सत्यमेव जयते

Comprehensive Abortion Care

Training and Service Delivery Guidelines

Third Edition

2023

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Ministry of Health and Family Welfare
Government of India

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Training and Service Delivery Guidelines

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Ministry of Health and Family Welfare
Government of India

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Acknowledgement

Abortions have been legal in India since the introduction of the Medical Termination of Pregnancy (MTP) Act in 1971. The Act gave a legal framework for the abortion services to be provided with safety under certain indications.

To further improve the access to safe abortion services, the MTP Act has recently been amended and the Medical Termination of Pregnancy (Amendment) Act, 2021 and the Medical Termination of Pregnancy (Amendment) Rules, 2021 as prescribed under the Act have come into force. These amendments intend to increase the ambit and access of women seeking legal abortion services for different reasons or indications.

To operationalize further the changes in the law at the state level, corresponding guidance is required for the providers and the programme managers so that actual realization of the benefits under the amendments can be passed onto the women. The Comprehensive Abortion Care (CAC) Guidelines hence, have been revised accordingly and all the changes have been incorporated. Updated information provided in the document includes details on newer aspects in the amendments like new indications for pregnancy termination, establishing of Medical Boards, revised documentation/reporting formats, and norms for capacity building of service providers esp. for Medical Methods of Abortion training, to enlist a few. It also aims to equip programme managers with the skills to plan and implement quality CAC services.

The Guidelines is an outcome of the deliberations of a group of technical experts. I would like to acknowledge their contribution towards the development of this document.

I am thankful to Dr P. Ashok Babu, Joint Secretary (RCH), MoHFW, for his guidance and keen engagement in taking forward the CAC initiatives so that women can benefit from its implementation. I am also thankful to all the experts contributing towards the development of this manual especially Ipas Development Foundation for taking a leading role in compilation.

I am confident that the Guidelines will help improve the quality of CAC services and facilitate increased access to safe abortion care at all levels.

(Dr. Sumita Ghosh)

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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
GI	Gastro-intestinal
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
PC&PNDT	Pre-Conception and 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

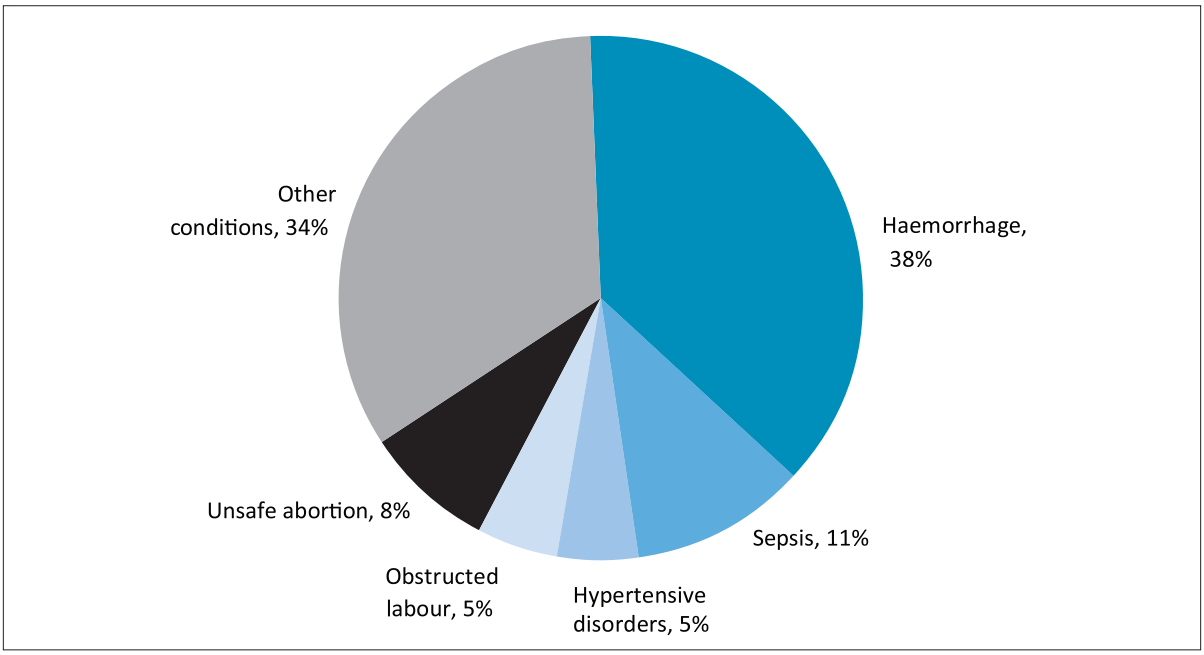
Abortion Scenario

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 or preventing unwanted pregnancy, 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 97/100,000 live births (RGI-SRS: 2018-20) 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 hesitate in going 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, Reproductive and Child Health (RCH) - II, and 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-centered approach

Abortion care services should be transformed from being just a medical procedure into a woman-centered 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-centered 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:
  - Services provided with empathy and respect
  - 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 reports

(C) Generating awareness (IEC/BCC)

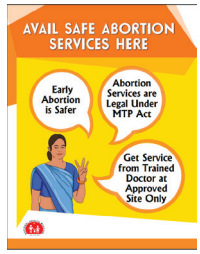
Activities that may be undertaken to create awareness on safe abortion care:

- 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

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
Site Signage	The Site Signage is developed to be put up at the facilities providing CAC services	• Availability of safe abortion services at the facility	• General public	
Poster: General Information on CAC	The poster is developed for display at the facilities to provide information on legality of abortion services	• Abortion services are legal in India • Abortion procedures are safer when conducted early in the pregnancy • Services should be availed from trained providers and approved sites	• General public • Community • ASHAs, ANMs, AWW and other health care workers	
Poster: Consequences of Unsafe Abortion Procedures	This poster is developed to make community and health care workers aware of consequences of abortions by untrained persons	• Complications that may be encountered if the procedure is performed by untrained providers	• Community • General public • Health care workers	
Leaflet: Reference Material for ASHAs	This leaflet is developed with different information points related to abortion care, for creating community awareness	• Methods available for abortions • Warning signs and symptoms during abortion process • Postabortion contraceptive methods available	• ASHAs / ANMs / AWWs • All health workers	
Poster: Post-abortion Contraceptive Methods	This poster is developed to focus on importance of adopting a contraceptive method alongwith abortion care procedure	• Different contraceptive methods available in the public health system and with ASHAs for distribution	• Community • General public • ASHAs/ANMs/ health care workers	

CHAPTER 2

Legal Aspects of Abortion Care

The Medical Termination of Pregnancy Act, enacted in 1971, governs the provision of abortions in India. The said Act was first amended in December 2002 followed by amendments in MTP Rules in June 2003, before the recent amendments in the Act & Rules in 2021.

Recent amendments in the MTP Act in March 2021 and Rules in October 2021, now allows the termination of a pregnancy up to 20 weeks, for extended range of indications for any woman; upto 24 weeks for special categories of women; and anytime during the pregnancy for substantial foetal abnormalities as approved by Medical Board. It offers protection to a practitioner if he/she adheres to and fulfils all the requirements of this Act.

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 nine 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/Medical Board, record keeping, and reporting are fulfilled.

The MTP Act[1] 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 (18 years and above) 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).

**According to the MTP Act, 'guardian' means a person who has the care and management of a minor or a mentally ill person.

***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[2] 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. 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.

[1]The MTP Act can be accessed at https://egazette.nic.in/WriteReadData/2021/226130.pdf
[2]For more information on the POCSO Act please refer http://policewb.gov.in/wbp/misc/2013/22-11.pdf

II. Training and Experience Requirement

The MTP (Amendment) Rules 2021 define the following experience/training requirement to perform MTPs at different gestation ages:

II.a. Up to 9 weeks gestation with MMA only

A practitioner with either

(i) Experience at any hospital for a period of not less than three months in the practice of obstetrics and gynaecology;

or

(ii) Has independently performed ten cases of pregnancy termination by medical methods of abortion under the supervision of a Registered Medical Practitioner in a hospital established or maintained, or a training institute approved for this purpose, by the Government.

All the RMPs under II.b and II.c below are also eligible to provide MMA upto 9 weeks.

II.b. 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.

All the RMPs under 1.c below are also eligible to provide MTP upto 12 weeks.

I.c. Beyond 12 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

III. When Can a Pregnancy be Terminated?

III.a. A pregnancy can be terminated by a registered medical practitioner upto 20 weeks of gestation 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 any woman or her partner for the purpose of limiting the number of children or preventing pregnancy
- 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

III.b. A pregnancy can be terminated by a registered medical practitioner between 20 - 24 weeks of gestation for the following special categories of women:

a. survivors of sexual assault or rape or incest;
b. minors;
c. change of marital status during the ongoing pregnancy (widowhood and divorce);
d. women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)];
e. mentally ill women including mental retardation;
f. the foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped; and
g. women with pregnancy in humanitarian settings or disaster or emergency situations as may be declared by the Government.

III.c. Pregnancy at any gestation age can be terminated by a registered medical practitioner if the foetus has substantial foetal abnormalities and the termination is approved by the Medical Board.

IV. Opinion for pregnancy termination at different gestation periods

The eligibility for giving opinion for pregnancy termination at different gestation ages is clearly defined in MTP (Amendment) Rules 2021:

Gestation	Providers Eligible
A. MTPs by MMA ONLY upto 9 weeks	1. Postgraduate degree/Diploma in ObGyn 2. 3 months experience in ObGyn 3. Six months house job in ObGyn 4. CAC/MTP Training 5. MMA Training
B. MTPs upto 12 weeks	1. Postgraduate degree/Diploma in ObGyn 2. One year experience in ObGyn 3. Six months house job in ObGyn 4. CAC/MTP Training
C. MTPs from: a. 13 – 20 weeks (any woman) b. 20 – 24 wks (special categories) c. Beyond 24 weeks (after diagnosis/ approval by medical board)	1. Postgraduate degree/Diploma in ObGyn 2. One year experience in ObGyn 3. Six months house job in ObGyn

V. Medical Boards

Medical boards are envisioned to be constituted to assess and approve/deny the pregnancy termination for substantial foetal abnormalities beyond 24 weeks of gestation.

Following are the details of the composition, powers and functions of the Medical Boards:

V.a. Composition of Medical Board

The Medical Board shall consist of the following, namely:

a. a Gynaecologist;
b. a Paediatrician;
c. a Radiologist or Sonologist;
d. such other number of members as may be notified in the official gazette by the State Government or Union Territory as the case may be.

V.b. Powers of the Medical Board:

i. to allow or deny termination of pregnancy beyond twenty-four weeks of gestation period after due consideration and ensuring that the procedure would be safe for the woman at that gestation age and whether the foetal malformation has substantial risk of it being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped;
ii. co-opt other specialists in the Board and ask for any additional investigations if required, for deciding on the termination of pregnancy.

V.c. Functions of the Medical Board:

i. to examine the woman and her reports, who may approach for medical termination of pregnancy;
ii. provide the opinion of Medical Board in Form D with regard to the termination of pregnancy or rejection of request for termination within three days of receiving the request for medical termination of pregnancy;
iii. to ensure that the termination procedure, when advised by the Medical Board, is carried out with all safety precautions along with appropriate counselling within five days of the receipt of the request for medical termination of pregnancy.

All the States/Union territories should form Medical Boards at Medical Colleges, District Hospitals, and other tertiary care centers across the state, which have all the required facilities as decided by the State/UT government administration. The identified Institutions must have provisions for conducting the required tests and investigations for arriving at the medical opinion and subsequently conducting the procedure. After finalizing the potential list of Medical Boards, the State/UTs Government must notify this list.

The primary responsibility of the Medical Board is to ensure the safety of woman for termination at that particular gestation and to determine if the foetal abnormality is substantial enough to qualify as either incompatible with life or associated with significant morbidity or mortality in the child, if born.

VI. 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.

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 Organizations (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
- DLC can approve the private facilities for pregnancy termination for either upto 12 weeks or 24 weeks, as per the request received in the application (Form A). The required infrastructure for both types of sites is given as Annexure 2.9

Medical Methods of Abortion

In case of the termination of an early pregnancy of up to nine 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.

For pregnancy termination beyond 24 weeks, sites should have the facility of USG guided procedures and blood storage units, in addition to the other required infrastructure for an approved MTP site.

For more details on the desired infrastructure at the site, refer to the Chapter no. 9: Health System Requirements for Provision of CAC Services.

VII. Documentation/Reporting of MTP Cases

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

1. Consent Form: Form C – for consent by the woman/guardian before the CAC procedure
2. RMP Opinion Form
   - Form I*** (for MTP upto 20 weeks by one RMP)
   - Form E (for MTPs between 20 – 24 weeks by two RMPs)
   - Form D (for MTPs beyond 24 weeks by Medical Board members)

3. Form II*** – Monthly Reporting Form (to be sent to the district authorities)
4. Form III*** – Admission Register for case records

*** Form I, II, III are given later as Annexures 2.2, 2.5 and 2.6 respectively as model forms and have to be notified in an official gazette by the state/UT government before their use for the documentation of CAC services

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.

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

Annexure 2.2

FORM I

RMP Opinion Form

(For gestation age upto twenty weeks)

[See Regulation 3]

I _____

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

_____

(Full address of the Registered Medical Practitioner)

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

Place:

Date:

Signature of the Registered Medical Practitioner

*of the reasons specified items (a) to (e) write the one which is appropriate:

a. in order to save the life of the pregnant woman,
b. in order to prevent grave injury to the physical and mental health of the pregnant woman,
c. 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,
d. as the pregnancy is alleged by pregnant woman to have been caused by rape,
e. as the pregnancy has occurred as a result of failure of any contraceptive device or methods used by a woman or her partner for the purpose of limiting the number of children or preventing pregnancy.

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

FORM E

Opinion Form of Registered Medical Practitioners
(For gestation age beyond twenty weeks till twenty-four weeks)
[See sub-rule (2) of rule 4A]

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 we 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)

which is beyond twenty weeks but till twenty-four weeks under special circumstances as given below*.

*Specify the circumstance(s) from (a) to (g) appropriate for termination of pregnancy beyond twenty weeks till twenty-four weeks:

(a) Survivors of sexual assault or rape or incest
(b) Minors
(c) Change of marital status during the ongoing pregnancy (widowhood and divorce)
(d) Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]
(e) Mentally ill women including mental retardation
(f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped
(g) Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government

We hear by give intimation that 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 Practitioner

Place:
Date:

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.

FORM D

(See sub-clause (ii) of clause (b) of rule 3A)

Report of the Medical Board for Pregnancy Termination Beyond 24 weeks

Details of the woman seeking termination of pregnancy:

1. Name of the woman:
2. Age:
3. Registration/Case Number:
4. Available reports and investigations:

S.No	Report	Opinion on the findings

5. Additional Investigations (if done):

S.No	Investigations done	Key findings

6. Opinion by Medical Board for termination of pregnancy:
   a) Allowed
   b) Denied

   Justification for the decision:

7. Physical fitness of the woman for the termination of pregnancy:
   a. Yes
   b. No

Members of the Medical Board who reviewed the case:

S.No	Name	Signature

Date and Time: ……

Annexure 2.5

FORM III

[Refer Regulation 5]

Admission Register

(To be destroyed on the expiry of five years from the date of the last entry in the Register)

Name of the Facility_____ **Month**_____ **Year**_____

S. No.	Date of Admission	Name of the Patient	Wife / Daughter of	Age	Religion	Address	Duration of Pregnancy	Reasons on 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 *(For pregnancy beyond 24 weeks mention the names of Medical Board members)*	Name of Registered Medical Practitioner(s) by whom Pregnancy is terminated	Method of MTP (MVA/ EVA/ MMA/ D&C/ Others)	Post Abortion Contraception (Tubal Ligation (TL)/IUCD/ OCP/ Injectables/ Others/ None)
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**

FORM II

[Refer Regulation 4(5)]

Month & Year: ……..

1. Name of the State:

2. Name of Hospital/approved place:

3. Duration of pregnancy: *(Give total number only under each sub-head)*

(a) Upto 9 weeks (Medical Methods of Abortion Only):

(b) Upto 12 weeks (Surgical Methods of Abortion Only):

(c) Between 12-20 weeks:

(d) Between 20 -24 weeks:

(e) Beyond 24 weeks:

4. Religion of woman: *(Give total number under each sub-head)*

(a) Hindu:

(b) Muslim:

(c) Christian:

(d) Others:

5. Termination with acceptance of contraception: *(Give total number under each sub-head)*

(a) Sterilization:

(b) IUCD:

(c) OCP/Injectable Contraceptive:

(d) Others:

6. Reasons for termination: *(Give total number under each sub-head)*

6a. Up to 20 weeks of gestation

(a) Danger to the life of the pregnant woman:

(b) Grave injury to the physical and mental health of the pregnant woman:

(c) Pregnancy caused by rape:

(d) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped:

(e) Failure of any contraceptive device or method:

6b. Between 20-24 weeks of gestation

(a) Survivors of Sexual Assault/Rape/Incest:

(b) Minors:

(c) Change of marital status during the ongoing pregnancy (widowhood and divorce):

(d) Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]:

(e) Mentally ill women including mental retardation:

(f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped:

(g) Women with pregnancy in humanitarian settings or disasters or emergency situations as declared by Government:

6c. Beyond 24 weeks of gestation

(a) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped:

Signature of the Officer In-charge with Date

FORM A

[See sub-rule (2) of rule 5]

FORM OF APPLICATION FOR THE APPROVAL OF A PLACE UNDER CLAUSE (b) OF SECTION 4 OF THE ACT

Category of approved place:

(A) Pregnancy can be terminated up to twelve weeks

(B) Pregnancy can be terminated up to twenty-four weeks

(i) Name of the place (in capital letters): .....

(ii) Address in full: .....

(iii) Non-Government or Private or Nursing Home or Other Institutions:

(iv) State, if the following facilities are available at the place:

CATEGORY A

(i) Gynaecological examination or labour table.

(ii) Resuscitation equipment.

(iii) Sterilization equipment.

(iv) Facilities for treatment of shock, including emergency drugs.

(v) Facilities for transportations, if required.

CATEGORY B

(i) An operation table and instruments for performing abdominal or gynaecological surgery.

(ii) Drugs and parental fluids in sufficient supply for emergency cases.

(iii) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

Place: .....

Date: .....

Signature of the owner for the place

FORM B

[See sub-rule (6) of rule 5]

CERTIFICATE OF APPROVAL

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

As read within upto……..…...weeks

Name of the Place……...

Address and other descriptions……...

……..

Name of the owner……...

Place :

Date : To the Government of the…….

Site Infrastructure Requirements

A. Requirements at Sites for Pregnancy Termination upto 12 weeks

i. Gynaecological examination or labour table.
ii. Resuscitation equipment.
iii. Sterilization equipment.
iv. Facilities for treatment of shock, including emergency drugs.
v. Facilities for transportations, if required.

B. Requirements at Sites for Pregnancy Termination upto 24 weeks

i. An operation table and instruments for performing abdominal or gynaecological surgery.
ii. Drugs and parental fluids in sufficient supply for emergency cases, notified by Central Government from time to time.
iii. Anaesthetic equipment, resuscitation equipment and sterilization equipment.

C. Requirements at Sites for Pregnancy Termination Beyond 24 weeks

a. An operation table and instruments for performing abdominal or gynaecological surgery;
b. Anaesthetic equipment, resuscitation equipment and sterilization equipment;
c. Availability of drugs, parental fluids and blood for emergency use, as may be notified by the Central Government from time to time; and
d. Facilities for procedure under ultrasound guidance

Counselling

'Counselling is a structured one to one interaction in which a person voluntarily receives emotional support and guidance from a trained person in a respectful 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 with an empathetic attitude and in a respectful way. 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 the 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 allays the apprehension, fear & guilt related to termination of pregnancy
- It helps the woman to choose the method for 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 choose and 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 and respectful while interacting with the woman and be sensitive to her needs
- 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, medical history, past use of contraceptive methods, and any humanitarian situation
- 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 pregnancy termination (MTP), explain to her, in simple language:
  - The range of available options of pregnancy termination techniques based on gestation
  - The pregnancy termination 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 during/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 for a follow-up visit
- 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 to terminate her pregnancy , 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 pregnancy termination
- 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 most pregnancy termination procedures. However, laparoscopic tubal ligation should be done only after the first trimester surgical 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 chosen contraceptive method

Critical steps during post-procedure counselling:

- Continue to ensure privacy and confidentiality and an empathetic and respectful 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 after first trimester abortion and within two weeks after second trimester or later abortions 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

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 upto 24 weeks**	**Beyond 24 weeks**	For pregnancy termination in second trimester and beyond 24 weeks, fertility will return within 4 to 6 weeks thus she should start using contraception as early as possible but not later than three weeks of the procedure.
A. Barrier Methods				
Condoms	As soon as sexual activity is resumed	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	Up to 48 hrs after foetus expulsion or later after 6 weeks. A method should be given to the woman for the interim period between 48 hours – 6 weeks post expulsion, till she is eligible for IUCD insertion again.	• No hormonal side effects • 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

Annexure 3.1 (contd.)

Post-abortion Contraceptive Methods				
Method	**Timing After Abortion**			**Additional Information**
	First Trimester	**Second Trimester upto 24 weeks**	**Beyond 24 weeks**	
C. Hormonal Contraception				
Combined Oral Contraceptives (COCs)	Immediately or up to seven days after abortion using surgical method. With MMA, COCs can be started on the day of misoprostol use or within next five days	Immediately or up to seven days after abortion	3 weeks after foetal expulsion	• 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
Injectables: MPA (Medroxy Progesterone Acetate)	Immediately or up to seven days after abortion, using surgical method. With MMA, can be started on the day of misoprostol use or within next five days	Immediately or up to seven days after abortion	Anytime after expulsion of foetus and latest by 3 weeks	• 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

Annexure 3.1 (contd.)

Post-abortion Contraceptive Methods				
Method	**Timing After Abortion**			**Additional Information**
	First Trimester	**Second Trimester upto 24 weeks**	**Beyond 24 weeks**	
C. Hormonal Contraception				
Implant	Can be started immediately or upto 7 days after vacuum aspiration procedure With MMA, it can be given on day of misoprostol use	Can be started immediately or within seven days after abortion	Can be started anytime after expulsion of foetus and latest by 3 weeks	• Highly effective • Can be started immediately, even if infection is present • Does not interfere with intercourse • Not user dependent, except for remembering to come for removal/re-insertion after three years • No supplies needed by user • May cause irregular bleeding, spotting, amenorrhea • Excessive bleeding may occur in rare instances • Fertility returns quickly after removal • No protection against STIs/ HIV/HBV
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	Anytime after expulsion of foetus and latest by 3 weeks	• 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 upto 24 weeks**	**Beyond 24 weeks**	
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	Anytime after expulsion of foetus and latest by 3 weeks	• 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)	Minilap sterilization can be performed concurrently or up to seven days after expulsion of foetus, 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
Male sterilization	Performed independent of the abortion procedure/ process			• 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 abovementioned 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

Below are 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 alright 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 woman is very upset about a foetal abnormality in a wanted pregnancy

- Be sensitive to the woman and assure her that you understand her feeling and emotions. Tell her that continuing this pregnancy will not be appropriate since the foetus will not grow normally and may have lot of health issues, if delivered.

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."

CHAPTER 4

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 Assessmentt

(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

Ultrasonography may be done if this facility is available at the centre, however this is not a mandatory requirement for the provision of MTP. An ultrasound may be helpful for accurate dating when there is a discrepancy in the size of the uterus by LMP and bimanual examination. It can also be used to detect ectopic pregnancies along with quantitative βHCG measurements.

For terminations beyond 24 weeks, this may be helpful in localizing the position of the placenta. Since it is an obstetric USG, it must be done in accordance with the Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) Act.

(D) Laboratory investigations

- Haemoglobin
- Urine for albumin and sugar
- Blood group/Rh especially in primigravida
- Urine for pregnancy test with Nischay kit

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 appropriate 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

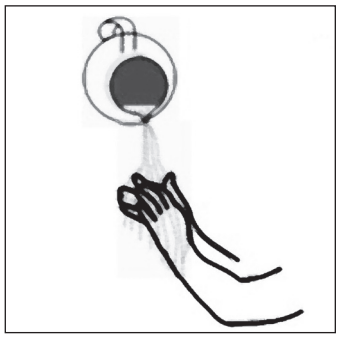


Figure 4: Hand Washing

(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:

- Wash 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.

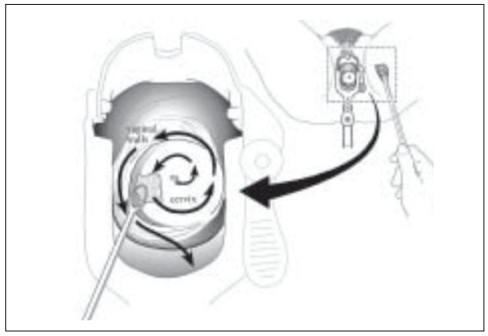


Figure 5: Cervical Antiseptic Preparation

(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. Some of the facilities further segregate the general waste into green (wet waste) and blue (dry waste) bins.

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 pitt
- 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 7), which is referred to as the EVA or suction machine.

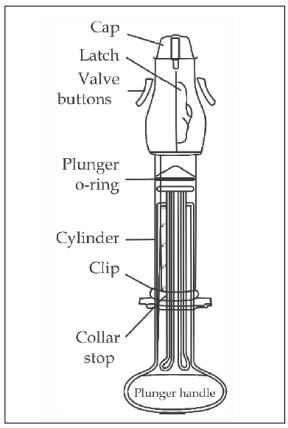


Figure 6: MVA Plus Aspirator

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.

Electric Vacuum Aspiration

EVA uses an electric pump or suction machine (Figure 7) attached to a cannula to evacuate uterine contents. EVA is typically used in centralised settings with higher caseloads.

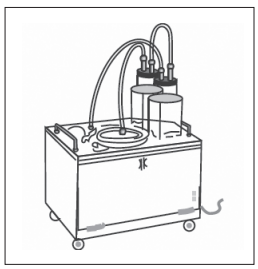


Figure 7: EVA Machine

Cannula (Figure 8)
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 8: 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 9)

Charge aspirator

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

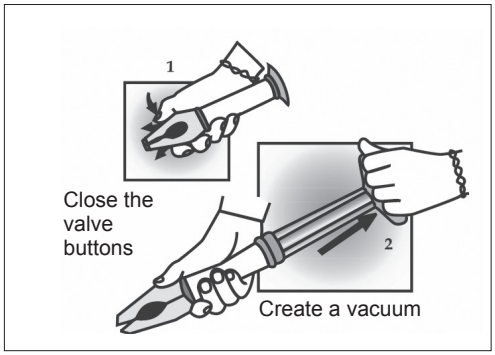


Figure 9: Preparing Instruments for MVA

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

Step 2: Prepare the woman

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

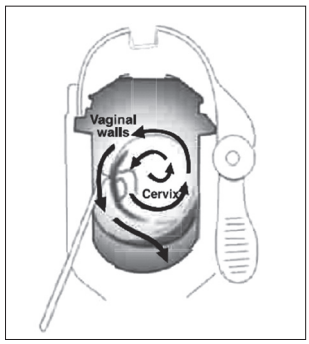


Figure 10: Antiseptic cervical preparation

Step 3: Perform cervical antiseptic preparation (Figure 10)

- 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 11)

- 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

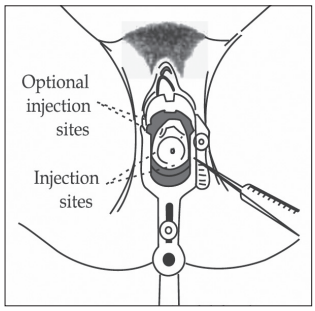


Figure 11: Paracervical Block

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 either sublingual 1-2 hours or buccal/vaginal 2-3 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 12)

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

Step 7: Suction of uterine contents (Figures 13-15)

- 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

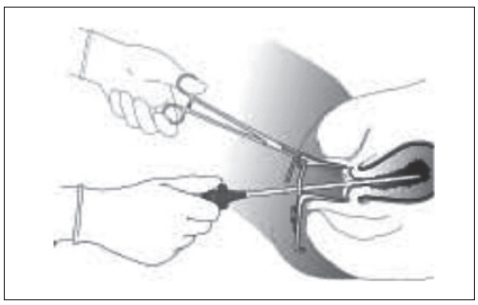


Figure 12

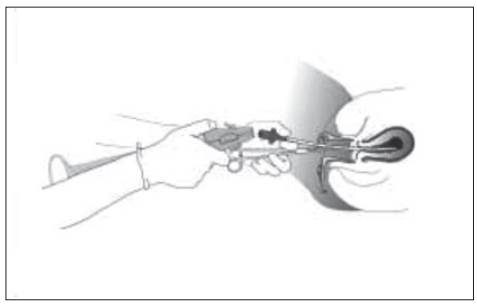


Figure 13

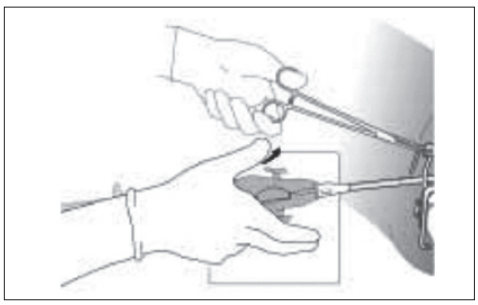


Figure 14

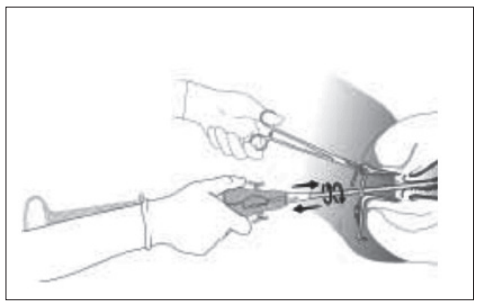


Figure 15

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 16)

- 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.

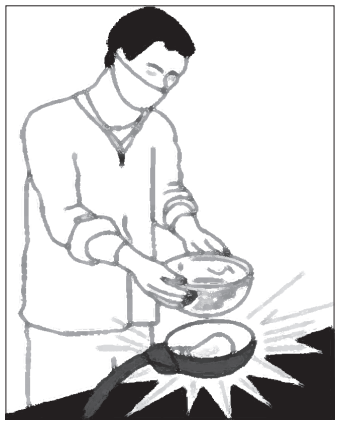


Figure 16: Inspect Tissue

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 17: Cleaning

(B) Cleaning (Figure 17)
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 or 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
  - 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
A combination of mifepristone and misoprostol is approved for the termination of pregnancy up to nine weeks (63 days) LMP.

> 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 to 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 eligible to terminate a first trimester pregnancy, can prescribe MMA drugs to perform the procedure.

In addition, as per MTP (Amendment) Rules 2021, RMPs with the following experience / training are also eligible to provide MTP services upto 9 weeks by MMA only:

i experience at any hospital for a period of not less than three months in the practice of obstetrics and gynaecology;

or

ii has independently performed ten cases of pregnancy termination by medical methods of abortion under the supervision of a Registered Medical Practitioner in a hospital established or maintained, or a training institute approved for this purpose, by the Government.

(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 health care sites
- Private sector facilities, which have been approved by the DLC as certified MTP sites under Section 4 of the MTP Act, 1971
- 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
- Offers more privacy
- Feasible with minimum technical assistance
- Less overall complication rate. No risk of cervical or uterine injury
- No instruments 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 nine weeks of LMP, and are:

- Willing to make three facility 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 not be given in case a woman does not have access to emergency care, if required during the MMA process.

Signs/symptoms indicating ectopic pregnancy 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 provide definitive 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 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.

MMA-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:

- 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 may last for 8 to 13 days. Soaking of two thick pads within one to two hours after taking misoprostol is acceptable but it should decrease over time after expulsion of POCs
- 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 drug 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 by the woman/guardian after being satisfied with all the information provided, and 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 methods of pregnancy termination.

Role of ultrasonography (USG)

Ultrasonography (USG): USG may be done at sites where these facilities are available. However, it is not mandatory for all women undergoing pregnancy termination with medical methods. USG needs to be performed for the following conditions:

i. Pre-procedure:

- Women with a suspicion of ectopic pregnancy (symptoms such as irregular vaginal bleeding, pelvic pain, 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 PC&PNDT Act should be followed.

V. Infrastructure Required for the Procedure

There is minimal infrastructure requirement for the outdoor clinic from where the drugs can be prescribed, up to nine 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, if available

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 in these cases
- 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 800mcg sublingual/buccal/vaginal

Table 1: Effectiveness of Misoprostol Administered by Different Routes

Route of Administration	Peak Levels Attained	Bioavailability
Sublingual	Rapidly (30 minutes)	Long duration (6 hours)
Vaginal[1]	Gradually (70-80minutes)	Longest duration (>6 hours)
Buccal	Gradually (70-80minutes)	Moderate duration (3 hours)
Oral (not recommended)	Rapidly (30 minutes)	Short duration (2 hours)

- Additional dose of misoprostol (400 mcg sublingual/vaginal) to be repeated in the conditions below:
  - The woman vomits within half-an-hour of the intake of 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

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

[1]Moistening the tablet before vaginal administration does not improve efficacy (ACOG, 2009)

- Prescribe drugs for pain relief, if required. Non-narcotic analgesics like ibuprofen should be provided. Non-steroidal anti-inflammatory drugs (NSAIDs) do not interfere with action of 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	200 mg mifepristone oral; Anti D 50mcg, if Rh negative
Day 3: misoprostol administration	800mcg (four tablets of 200 mcg each) 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

Ready Reckoner for Providers for MMA provision is given as Annexure 7.1

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 thrice a day for five days for lactating women.

(B) Analgesics
Pain is an accompaniment with the process of abortion. Women counselled properly may tolerate pain better. 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 usually required.
- 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 timely 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/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 or refer to the appropriate higher level

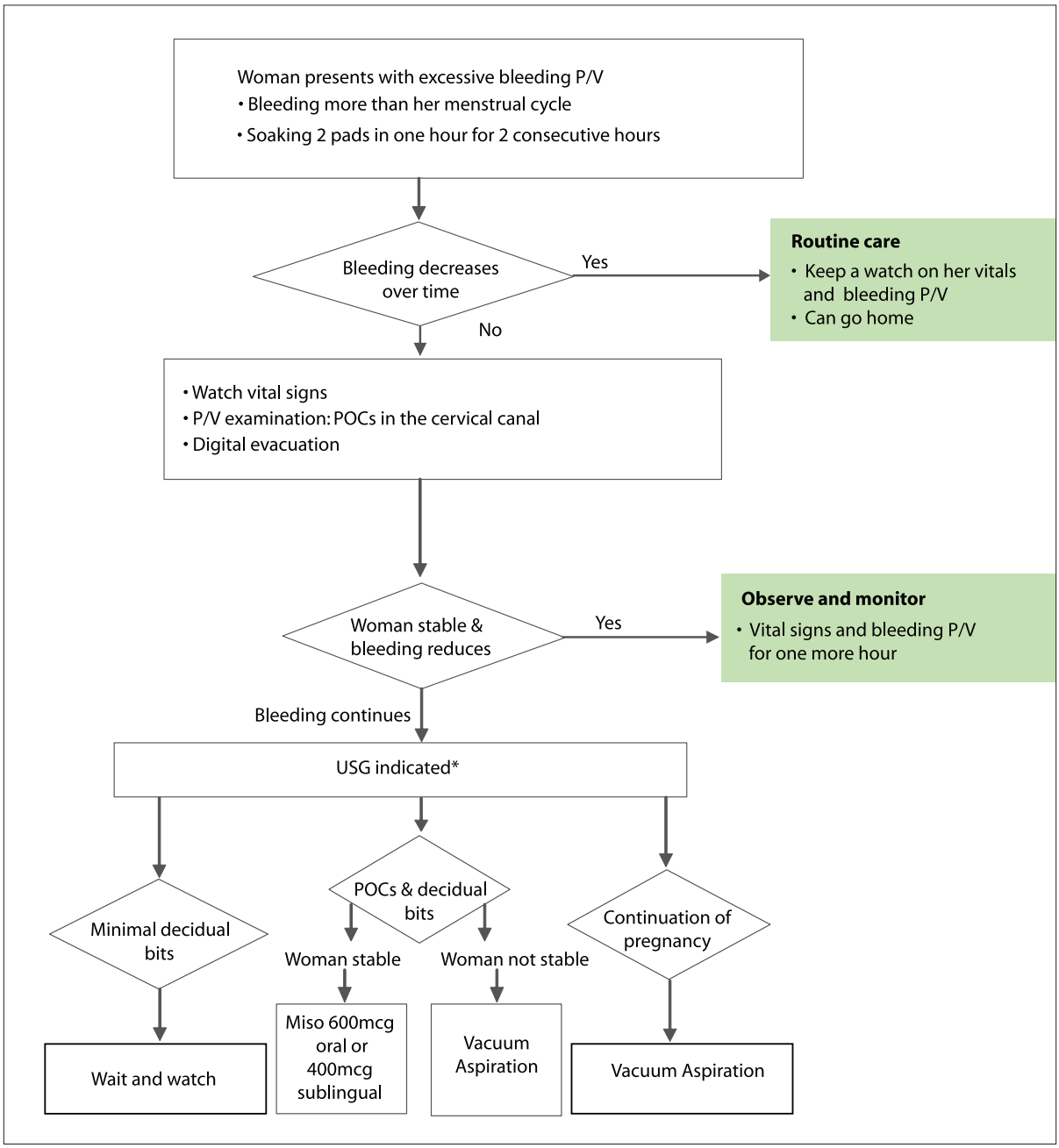
  (ii) If no gestation sac is visible on USG, but bleeding continues owing to decidual bits in the uterine cavity, manage conservatively, without any medication or intervention, as these are expelled spontaneously in most cases. An additional visit after seven days will have to be planned to ensure completion 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 terratogenic effect on the foetus. 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:

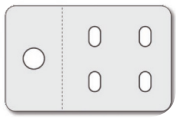
- Oral Hormonal contraceptive methods, whether combined (estrogen and progestogen) or progestin-only, can be started on the day of the Misoprostol administration (day 3).
- Injectable hormonal methods (Injection-MPA/Antara Programme) can be started on day 3 of the MMA protocol.
- Implant can be started on day 3 of the MMA protocol.
- Centchroman can be started on day 3 of the MMA protocol
- IUCD can be inserted after confirming complete abortion and ruling out contraindications, on day 15 of MMA protocol.
- Condoms can be used as soon as she resumes sexual activity during the MMA process
- Tubal ligation can be done after the next menstrual cycle. However, if desirous of concurrent tubal ligation, woman maybe referred to the appropriate centre for vacuum aspiration with concurrent tubal ligation.

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



Medical Methods of Abortion (MMA)

Ready Reckoner for Provider

FIRST VISIT DAY 1	SECOND VISIT DAY 3	THIRD VISIT DAY 15
What to do		
• Physical and pelvic examination • Confirm eligibility (upto 9 weeks) • Informed consent • **Mifepristone 200 mg orally** • Offer Anti-D 50 mcg to Rh negative women	• **Misoprostol 800 mcg sublingual/buccal/ vaginal** • Observe for 4 hours • Analgesics: Ibuprofen 400 mg • Contraceptive options: hormonal methods (oral, injectable, implant), Centchroman, condoms	• Pelvic examination to ensure the completion of abortion • Contraceptive options: - IUCD 380A, 375 - Condoms - Sterilization after next menstrual cycle
Tell the woman		
• Misoprostol administration after two days (at facility/home) • 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	• 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)	• About immediate return to fertility • Report back if there are no periods within 6 weeks of completion of the abortion process
3% women may expel completely with Mifepristone alone but Misoprostol schedule should be completed	75% women abort within 4-6 hours after Misoprostol administration	USG if examination does not confirm the completion of procedure

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.

CHAPTER 8

Termination of Pregnancies Beyond 12 Weeks

Abortions beyond 12 weeks 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 abortions in later gestations 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 may have to terminate a pregnancy beyond the first trimester. Thus, it is essential that these services are available and accessible.

Provider's eligibility

A registered medical practitioner with qualifications as laid down in the MTP Act and Rules is eligible to terminate a pregnancy beyond 12 weeks (Refer Chapter 2: Legal Aspects of Abortion Care – Who can terminate a pregnancy?)

Site eligibility

- 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
- Private sector facilities are permitted to provide second trimester terminations upto 24 weeks after approval from the district level committees and beyond 24 weeks if notified in the state/UT gazette or have infrastructure in accordance with the MTP (Amendment) Rules 2021
- For pregnancy termination beyond 24 weeks, sites (public/private) should have the facility of USG guided procedures and blood storage units, in addition to the other required infrastructure for terminations till 24 weeks.

(Refer Chapter 2: Legal Aspects of Abortion Care – Annexure 2.9: Site Requirement for Pregnancy Termination)

Indications

- The MTP Act allows the termination of a pregnancy upto 20 weeks gestation when opinion is formed by one registered medical practitioner and as per indications in the MTP Act.
- MTP (Amendment) Act & Rules 2021 have defined indications for pregnancy termination between 20 – 24 weeks and beyond 24 weeks.

(Refer to Chapter 2: Legal Aspects of Abortion Care – When can a pregnancy be terminated)

The provider should try to ascertain that MTP is not being sought following prenatal sex determination, while talking to the woman.

II. Counselling

It is important to recognise that in late-term abortion services, some women will be aborting a wanted pregnancy for medical reasons (foetus with congenital anomalies) or being in other compelling situations as mentioned above 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 beyond 12 weeks must include careful assessment of medical and psychological conditions (refer Chapter 4: Clinical assessment).

Pre-procedure assessment includes the following:

- Detailed history
- General physical examination
- Bimanual/pelvic/abdominal examination
- Informed consent
- Investigations – Hb, urine routine examination and blood group (ABO Rh) are essential (Refer Chapter 4: Clinical Assessment)
- USG to localize placenta and rule out other contraindications, if required
- Filling of documentation formats as per the MTP Act

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

In addition:

- All terminations beyond 12 weeks are to be done as indoor/facility based 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 Pregnancy Termination Beyond 12 Weeks Gestation

(A) Surgical methods
(B) Medical methods
(C) Miscellaneous

(A) Surgical methods

(i) Dilatation and Evacuation (D&E)
(ii) Hysterotomy

(A) Surgical Method

(A) i. Dilatation & Evacuation (D&E)
It is a safe and effective surgical technique for abortions > 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

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

- Non-narcotic analgesics, such as Ibuprofen, 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 weeks. It decreases the risk of cervical injury and uterine perforation.

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

- Misoprostol
- Foley's Catheter can be inserted and kept for 4 to 6 hours after inflating its bulb with 10ml of normal saline
- Dinoprostone gel (especially in cases of previous caesarean section)

Misoprostol
Misoprostol (400mcg) is used vaginally or sublingually before the procedure for cervical dilatation. One additional dose of 400mcg sublingual/vaginal may be given if the dilatation is inadequate after four hours or rarely dilators may have be used.

Advantages of using misoprostol for dilatation:

- It is a highly effective drug for inducing cervical dilatation and uterine contractions

Disadvantages of using misoprostol for dilatation:

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

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

Check the foetal parts/POCs to ensure completeness of the procedure.

(A) ii 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 these procedures. The WHO recommended protocols for reference is given as Annexure 8.1 and other international protocols as Annexure 8.2.

Medical methods in late-term termination involve two steps during the process of pregnancy termination:

- Cervical priming
- Inducing uterine contraction

Advantages of medical methods

- Non-surgical method
- 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 also used to stimulate uterine contractions and induce abortions beyond 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 earlier 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. This is supplemented by intravenous oxytocin to induce uterine contractions to complete the abortion process.

Ethacridine is currently not available in India.

V. Post-procedure Care

Post-procedure care

A woman should remain in the healthcare facility for at least four hours after the foetal/POC expulsion 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, blood pressure and that the uterus is well contracted 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 or the bleeding stops and her chosen contraceptive method becomes effective

She should return for a follow-up examination within the next 7 – 14 day. The following tasks should be undertaken before the woman is discharged from the facility:

- Contraceptive counselling with contraceptive method provision, when requested
- Address other health issues – anaemia, reproductive tract infections (RTIs), HIV, domestic violence, cancer screening, as per the need
- 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

- Follow-up visit should be scheduled within 7 – 14 days of 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
  - 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: Vacuum Aspiration – Complication and Management.

Lacerations and perforation

Minor lacerations

With a D&E procedure, minor lacerations can occur during cervical dilatation; cervical injury can occur during foetal passage with 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: Vacuum 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: Vacuum 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: Vacuum Aspiration – Complication and Management.

Shock
Shock in these cases most often results from haemorrhage or sepsis.

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

Annexure 8.1

WHO Recommended Protocols for Second Trimester Termination by Medical Methods

(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.

Drug Protocol (WHO 2022)
- 200mg oral mifepristone followed 24-48 hours later by 400mcg misoprostol vaginal or sublingual every 4 - 6 hours

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. If NSAIDs are not available, Acetaminophen is an alternative option for pain management.

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 than the combined regimen

Drug Protocol
400mcg misoprostol, vaginal or sublingual, every 4 -.6 hours (WHO 2022).

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 intravenous oxytocin infusion, such as 20 units in 500 ml normal saline, given at 50 ml/hr

Annexure 8.2

Other Suggestive Protocols for Late-term Terminations

Source	Day 1	36 – 48 hours later	Repeat doses
Royal College of Obstetricians & Gynaecologists 2011 (13 – 24 weeks)	200 mg oral Mifepristone	Misoprostol 800 mcg vaginal	Misoprostol 400 mcg vaginal or oral every 3 hours up to 4 further dose*
National Abortion Federation 2015 (>14 weeks from LMP)	200 mg oral Mifepristone	Misoprostol 400 mcg vaginal, buccal, or sublingual	Every 3-4 hours

*If expulsion does not occur, mifepristone can be repeated three hours after the last dose of misoprostol and 12 hours later misoprostol can be recommenced.

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/MMA 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 utilization 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.

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 first trimester 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 container 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 terminations beyond 12 weeks

In addition to all the requirements listed for a first trimester VA procedure, the following are needed for the procedures done for gestation age > 12 weeks:

Essential equipment/instruments

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

Equipment for resusication/anaesthesia

- Boyle's apparatus
- Endotracheal tubes

Ultrasonography machine

- For guided procedures in late term abortions

Essential supplies

- Sutures of different sizes

Essential drugs

- Mifepristone
- Misoprostol
- Injection Oxytocin

Drugs for treatment of emergencies

- Same as for VA procedure

The suggestive 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	2
1.2	Screen/curtain for privacy	1	1	1	2
1.3	Cusco's speculum (medium and large)	3 (2 & 1)	3 (2 & 1)	6 (3 & 3)	10 (5 & 5)
1.4	Foot step	1	1	1	2
2	***Procedure room***				
2.1	Examination/labour table	1	1	1	2
2.2	Suction machine/foot pump	1	1	1	2
2.3*	MVA Aspirator	2	2	3	5
2.4	Light source	1	1	1	2
2.5	Foot step	1	1	1	2
3*	***Instruments***				
3.1	Dilator set	1	1	3	5
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 & Blunt curette	2	2	2	4
3.5	Ovum forceps	0	1	3	5
3.6	Cannulae of different sizes	2 sets	2 sets	3 sets	5 sets
3.7	Bowl/ kidney tray	1	2	3	5
3.8	Instrument tray	1	2	1	2
3.9	Instrument for gyne/abd surg			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	84	112	140	490
	Cap Ampicillin (2 may require this)	30	30	45	150
6.2	Analgesics - Tab Ibuprofen	54	72	90	315
6.3	Combipack (1 Mife, 4 Miso)	5	8	12	20
6.4	Tab Misoprostol (200 microgm)	20	30	56	168
6.5	Tab Perinorm	8	12	12	40
6.6	Inj. Oxytocin	10	10	60	120
6.7	Inj. Diazepam (no.s who may require, also depends on site proticol for analgesia)	2	2	4	10
6.8	Inj. Atropine (no.s who may require - 100%, also depends on site proticol)	6	8	10	35
6.9	Inj. Adrenaline (no.s who may require)	1	1	2	5
6.10	Inj. Aminophylline	2	2	3	10
6.11	Inj. Sodium-Bi-Carbonate 7.5%	1	1	2	5
6.12	Inj. Calcium Gluconate-10%	2	2	3	5
6.13	Inj. Perinorm	2	3	5	10
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	2	2	5	10
6.21	Normal saline	2	2	5	10
6.22	I/V sets	2	2	5	20
6.23	I/V cannula / scalp vein sets	2	2	5	20

	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 syrines (2 ml)	24	32	40	140
7.4	Disposable syrines (10 ml)	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	Foley's cathetar	2	2	3	10
7.9	Plastic gowns	2	2	4	4
7.10	Perineal sheet	2	2	4	10
7.11	Trolley sheet	2	2	4	10
7.12	Surgical masks (disposable) - no. of boxes	1	1	1	2
7.13	Head caps (disposable) - no. of boxes	1	1	1	2
7.14	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	8 (50% MMA - 4 cases)	12 (50% MMA - 6 cases)	15 (50% MMA - 8 cases)	35 (30% MMA - 10 cases)
Second trimester cases			2	8

*Not required for sites providing only MMA services

CHAPTER 10

Operationalizing MTP/CAC and MMA Trainings

I. Introduction

The MTP Act, 1971, along with the MTP Rules,1975, permits MBBS doctors to provide first trimester MTP/CAC services (by surgical/medical methods) 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.

Further, the MTP (Amendment) Rules,2021 permits MBBS doctors to provide MTP/CAC services upto nine weeks by MMA only, after they undergo training at a government approved training centre and perform 10 MMA cases independently or have three months experience of working in any hospital in the department of Obstetrics & Gynecology.

This chapter provides broad guidelines on:

- Establishing an MTP/CAC and MMA 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 and MMA trainings

Budget for MTP/CAC and MMA training

All expenses for MTP/CAC and MMA training of public sector providers should be budgeted for, under the maternal health component of the district and state PIP. The total estimate for conducting MTP/CAC and MMA 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 and MMA 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, drugs, supplies and infrastructure); monitoring of training at the training centre and also for post-training follow-up at the service delivery sites should be put in the respective PIPs.

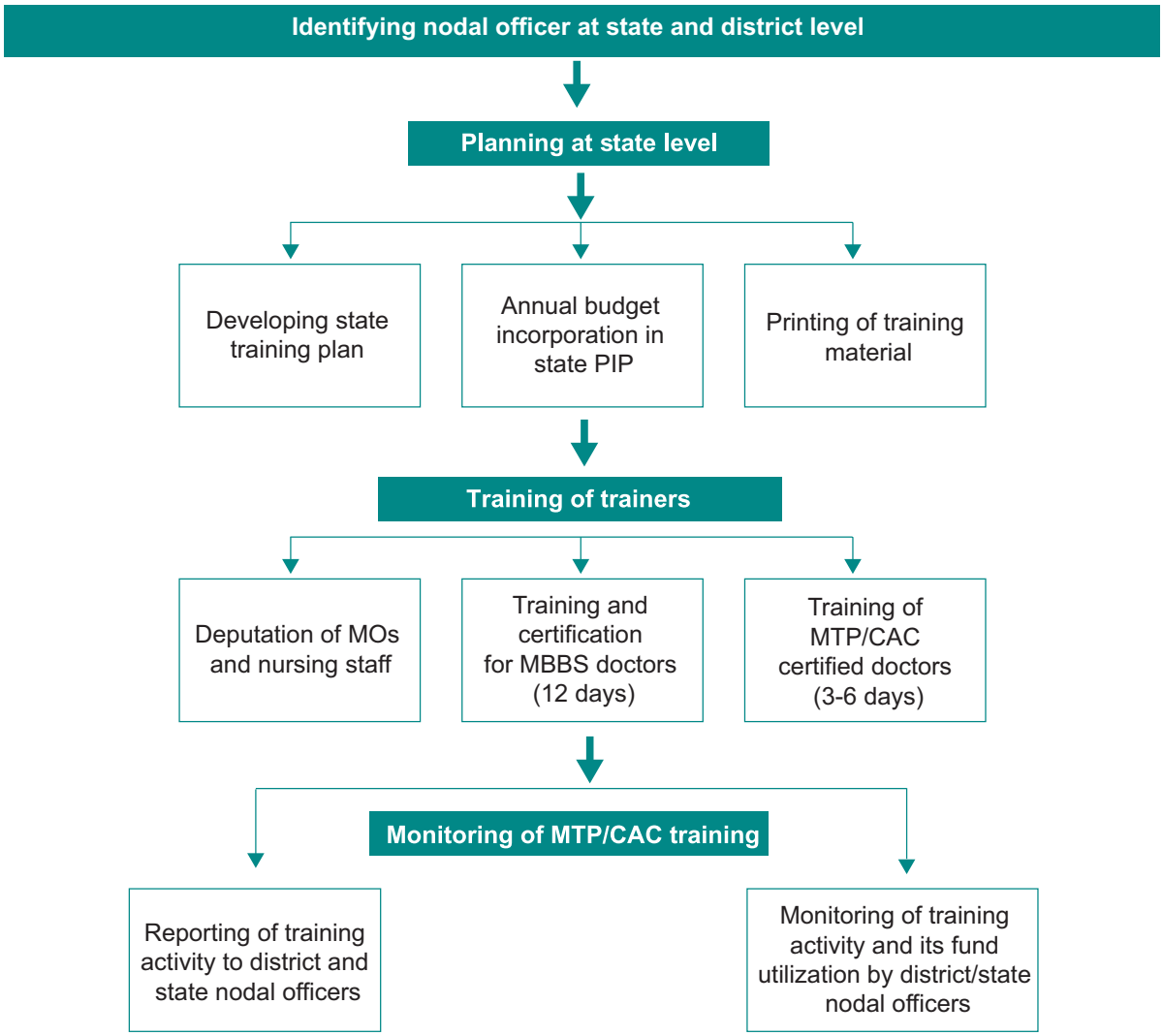
II. The Roll-out of MTP/CAC Trainings (Figure 18)

The roll-out of MTP/CAC trainings 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 printing of training material; planning of training activities including developing training calendars, deputing medical officers and nursing staff for training, and monitoring of training activities

[1]TA/DA is not applicable in cases of trainees from the private sector.

Figure 18: Roll-out of MTP/CAC Training Programme



Selection of an MTP/CAC training centre

Public (secondary and tertiary-level facilities) and private/NGO sites approved by the state government as training centres are eligible to provide MTP/CAC training.[2] These sites should fulfill the following criteria:

- Approved MTP/CAC service delivery site (in case of private/NGO sites)
- Providing MTP/CAC cases with appropriate technology

[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.

- 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
- 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
- Willingness of the administrative head and the department staff to take on responsibility for conducting MTP/CAC training, data collection and reporting

Conducting MTP/CAC trainings

i. ToT workshop

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

Location: The ToTs can be conducted at the identified training centres. It may also be conducted collectively for a specified number of training centres at the state level with linkage to one of the existing training centre for hands on cases.

Resource persons: Lead trainers identified by the state or experienced in conducting ToTs for MTP/CAC. The team should include gynaecologists (MD/DGO) performing MTPs/CAC with appropriate technology.

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.

Participants/trainees: Head of the department of ObGyn and faculty members of the training centre/s. 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: ideal batch size is 10 - 12 doctors.

Workshop content: The suggested sessions and sample session plan for the ToT workshop is given in Annexure 10.1 and 10.2 respectively.

ii. MTP/CAC training and certification of MBBS doctors

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

Location: CAC training centres that are/maintained/approved by the government.

Trainer: 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 facility incharge, with a copy of the communication to the CMO of the district for necessary action, including payment of TA/DA.

Batch size: Depending 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 10.1 and 10.3, 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), a certificate (Annexure 10.5) should be issued by the training centre, signed by the head of the ObGyn department or a master trainer, certifying the trainee to provide first trimester MTP/CAC services.

iii. MTP/CAC Orientation Programme for Certified Providers

Objective: To reorient and update 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: MTP/CAC training centres that are maintained/approved by the government.

Trainer: 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 MVA procedures.

Batch size: Three to six participants.

Course content: The suggested sessions and session plan for the programme are given in Annexures 10.1 and 10.6 respectively.

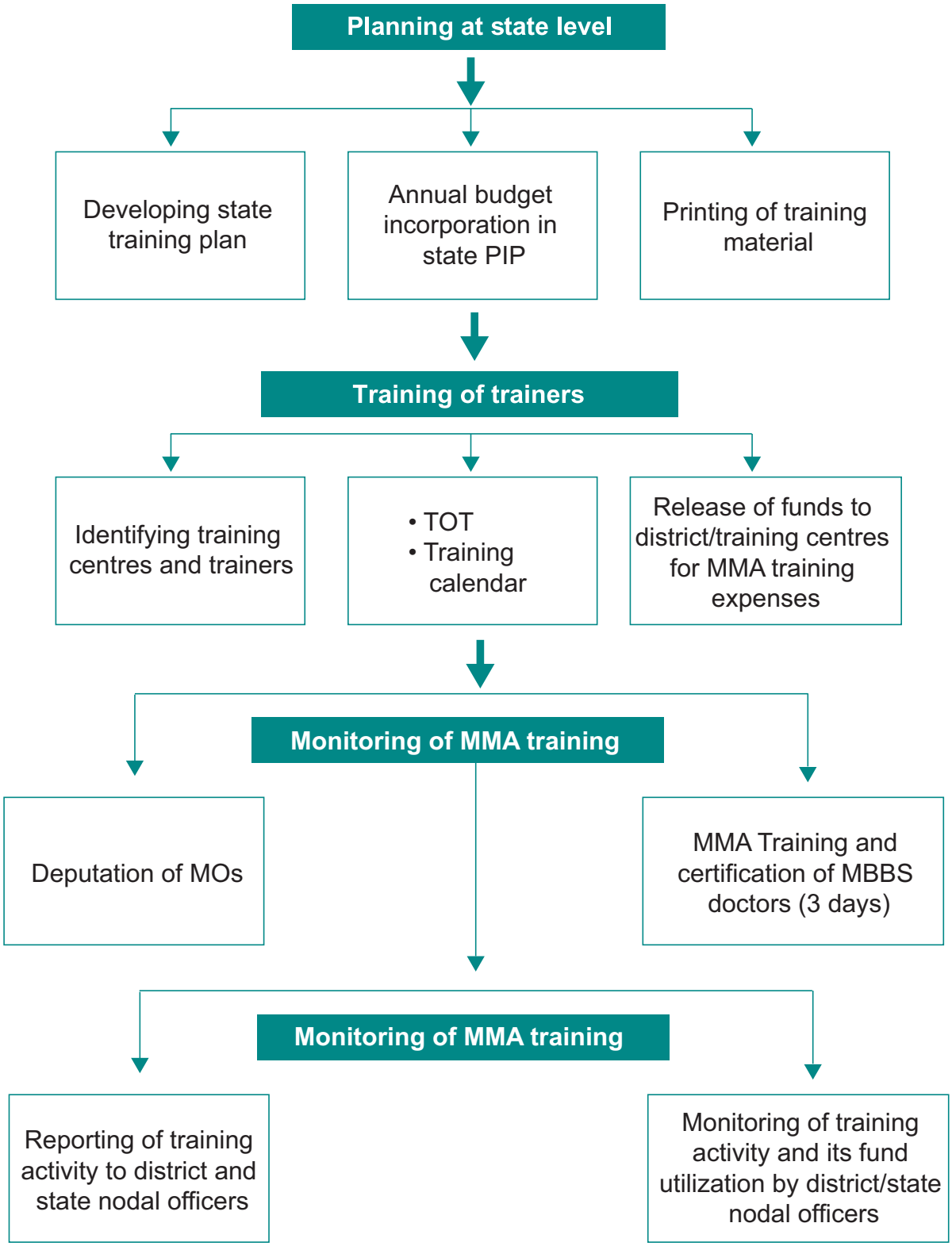
II. The Roll-out of MMA Trainings (Figure 19)

The roll-out of MMA training consists of the following main components:

- ***Programme management:*** CAC state nodal officer or other identified official will be involved in the selection of MMA training centres; the printing of training material; planning of training activities including developing training calendars, deputing medical officers for training and monitoring of training activities
- ***Planning of MMA training activities,*** which include the training of trainers (ToTs), and MMA training for medical officers. Reporting of the training should be done on a regular basis to the concerned authority
- Establishing sites for providing MMA services in public sector health system

The detailed process flow of operationalizing MMA training is presented in Figure 19

Figure 19: Roll-out of MMA Training Programme



Selection of a training centre for MMA Training

Public (MCH/DH/SDH/FRU), and private/NGO sites approved by the state government are eligible to provide MMA training. These sites should fulfill the following criteria:

- Approved MTP/CAC service delivery site (in case of private/NGO sites)
- Providing MTP/CAC cases with MMA with standard protocol
- Annual caseload of induced/spontaneous/incomplete abortion to be atleast 400 to provide the trainees with an opportunity to practice clinical skills
- Adequate infrastructure, including drugs, equipment and supplies for the MTP/CAC service delivery with MMA. Refer to Chapter 9 for more details
- Availability of space/room and other training infrastructure to conduct MMA training
- MTP/CAC certified provider, who should have attended a ToT workshop to become government approved MMA trainers
- Willingness of the administrative head and the department staff to take on responsibility for conducting MMA training, data collection and reporting

Conducting MMA trainings

i. ToT workshop

Objective: To create a cadre of master trainers who would provide ongoing MMA training to medical officers at the identified training centres.

Location: The ToTs can be conducted virtually or in-person at state/district level, collectively for a group of trainers from various training centres.

Trainer: Lead trainers identified by the state or experienced in conducting ToTs for MMA Training

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

Duration: One day

Batch size: Maximum of 20 doctors.

Workshop content: The suggested sessions and sample session plan for the MMA ToT workshop are given in Annexures 10.7 and 10.8 respectively.

ii. MMA training and certification for MBBS doctors

Objective: To train and certify MBBS doctors to provide MTP/CAC services upto nine weeks with MMA only.

Location: Identified training centres that have been approved by the government.

Trainer: Master trainers oriented through MMA ToT workshops.

Participants/trainees: MBBS doctors (from the public and private sectors) who are registered with a State Medical Council.

Duration: Three days. The extension of the training days can be undertaken on the suggestion of the master trainer if more hands on case practice is required to achieve the desired competence. Master trainer will inform the facility incharge, with a copy of the communication to the CMO of the district for necessary action, including payment of TA/DA.

Batch size: 8 – 10 trainees, dependent on the MTP/CAC caseload per month at the training centre, so that trainees can have adequate hands-on practice.

Course content: Includes didactic sessions and hands-on training on the anatomical models and live cases to ensure the acquisition of the required skills for gestation age/uterine size assessment for MMA.

The suggested didactic sessions, along with a sample session plan for the MMA certification course, are given as Annexure 10.9

To acquire the clinical skills of assessing the uterine size, trainee must perform independently 10 cases of MMA to acquire competence with uterine size of different gestation age.

MMA manual covering the relevant chapters should be given to all the trainees, for future reference.

A sample certificate (Annexure 10.10) should be issued by the training centre, signed by the head of the ObGyn department or a master trainer, certifying the trainee to provide MTP/CAC services upto 9 weeks with MMA only.

Annexure 10.1

Suggested Sessions for MTP/CAC Trainings

Clinical topics

- Clinical assessment before the MTP/CAC procedure
- Uterine evacuation methods for first trimester
- Vacuum aspiration (manual – MVA and electric - EVA,
- Medical methods of abortion (MMA)
- Methods for terminations beyond 12 weeks
- Pre- and post-procedure care
- Managing complications of abortions

Support/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
- Adult learning principles (for ToT only)

Annexure 10.2

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

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

State Government Logo

CERTIFICATE OF PARTICIPATION

.....

PARTICIPATED & SUCCESSFULLY COMPLETED THE

COMPREHENSIVE ABORTION CARE TRAINING PROGRAMME

HELD AT .....

FROM ..... TO .....

For Provision of Medical Termination of Pregnancy Services upto 12 Weeks
As Specified in Rule 4-C of the MTP Rules, 2003

.....
Dr.....
Dept of Obstetrics & Gynaecology
.....

Annexure 10.6

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

Annexure 10.7

Sessions for MMA Trainings

i. Overview of Medical Methods of Abortion
ii. Clinical Assessment and Eligibility Screening
iii. MMA Protocol
iv. MTP Act & Documentation
v. Counselling Skills
vi. Managing Side-effects and Complications associated with MMA
vii. Post-abortion Contraception
viii. Model & Hands on Practice

Annexure 10.8

Sample session plan for a MMA ToT workshop:

Time	Session
9.30 – 10.00 am	Registration Pre-test
10.00 – 10.30 am	Introduction to Goal & Objectives Introduction of Participants
10.30 – 11.30 am 11.30 – 12.15 pm	Overview of Medical Methods of Abortion & MMA Protocol Clinical Assessment & Eligibility Screening for MMA
12.15 – 12.30 pm	Tea Break
12.30 – 1.30 pm 1.30 – 2.30 pm 2.30 – 3.30 pm 3.30 – 4.00 pm 4.00 – 4.20 pm	Dealing with Side-effects and Complications with MMA Lunch Legal aspects of MMA and Documentation formats Contraceptive Options with MMA Operationalizing MMA Trainings
4.20 pm	Post Test Valedictory

Annexure 10.9

Suggested Session Plan for MMA Certification Course

Day 1:	
Time	**Session**
9.30 -10:00 am	Registration & Pre-Test
10.00 – 10.30 am	Introduction Goal & Objectives
10.30 – 11.30 am	Overview of Medical Methods of Abortion
11.30 – 12.30 pm	Clinical Assessment and Eligibility Screening for MMA
12.30 – 1.30 pm	Lunch
1.30 – 3.00 pm	Counselling Skills for MMA & Practice
3.00 – 3.15 pm	Tea
3.15 – 4.30 pm	MTP Act & Rules related to MMA Documentation Formats
4:30 PM	Evaluation and Planning for next day

Day 2:	
Time	**Session**
9.00 am – 12.00 N	Hands on Practice on Live Cases: Eligibility Screening; Counselling; Documentation
12.00 – 12.15 pm	Tea
12.15 – 1.00 pm	Dealing with Expected Side-effects of MMA Drugs
1.00 – 2.00 pm	Lunch
2.00 – 3.00 pm	Potential Complications with MMA and their Management
3.00 – 3.15 pm	Tea
3.15 – 4.00 pm	Operationalization of MMA Services at Facilities

Day 3:	
Time	**Session**
9.00 am – 12.00 N	Hands on Practice on Live Cases: Eligibility Screening; Counselling; Documentation
12.00 – 12.15 pm	Tea
12.15 – 1.30 pm	Post-abortion Contraception with MMA
1.30 – 2.30 pm	Lunch
2.30 – 3.00 pm	Post test Training evaluation
3.00 – 4.00 pm	Next steps & Valedictory

Annexure 10.10

State logo

CERTIFICATE

MEDICAL METHODS OF ABORTION TRAINING

DR .....

PARTICIPATED & SUCCESSFULLY COMPLETED THE

MEDICAL METHODS OF ABORTION TRAINING

Held from ……. To ……..

He/She is Certified to Provide MTP Services upto Nine Weeks with MMA Only

As Specified under **Rule 4 (ca) of MTP (Amendments) Rules 2021**

…….
Dr …….
CMHO/DHO/CS
District ……

…….
Dr…….
Dept of Obst & Gynae
……..(Facility)

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