- Analgesics: Ibuprofen, Paracetamol
- Injection Atropine Sulphate
- Local anaesthetic: Injection Lignocaine 1-2%
- Injection Diazepam
- Uterotonics: Injection Oxytocin, injectable prostaglandins, and misoprostol
- Normal saline, Dextrose 5% and Ringer lactate solution with I/V sets and cannulae or scalp vein sets

Drugs for treatment of emergencies

- Injection Adrenaline
- Injection Aminophyline



- Injection Sodium Bicarbonate 7.5%
- Injection Calcium Gluconate 10%
- Antiemetics: Injection Metclopramide or a suitable alternative
- Antihistaminics: Injection Promethazine Hydrochloride or a suitable alternative
- Steroids: Injection Hydrocortisone Succinate
- Injection Frusemide
- Injection Dopamine

(B) Drugs required for medical methods of abortion
The facility offering MTPs using MMA should essentially have the following drugs:

- Mifepristone
- Misoprostol
- Analgesics: Ibuprofen or a suitable alternative
- Antiemetics: Tablet Metclopramide or a suitable alternative

(C) Infrastructure required for second trimester terminations
In addition to all the requirements listed for a VA procedure, the following are needed for the second trimester procedures:

Essential equipment/instruments

- Ovum forceps
- Instruments for laparotomy, gynaecological and abdominal surgery

Equipment for resusication/anaesthesia

- Boyle's apparatus
- Endotracheal tubes

Equipment for infection prevention and sterilization

- Same as for VA procedure.

Essential supplies

- Sutures of different sizes, in addition to the requirement enlisted under VA

Essential drugs

- Mifepristone
- Misoprostol
- Injection Oxytocin

Drugs for treatment of emergencies

- Same as for VA procedure

The functional equipment stock at the beginning of each month for various levels of the health facilities is given in the table:

Functional Stock at the Facility at the Beginning of the Month

	Item	PHC	CHC	SDH/RH	DH
1	***Examination room***				
1.1	Examination table	1	1	1	1
1.2	Screen/curtain for privacy	1	1	1	1
1.3	Cusco's speculum (medium and large)	3 (2 & 1)	3 (2 & 1)	4 (2 & 2)	10 (5 & 5)
1.4	Foot step	1	1	1	1
2	***Procedure room***				
2.1	Examination/labour table	1	1	1	1
2.2	Suction machine/foot pump	1	1	1	1
2.3	MVA aspirator and cannula sets	2	2	3	5
2.4	Light source	1	1	2	2
2.5	Foot step	1	1	1	1
3	***Instruments***				
3.1	Dilator set	1	1	2	3
3.2	Sim's speculum (medium and large)	2 (1 & 1)	4 (2 & 2)	4 (2 & 2)	5 (3 & 2)
3.3	Sponge-holding forceps	2	2	3	5
3.4	Sharp and blunt curette	2	2	3	5
3.5	Ovum forceps	0	1	1	2
3.6	Volsellum	2	4	4	5
3.7	Bowl/kidney tray for antiseptic and POC inspection	2	4	5	8
3.8	Instrument tray	1	2	3	5
3.9	Instrument for gynae/abd surgery (sets)			1	2
3.10	Instrument trolley	1	1	1	2
4	***Resuscitation equipment***				
4.1	Oral airway	1	1	1	2
4.2	Face mask	1	1	1	2
4.3	Ambu bag	1	1	1	2
4.4	Oxygen cylinder with reducing valve flow meter	1	1	2	3
4.5	Boyle's apparatus	0	0	1	1



	Item	PHC	CHC	SDH/RH	DH
5	***Sterilization equipment***				
5.1	Autoclave	1	1	1	2
5.2	Boiler	1	1	1	2
5.3	Cidex tray	1	1	1	2
6	***Drugs and parenteral fluid***				
6.1	Antibiotics: Tab Doxycycline	56	84	140	490
	Cap Ampicillin	30	30	45	150
	Tab Azithromycin	12	12	15	45
6.2	Analgesics: Tab Ibuprofen	54	72	90	315
6.3	Tab Misoprostol (200mcg)	18	24	30	106
6.4	Tab Mifepristone	3	4	5	18
6.5	Tab Perinorm	9	12	15	54
6.6	Tab Lomotil	8	12	12	40
6.7	Inj. Oxytocin	10	10	20	40
6.8	Inj. Diazepam	2	2	4	10
6.9	Inj. Atropine	6	8	10	35
6.10	Inj. Adrenaline (nos. who may require)	2	2	2	5
6.11	Inj. Aminophylline	2	2	3	10
6.12	Inj. Sodium Bicarbonate 7.5%	2	2	2	5
6.13	Inj. Calcium Gluconate 10%	2	2	3	5
6.14	Inj. Avil/Phenergan	2	2	3	10
6.15	Inj. Hydrocortisone	2	2	3	5
6.16	Inj. Frusemide	2	2	3	5
6.17	Inj. Dopamine	4	4	6	20
6.18	Inj. Xylocaine/Lignocaine (vials)	2	2	3	5
6.19	5% Dextrose	2	2	5	10
6.20	Ringer lactate	4	4	10	20
6.21	Normal saline	4	4	10	20
6.22	I/V sets	6	8	10	35
6.23	I/V cannula/scalp vein sets	6	8	10	35

	Item	PHC	CHC	SDH/RH	DH
7	***Supplies***				
7.1	Povidone iodine solution bottles	4	4	6	10
7.2	Bleaching powder				
7.3	Disposable syringes (2ml)	24	32	40	140
7.4	Disposable syringes (10ml)	12	16	20	80
7.5	Surgical gloves (pairs)	24	32	40	175
7.6	Utility gloves	2	4	4	10
7.7	Cotton/gauze	2 packets	2 packets	3 packets	5 packets
7.8	Plastic gowns	2	2	4	4
7.9	Perineal sheet	2	2	4	10
7.10	Trolley sheet	2	2	4	10
7.11	Surgical masks (disposable) – no. of boxes	1	1	1	2
7.12	Head caps (disposable) – no. of boxes	1	1	1	2
7.13	OT slippers	10	10	15	20

The above requirements are based on the following assumptions for MTP caseload:

	PHC	CHC	SDH/RH/FRU	DH
First trimester cases	6 (50% MMA cases - 3)	8 (50% MMA cases - 4)	10 (50% MMA cases - 5)	35 (50% MMA cases - 18)
Second trimester cases			1	5



CHAPTER 10

Operationalizing MTP/CAC Trainings

I. Introduction

The MTP Act, 1971, along with the MTP Rules,1975, permits MBBS doctors to provide first trimester MTP/CAC services only after they undergo training at a government approved training centre and gain experience of observing 10 MTP/CAC cases, assisting 10 cases and performing five cases independently.

This chapter provides broad guidelines on:

- Establishing an MTP/CAC training system within the state under the guidance of the Ministry of Health and Family Welfare, Government of India
- Establishing training centres and conducting MTP/CAC trainings

II. The Roll-out of MTP/CAC Trainings (Figure 19)

The roll-out of MTP/CAC trainings at the state level consists of the following main components:

- ***Programme management***, which includes the identification of key officials at the state and district levels who would be involved in the selection of MTP/CAC training centres; the development of training material; planning of training activities such as developing training calendars, deputing medical officers and nursing staff for training and monitoring of training activities
- ***MTP/CAC training activities***, which include the training of trainers (ToTs); an orientation programme for certified providers; and certification training for medical officers. Reporting of the training should be done on a regular basis to the concerned authority
- ***Establishing sites for providing MTP/CAC*** services in public sector health system
- ***Budgeting and finance disbursement***, which includes the proper planning and budgeting of MTP/CAC trainings in the state PIP as per the defined norms

The detailed process flow of operationalizing MTP/CAC training in the states is presented in Figure 19; given below is a description of some key operational elements of MTP/CAC trainings.

III. Planning and Orientation for MTP/CAC Training

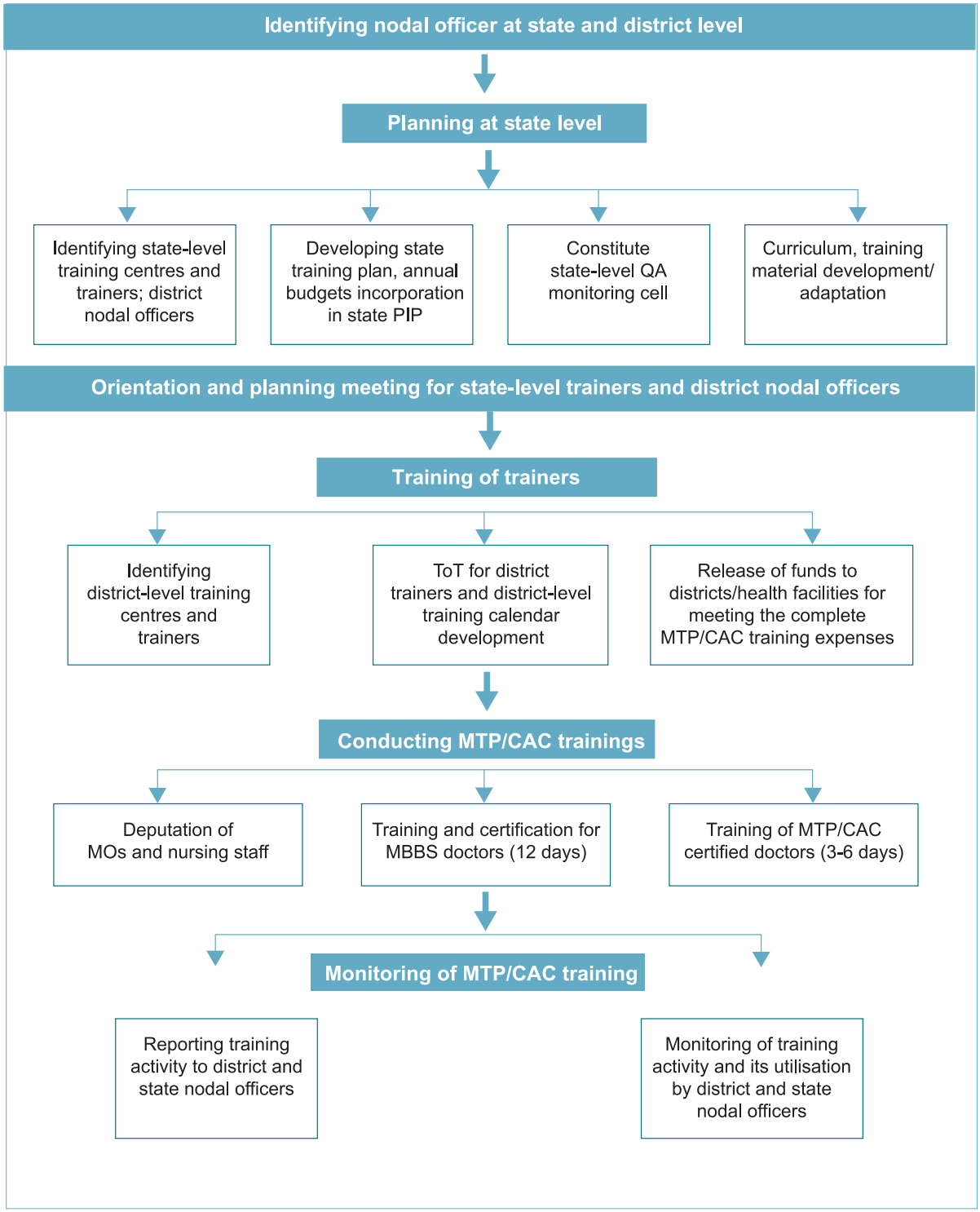
(A) Orientation and planning workshop

Objective: To orient the state and district nodal persons, state master trainers, state and district programme managers and training coordinators, members of the QA cell and SIHFW faculty.

Location: SIHFW/State Directorate of the H&FW/State Health Society office.

Resource persons: Technical experts from the National Institute of Health & Family Welfare, National Health Systems Resource Centre, MoHFW, Medical Colleges, etc. and persons involved in planning the MTP/CAC roll-out and its operationalization at the state/central levels.

Figure 19: Roll-out of MTP/CAC Training Programme at State and District Levels





Participants/trainees: State and district nodal persons for the MTP/CAC trainings, state master trainers, state and district programme managers and training coordinators, members of the QA cell and SIHFW faculty.

Duration: One-day (eight-hour) workshop.

Batch size: The optimal number of participants is around 20. If there are more participants, the workshop should be conducted in two batches.

Workshop content: The workshop will cover the training roll-out, QA monitoring, budgets, operationalizing services and the sessions to be included in the training programmes. The suggested agenda is given in Annexure 10.1.

Budget for MTP/CAC training

All expenses for MTP/CAC training of public sector providers should be budgeted for under the maternal health component of the district and state PIP. These can be drawn from the RCH flexipool fund placed at the disposal of the states. For this purpose, the revised RCH norms should be followed. The total estimate for conducting MTP/CAC training should be calculated. It must include the cost of components such as:

- TA/DA/honorarium/accommodation for trainers/trainees, as applicable[1]
- Photocopying/printing of training manuals and other logistic/administrative expenses
- Monitoring of MTP/CAC trainings and service delivery

The annual training plan should guide the number of providers to be trained and budget required. The state nodal officer will ensure that adequate funds are transferred to the districts ahead of the training. Similarly, the district nodal officer should ensure the release of funds to the identified training centre/s ahead of the training and also that the TA/DA of the participants is distributed in time.

Adequate funds for strengthening service delivery sites (provision of required equipment and infrastructure); monitoring of training at the training institute and also for post-training follow-up at the service delivery sites should be put in the respective PIPs.

Selection of an MTP/CAC training centre

Public (secondary and tertiary-level facilities), private and NGO sector service delivery sites can be approved by the state government as training centres for providing MTP/CAC training.[2] Service delivery sites need to fulfill the following criteria to be eligible to be approved as an MTP/CAC training centre:

- Approved MTP/CAC service delivery site providing MTP/CAC services with appropriate technology
- Annual MTP/CAC and incomplete abortion caseload of more than 400. Cases of incomplete abortion also provide the trainees with an opportunity to practice clinical skills
- Adequate infrastructure, including operation theatre, equipment and supplies for the MTP/CAC service delivery. Refer to Chapter 9 for more details
- Availability of space/room and other training infrastructure to conduct MTP/CAC training of six to eight persons

[1]TA/DA is not applicable in cases of trainees from the private sector.
[2]Private and NGO sector service delivery sites that are keen to get approval for MTP/CAC training should apply to the state authorities as appropriate. The state government has the flexibility to provide reimbursement to these sites for conducting MTP/CAC trainings.

- Minimum of two MTP/CAC certified providers, one of whom has to be a gynaecologist (MD/DGO). Both of them should have attended a ToT workshop to become government approved MTP/CAC trainers
- The providers should be offering MTP/CAC services with safe and appropriate technology as per the standardized protocol
- Willingness of the administrative head and the department staff to take on responsibility for conducting MTP/CAC training, data collection and reporting

(B) Conducting MTP/CAC trainings

i. ToT workshop

Objective: To create a cadre of district-level MTP/CAC master trainers who would provide ongoing training to medical officers and nursing staff at the identified district-level training centres. These master trainers would also orient the site staff towards the MTP/CAC training.

Location: One/two state-level training centres identified by the state. The SIHFW, in collaboration with nearby medical colleges, could conduct the state-level ToTs.

Trainer: Lead trainers identified and oriented by the state or experienced in conducting ToTs for MTP/CAC. They have to be gynaecologists (MD/DGO) performing MTPs/CAC with appropriate technology.

Participants/trainees: Head of the department of ObGyn and faculty members of the district-level training centres. They can be gynaecologists (MD/DGO) or MTP/CAC trained and certified MBBS doctors performing MTPs/CAC with appropriate technology.

Duration: The ideal duration of a ToT workshop is four days but a minimum of three days should be adhered to. It should be ensured that this does not hamper the regular service provision at the facilities.

Batch size: Should not exceed 8 to 10 doctors.

Workshop content: The suggested sessions and sample session plan for the ToT workshop are given in Annexure 10.2.

ii. MTP/CAC training and certification for MBBS doctors

Objective: To train and certify MBBS doctors to provide safe and legal first trimester MTP/CAC services.

Location: State/district-level training centres that have been approved by the government.

Trainer: State/district-level master trainers developed through ToT workshops.

Participants/trainees: MBBS doctors (from the public and private sectors) who are registered with a State Medical Council. Public sector doctors, who have been in service for at least three years and have more than five years to retire, should be deputed for training. Contractual doctors should only be included in the training if the regular doctors are not available.

Duration: Depends on the MTP/CAC caseload at the training centre. Normally this takes about two weeks (extendable by one week if the caseload is insufficient). This is because each trainee needs to observe, assist and perform cases as per the requirements under the law. The extension of the training days for these trainees can be undertaken on the suggestion of the master trainer, who will inform the MS, with a copy of the communication to the CMO of the district for necessary action, including payment of TA/DA.



Batch size: Dependent on the MTP/CAC caseload per month at the training centre, so that trainees can have adequate hands-on practice. No more than three trainees per batch should be taken at the centres that have 400 cases per year. If a centre has more than 400 cases, the number of trainees per batch can be increased in consultation with the master trainers of the centre. For every additional 100 cases at a training centre, one more trainee can be taken in the batch.

Course content: Includes didactic sessions on clinical and non-clinical topics and hands-on training on the anatomical models and live cases to ensure the acquisition of the required skills.

The suggested didactic sessions, along with a sample session plan for the MTP/CAC certification course, are given as Annexures 10.3(a) and 10.3(b), respectively.

To acquire the clinical skills, each trainee doctor must undergo hands-on training during which each trainee must:

- Observe 10 MTP/CAC cases
- Assist in 10 MTP/CAC cases
- Perform five MTP/CAC cases independently (under supervision)

It is recommended that the hands-on training should include exposure to all technologies of safe abortion care. These cases should, therefore, be spread across all the technologies – EVA, MVA and MMA.

All the trainee doctors should record the cases they have done independently in their notebooks and get them signed by the trainer who supervised him/her.

A manual covering the relevant chapters could be given to all the trainees, for future reference.

Certification of trainees

The trainee doctor should be evaluated for MTP/CAC skills by a trainer, using a checklist. A sample skills checklist is given as Annexure 10.4. If the skills of the trainee are found to be satisfactory (13 critical steps performed correctly for two cases), a certificate (Annexure 10.5) should be issued by the training centre, signed by the head of the ObGyn department or training centre, certifying the trainee to provide first trimester MTP/CAC services.

iii. MTP/CAC Training Programme for Certified Providers

Objective: To reorient ObGyns and MTP/CAC trained MBBS doctors and help them adopt newer and safer technologies such as vacuum aspiration and medical methods of abortion.

Location: State/district-level MTP/CAC training centres that have been approved by the government.

Trainer: State/district-level master trainers developed through ToT workshops.

Participants/trainees: ObGyns and MTP/CAC trained MBBS doctors.

Duration: Three to six days, depending on the availability of the MTP/CAC caseload at the training centre. Each trainee needs to have hands-on experience of two to three MVA procedures.

Batch size: Three to six participants.

Course content: The suggested sessions and session plan for the programme are given in Annexure 10.6.

It is recommended that, wherever possible, providers undergoing MTP/CAC training should be accompanied by a nursing staff/OT staff/ANM from the site. It should, however, be ensured that their absence does not disrupt any of the emergencies and routine surgical procedures at the sites. As the law does not currently allow this cadre of staff to provide abortion services, they could be included in the relevant non-clinical sessions to enable them to provide counseling to women and support the medical officer in infection prevention and instrument processing.



Annexure 10.1

Suggestive Agenda of Planning and Orientation Workshop

Time	Topic
9.00 – 9.30 am	Registration
9.30 – 10.30 am	Welcome Introduction of the participants Objectives and expected outcomes Expectations and norms
10.30 – 11.00 am	Abortion scenario
11.00 – 11.15 am	Tea
11.15 am – 1.00 pm	Operational roll-out (training plan, monitoring and evaluation, materials, budget, disbursement of funds) Discussion on its operationalization
1.00 – 2.00 pm	Lunch
2.00 – 3.30 pm	Sessions for the subsequent trainings
3.30 – 3.45 pm	Tea
3.45 – 4.45 pm	Teaching/training methodology, adult learning principles
4.45 – 5.15 pm	Discussion on the session/material contents
5.15 – 5.30 pm	Wrap up Vote of thanks

Annexure 10.2

Suggested Sessions and Plan for Training-of-Trainer's Workshop

(A) Suggested sessions for the ToT workshop:

- Abortion scenario
- Reproductive rights
- Law and abortion (MTP Act & Rules)
- Adult learning principles
- Counselling skills
- Post-abortion contraceptive services
- Uterine evacuation methods for first trimester
- Clinical assessment
- Hands-on pelvic model and live cases for MVA, EVA and MMA procedure
- Hands-on model practice and live cases for IUCD insertion
- Vacuum aspiration
- Infection prevention
- Medical methods of abortion
- Methods of second trimester abortion
- Complications of abortion
- Operationalizing training and service delivery



(B) Sample session plan for a ToT workshop:

Day 1	
Time	**Session**
9.30 – 10.00 am	Registration Pre-test
10.00 – 11.00 am	Introduction to Goal & Objectives Introduction of Participants
11.00 am – 12.00 N	Law and Abortions
12.00 – 12.15 pm	Tea Break
12.15 – 1.30 pm	Vacuum Aspiration & Instrument handling Pelvic Model Demonstration
1.30 – 2.30 pm	**Lunch**
2.30 – 3.30 pm	Pre-test Analysis Abortion Scenario
3.30 – 4.15 pm	Reproductive Rights
4.15 pm	Evaluation & Planning for next day

Day 2	
Time	**Session**
9.30 – 11.00 am	Recap Day 1 Medical Methods of Abortion
11.00 am – 12.00 N	Clinical Assessment Uterine Evacuation Methods
12.00 – 12.15 pm	Tea Break
12.15 – 1.30 pm	OT cases
1.30 – 2.30 pm	**Lunch**
2.30 – 3.30 pm	OT case review Post-abortion Contraceptive Services
3.30 – 4.15 pm	Post-abortion IUCD Insertion demo on Model
4.15 pm	Evaluation & Planning for next day

Day 3	
Time	**Session**
9.30 – 11.00 am	Recap Infection Prevention
11.00 am – 12.00 N	Model practice for MVA and IUCD
12.00 – 12.15 pm	Tea Break
12.15 – 1.30 pm	OT cases
1.30 – 2.30 pm	**Lunch**
2.30 – 3.30 pm	OT case review Counselling Skills
3.30 – 4.15 pm	Adult Learning Principles
4.15 pm	Evaluation & Planning Assign microteaching sessions

Day 4	
Time	**Session**
9.30 – 11.00 am	Recap Day 1 Complications of Abortions
11.00 am – 12.00 N	Second Trimester Terminations
12.00 – 12.15 pm	Tea Break
12.15 – 1.30 pm	Microteaching Sessions
1.30 – 2.30 pm	**Lunch**
2.30 – 4.00 pm	Operationalizing CAC trainings Training Evaluation Valedictory

Annexure 10.3 (a)

Suggested Didactic Sessions for MTP/CAC Certification Course

Clinical topics

- Clinical assessment before the MTP/CAC procedure
- Uterine evacuation methods for first trimester – manual vacuum aspiration (MVA), electric vacuum aspiration (EVA), medical methods of abortion (MMA)
- Pre- and post-procedure care
- Managing complications of abortions

Non-clinical topics

- Abortion scenario
- Reproductive rights
- Laws and abortions (MTP Act and Rules)
- Counselling skills
- Post-abortion contraception services
- Infection prevention
- Operationalizing CAC service delivery post-training



Suggested Session Plan for MTP/CAC Certification Course

Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
9.00 am – 1.00 pm	Registration Pre-test Introduction of participants	MTP OPD Understanding functioning of OPD	MTP OPD Skills demo on clinical assessment	MTP OPD Skills demo on clinical assessment	MTP OPD/OT Observe cases	MTP OPD Observe cases
1.00 – 2.00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
2.00 – 3.00 pm	Objectives of the training Expectations	Law and Abortions	Counselling Skills	Vacuum Aspiration	Post-abortion Contraceptive Choices	Medical Methods of Abortion
3.00 – 3.15 pm	Tea	Tea	Tea	Tea	Tea	Tea
3.15 – 4.15 pm	Abortion Scenario Plan for next day	Components of Clinical Assessment Plan for next day	Infection Prevention Plan for next day	MVA demonstration on pelvic model Plan for next day	Post-abortion IUCD Practice IUCD insertion Plan for next day	Uterine Evacuation Methods Practice IUCD insertion Plan for next day
Week 2	**Day 7**	**Day 8**	**Day 9**	**Day 10**	**Day 11**	**Day 12**
9.00 am – 1.00 pm	OT/OPD Assist cases, Post-procedure care	OT/OPD Assist MTP case, Post-procedure care	OT/OPD Assist/ perform cases	OT/OPD Assist/ perform cases	OT/OPD Assist/ perform cases	OT/OPD Assist/ perform cases
1.00 – 2.00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
2.00 – 3.00 pm	Complications of Abortions	Reproductive Rights Practice counseling skills	Practice MVA procedure on pelvic model	Practice CAC Documentation	Practice MVA/IUCD insertion on model	Certificate distribution
3.00 – 3.15 pm	Tea	Tea	Tea	Tea	Tea	
3.15 – 4.15 pm	Practice MVA procedure on pelvic model Plan for next day	Practice IUCD insertion on model Plan for next day	Practice MVA /IUCD insertion on model Plan for next day	Practice MVA/ IUCD insertion on model Plan for next day	Practice MVA/IUCD insertion on model Plan for next day	

Annexure 10.4

Skills Checklist:
Uterine Evacuation Procedure with MVA

Skills	Case 1				Case 2			
	Yes		No	Comments	Yes		No	Comments
	Satisfactorily	Unsatisfactorily			Satisfactorily	Unsatisfactorily		
Prepares the instruments								
Checks vacuum retention of aspirator*								
Prepares the woman								
Asks woman to empty her bladder*								
Puts on barriers and washes hands*								
Performs cervical antiseptic prep								
Follows No-Touch Technique*								
Uses antiseptic sponges to clean os and vagina*								
Performs pelvic examination to confirm assessment findings*								
Administers paracervical block								
Injects 1-2 ml at tenaculum site after aspiration								
Inject 4 – 5 ml of lignocaine at 4 and 8'o clock position after aspiration*								
Uses positive, respectful, supportive reassurance								
Dilates cervix								
Gently dilates cervix with cannula until it fits snugly*								
Inserts cannula								
Rotates cannula while gently applying pressure								
Inserts cannula up to the fundus and withdraws slightly								
Evacuates uterine contents								
Attaches charged aspirator to the cannula*								
Release buttons to start vacuum*								
Evacuates uterine contents by to and fro motion*								
Inspects tissue								
Empties aspirator contents into container								
Looks for POC*								
Concurrent procedures								
IUCD insertion/sterilization								
Instrument processing								
Processes instruments*								
Removes barriers and washes hands								

* indicates 13 critical steps, that need to be performed correctly to be labelled as procedure performed satisfactorily



(Insert respective state gov. logo)

CERTIFICATE OF COMPLETION

Participated & successfully completed the

Comprehensive Abortion Care Training Program

Held at ..... from ..... to .....

He/She is certified to provide MTP Services upto 12 weeks as specified in Rule 4-C of the MTP Rules, 2003

.....

Dr.....

Department of Obstetrics & Gynecology

.....

Annexure 10.6

Suggested Didactic Sessions and Session Plan for MTP/CAC Training of Certified Providers

(A) The suggested didactic sessions for the MTP/CAC training for certified providers:

Clinical topics

- Uterine evacuation methods for first trimester – manual vacuum aspiration (MVA), electric vacuum aspiration (EVA),medical methods of abortion (MMA)
- Methods of second trimester abortions
- Managing complications of abortions
- Demonstration and practice of MVA on anatomical model
- Hands-on practice: Two to three cases

Non-clinical topics

- Reproductive rights
- Counselling skills
- Infection prevention
- Law and abortions
- Post-abortion contraceptive services

(B) The suggested session plan for the MTP/CAC training for certified providers:

Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
9.30 – 11.30 am	Registration Pre-test Goal & Objectives Introduction	Medical Methods of Abortion	Infection Prevention	Complications of Abortions	Counselling in OPD OT cases followed by post-procedure care	Counselling in OPD OT cases followed by post-procedure care
11.30 am – 1.00 pm	Law and Abortion	Post-abortion Contraceptive Services	OT cases	OT cases		
1.00 – 2.00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
2.00 – 3.15 pm	Vacuum Aspiration	Clinical Assessment	Counselling Skills	Uterine Evacuation Methods	Reproductive Rights	Complete Documentation
3.15 – 3.30 pm	Tea	Tea	Tea	Tea	Tea	Tea
3.15 – 4.00 pm	Abortion Scenario Plan for next day	Post-abortion IUCD Plan for next day	MVA practice on model Plan for next day	Second Trimester Terminations Plan for next day	Practice IUCD insertion Plan for next day	Valedictory

List of References

1. Clinical Practice Handbook for Safe Abortion, WHO 2014
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6. Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994
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   http://nhm.gov.in/images/pdf/programmes/family-planing/guidelines/Post_Abortion_Family_Planning.pdf

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