



सत्यमेव जयते



Abortion scenario  
Reproductive Rights  
Law and Abortions  
Cour  
Clinical assessment  
Medical Methods of Abortion  
Infection Prevention  
Vacuum Aspiration  
Complications of Abortions  
Post Abortion Contraceptive Choices  
Second Trimester Pregnancy Termination

**Provider's Manual**  
**Comprehensive  
Abortion  
Care**

April 2014

**Maternal Health Division**  
**Ministry of Health and Family Welfare**  
**Government of India**





# Comprehensive Abortion Care

## Provider's Manual

April 2014

**Maternal Health Division**  
Ministry of Health and Family Welfare  
Government of India

In collaboration with:







**Anuradha Gupta, IAS**

Additional Secretary &  
Mission Director, NRHM  
Telefax : 23062157  
E-mail : anuradha-gupta@outlook.com



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi - 110011

## Foreword

The Millennium Development Goal 5 (MDG 5) enjoins nations to reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio. Accordingly, the Ministry of Health and Family Welfare, Government of India has committed to reduce the MMR to 150 per 100,000 live births by the year 2015. Under the National Health Mission, systematic efforts have been made to improve the reach and quality of health care services in the public sector facilities. Consequently, we have witnessed a gradual yet steady decline in the MMR from 398 per 100,000 live births in 1997-98 to 212 in 2007-2009 and 178 in 2010-12.

It is rather worrisome that in spite of a liberal and enabling environment, unsafe abortions continue to be the reason for a large number of maternal deaths. Recent estimates suggest that eight percent of maternal mortality continues to occur due to unsafe abortion. This is clearly unacceptable as these deaths are preventable.

The Medical Termination of Pregnancy (MTP) Act 1971 governs the provision of abortion care services. In spite of the liberal provisions of this Act, lack of access to safe abortion continues to be a reality for a large majority of women, especially in rural areas. The primary reason for lack of access to these services has been the inadequate number of providers trained and certified to provide MTP services in accordance with the Act, especially in the public health facilities.

While some efforts are being made by all the states to train and certify medical officers in comprehensive abortion care, the training curriculum lacks standardization and therefore does not ensure the requisite levels of skills and competencies after training. Evidently, the resources invested in MTP trainings are not optimally utilized. Even though the providers obtain MTP certification, many do not initiate service provision due to lack of clinical competence and confidence. These challenges seem formidable. They are not, however, insurmountable. Under the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategic approach, focused efforts are envisaged for providing Comprehensive Abortion Care (CAC) services and creating a demand for these services at the appropriate level of public health facilities.

This CAC training package which includes a Trainer's and a Provider's manual, has been developed by the Maternal Health division of the Ministry of Health & Family Welfare in response to the need for a standardized training curriculum for providers. It also incorporates concise Operational Guidelines for programme managers to implement and monitor the services. The training package is an outcome of the deliberations of a group of technical experts. It also draws upon the experience gained from the CAC trainings currently underway. The package is designed to provide requisite clinical skills to the providers, increase the capacity of nursing staff to support the providers and also provide the trainers with aids and detailed guidelines on how to conduct the CAC trainings. It also aims to equip programme managers with the skills to plan and implement quality CAC services.

I believe that the training package, will enhance the skills of doctors, both Ob-Gynae specialists, medical officers and programme managers in providing respectful, confidential and high quality abortion care services to the women in need of these services. This will undoubtedly contribute to our efforts towards achieving MDG 5.

(Ms. Anuradha Gupta)





**Dr. RAKESH KUMAR, I.A.S**  
JOINT SECRETARY  
Telefax : 23061723  
E-mail : rk1992uk@gmail.com  
E-mail : rkumar92@hotmail.com



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi - 110011

## Preface

The National Health Mission provided states with opportunities to revamp the existing service delivery systems. These include, inter alia, strengthening health infrastructure, capacity enhancement of human resources and piloting innovative approaches. The multi-pronged approach under the NHM has contributed to the steady reduction in maternal mortality. However, 8% of maternal mortality continues to be due to unsafe abortions. Moving forward, increasing access to safe abortion care services would be the cornerstone to reducing these avoidable maternal deaths.

India's commitment to attaining the Millennium Development Goal 5 by 2015 can only be achieved through a comprehensive and integrated approach that focuses on the 'continuum of care' for women. The Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) strategy is a path-breaking approach adopted by the Government of India. Provision of respectful, confidential abortion care services that take into account factors influencing women's health needs and her personal circumstances are integral to the RMNCH+A strategy. Therefore, in addition to skill building for developing clinical competencies, providers require training to strengthen knowledge and skills on aspects like respect for women's rights, privacy and confidentiality and sensitivity towards the mental and social conditions of women seeking abortion care services.

The Maternal Health division of the Ministry of Health and Family Welfare, Government of India constituted a core group of experts including programme officers from the MH division, Obstetrician-Gynecologists from premier medical colleges and hospitals and experts from Ipas to develop a standardized training package for Comprehensive Abortion Care (CAC) drawing from the experiences gained from the states, extant national guidelines and global evidence.

This package comprises of: (a) Trainer's and Provider's Manuals (b) Power point presentations (c) Posters on technical content (d) MVA training CD and (e) Operational guidelines for programme managers to monitor and supervise the services.

The purpose of these manuals is to:

- Provide standardized training material including teaching aids to all states for CAC services;
- Strengthen skills of Medical Officers for performing safe MTPs, the skills of ANMs and Nurses in pre and post abortion counseling and post training supportive supervision and follow up;
- Assist in strengthening the currently available abortion care services and improving the overall quality of care and
- Promote the concept of woman-centric care in the provision of abortion services.

I believe that the modular CAC training package offers the adaptability to address varied training needs across the different states. I am confident that the package will help master trainers improve the quality of CAC trainings and facilitate increased access to safe abortion care at all levels, especially at the primary level health care facilities.

(Dr. Rakesh Kumar)





**DR. MANISHA MALHOTRA**

MBBS, DGO, MD (CHA)  
Deputy Commissioner (Maternal Health)  
Telefax : 91-11-23063479  
E-mail : drmisham32@gmail.com



भारत सरकार  
स्वास्थ्य एवं परिवार कल्याण मंत्रालय  
निर्माण भवन, नई दिल्ली - 110011  
Government of India  
Ministry of Health & Family Welfare  
Nirman Bhavan, New Delhi - 110011

## Acknowledgement

The Comprehensive Abortion Care (CAC) training package is devised to improve abortion care services under the National Health Mission. The Maternal Health Division of the Ministry of Health and Family Welfare has developed this training package in the form of Trainer's and Provider's Manuals and Operational Guidelines on Comprehensive Abortion Care in response to the need to strengthen providers' and trainers' knowledge, skills and attitudes for providing culturally appropriate women-centered services and to provide guidance to programme managers at all levels in implementing and monitoring these services to achieve the desired outcomes.

The constant encouragement provided by Shri Lov Verma (Secretary, Health and Family Welfare), Shri Keshav Desiraju (former Secretary, Health and Family Welfare) and the amazing guidance and support provided by Ms Anuradha Gupta, Additional Secretary and Mission Director has been invaluable in giving shape to this initiative. I am also grateful to Joint Secretary (RCH), Dr. Rakesh Kumar, for the motivation and support provided by him during the development of the package.

I would particularly put on record my sincere appreciation for the tireless efforts of the Ipas team of Dr. Sangeeta Batra and Ms. Shilpa Maiya under the able leadership of Vinoj Manning, Country Director, Ipas.

I would like to put on record the hard work put in by the core group of experts, particularly Dr. Pratima Mittal (Prof. and HOD, Ob-Gynae, Safdarjung Hospital), Dr. Puneeta Mahajan (Consultant, Ob-Gynae and MS, Sanjay Gandhi Memorial Hospital, Govt. of NCT, Delhi) and Dr. Sudha Salhan (Former HOD, Ob-Gynae, Safdarjung Hospital) who have provided their guidance and enriched the manual with their excellent technical knowledge on the subject.

My sincere thanks are also due to the Consultants of the Maternal Health Division and the CAC trainers from medical colleges and District Hospitals who aided and supported the core group of experts.

I sincerely acknowledge the contribution made by Dr. B.D. Athani, Special D.G.H.S. & Medical Superintendent, Safdarjung Hospital and Dr. Aruna Batra (Former HOD, Ob-Gynae, Safdarjung Hospital) who facilitated the pre-testing of the manuals at the Safdarjung Hospital, New Delhi.

I am confident that this training package will prove to be a helpful tool for the trainers, providers and programme managers and will enable them to improve the clinical as well as non-clinical aspects of CAC trainings and in planning, implementation and monitoring of CAC Services in the States. We would welcome feedback and any suggestion for improving further editions of this package.

(Dr. Manisha Malhotra)

### Healthy Village, Healthy Nation



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



# List of Acronyms

ANM	- Auxiliary Nurse Midwife
ASHA	- Accredited Social Health Activist
BCC	- Behaviour Change Communication
CAC	- Comprehensive Abortion Care
CDSCO	- Central Drugs Standard Control Organization
CHC	- Community Health Center
CMO	- Chief Medical Officer
COC	- Combined Oral Contraceptive
D&C	- Dilatation and Curettage
D&E	- Dilatation and Evacuation
DCGI	- Drug Controller General of India
DGHS	- Directorate General of Health Services
DH	- District Hospital
DIC	- Disseminated Intravascular Coagulopathy
DLC	- District Level Committee
DMPA	- Depot Medroxyprogesterone Acetate
EC	- Emergency Contraception
ECP	- Emergency Contraceptive Pill
EDL	- Essential Drug List
ETO	- Ethylene Oxide
EVA	- Electric Vacuum Aspiration
FIGO	- International Federation of Gynaecology and Obstetrics
FRU	- First Referral Unit
GA	- General Anaesthesia
GoI	- Government of India
Hb	- Haemoglobin
HBV	- Hepatitis B Virus
HCG	- Human Chorionic Gonadotropin
HIV	- Human Immunodeficiency Virus
HLD	- High Level Disinfection
HMIS	- Health Management Information System

IEC	- Information Education and Communication
IPC	- Inter Personal Communication
IUCD	- Intrauterine Contraceptive Device
JSSK	- Janani Shishu Suraksha Karyakram
LARC	- Long Acting Reversible Contraception
LMP	- Last Menstrual Period
MCH	- Maternal Child Health
MDR	- Maternal Death Review
MMA	- Medical Methods of Abortion
MMR	- Maternal Mortality Ratio
MTP	- Medical Termination of Pregnancy
MVA	- Manual Vacuum Aspiration
NACO	- National AIDS Control Organization
NACP	- National AIDS Control Program
NAS	- National Ambulance Service
NCT	- National Capital Territory
NGO	- Non-Governmental Organization
NPP	- National Population Policy
NRHM	- National Rural Health Mission
NSAID	- Non Steroidal Anti Inflammatory Drug
OCP	- Oral Contraceptive Pill
P/V	- Per Vaginum
PCPNDT	- Pre-Conception Pre-Natal Diagnostic Techniques
PHC	- Public Health Center
PID	- Pelvic Inflammatory Disease
PIP	- Program Implementation Plan
POC	- Products of Conception
PRI	- Panchayati Raj Institution
RCH	- Reproductive and Child Health
RH	- Reproductive Health
RMNCH+A	- Reproductive, Maternal, Newborn, Child and Adolescent Health
RMP	- Registered Medical Practitioner
RTI/STI	- Reproductive Tract Infection/Sexually Transmitted Infection
SCM	- Syndromic Case Management
SDH	- Sub District Hospital

- SN - Staff Nurse
- SRHR - Sexual and Reproductive Health and Rights
- SRS - Sample Registration Survey
- STD - Sexually Transmitted Disease
- TLC - Total Leukocyte Count
- UNDP - United Nations Development Programme
- UNFPA - United Nations Population Fund
- USG - Ultra Sonography
- UT - Union Territory
- VA - Vacuum Aspiration
- VIPP - Visualization in Participatory Program
- WHO - World Health Organization



# List of Contributors

## Core Group of Experts

1. **Dr. Manisha Malhotra**, Deputy Commissioner, Maternal Health, Ministry of Health and Family Welfare, Government of India
2. **Dr. Pratima Mittal**, Professor and Head, Department of Obstetrics and Gynaecology, Vardhman Mahavir Medical College and Safdarjung Hospital, Delhi
3. **Dr. Puneeta Mahajan**, Consultant, Department of Obstetrics and Gynaecology and Medical Superintendent, Sanjay Gandhi Memorial Hospital, Government of NCT, Delhi
4. **Dr. Sudha Salhan**, Professor, Department of Obstetrics and Gynaecology, North Delhi Municipal Corporation Medical College and Hindu Rao Hospital and Ex Head of Department, Department of Obstetrics and Gynaecology, Safdarjung Hospital, Delhi
5. **Dr. Sangeeta Batra**, Senior Advisor, Health Systems, Ipas
6. **Dr. Ravinder Kaur**, Senior Consultant, Maternal Health, Ministry of Health and Family Welfare, Government of India

## Other Contributors

7. **Dr. Himanshu Bhushan**, Deputy Commissioner, Maternal Health, Ministry of Health and Family Welfare, Government of India
8. **Dr. Dinesh Baswal**, Deputy Commissioner, Maternal Health, Ministry of Health and Family Welfare, Government of India
9. **Dr. S. K. Sikdar**, Deputy Commissioner, Family Planning, Ministry of Health and Family Welfare, Government of India
10. **Dr. Sunita Singal**, Senior Administrative Grade Officer, Department of Obstetrics and Gynaecology, Vardhman Mahavir Medical College and Safdarjung Hospital, Delhi
11. **Vinoj Manning**, Country Director, Ipas
12. **Dr. Rajeev Agarwal**, Senior Consultant, Maternal Health, Ministry of Health and Family Welfare, Government of India
13. **Dr. Pushkar Kumar**, Senior Consultant, Maternal Health, Ministry of Health and Family Welfare, Government of India
14. **Dr. Indu Chadha**, Head, Department of Obstetrics and Gynaecology, B. J. Medical College, Ahmedabad, Gujarat

15. **Dr. R. Rajendran**, Former Professor and Chief Anaesthetist, Institute of Obstetrics and Gynaecology, Egmore, Chennai
16. **Shilpa Maiya**, Program Coordinator, Health Systems, Ipas
17. **Amit Rawat**, Program Coordinator, Community Access, Ipas

# Content

Foreword .....	iii
Preface.....	v
Acknowledgment .....	vii
List of Acronyms .....	ix
List of Contributors.....	xiii
1. Abortion Scenario.....	1
2. Reproductive Rights .....	11
3. Law and Abortions .....	17
4. Counselling Skills.....	35
5. Clinical Assessment .....	47
6. Medical Methods of Abortion (MMA).....	59
7. Infection Prevention.....	77
8. Vacuum Aspiration (VA) .....	95
9. Complications of Abortions.....	111
10. Post-abortion Contraceptive Choices.....	123
11. Second Trimester Pregnancy Termination.....	139



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

# **Chapter 1** **ABORTION** **SCENARIO**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 1. Abortion Scenario

## Contents

Self Assessment Tool

Public Health Perspective of Illegal and Unsafe Abortions

Abortion Scenario in the Country/States

Policies for Safe Abortion Care

CAC: Woman Centered Approach

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) Health care workers' attitude does not affect quality of care - True or False
- 2) A comprehensive approach to abortion care focuses exclusively on women's physical health needs - True or False
- 3) Comprehensive Abortion Care Training and Service Delivery Guidelines, published by the Government of India, recommend the use of internationally approved technologies such as MVA, MMA and EVA - True or False
- 4) Unsafe abortion contributes to \_\_\_\_\_% of all maternal deaths in India.
- 5) Circle the three key elements of woman centered abortion care:
  - a. Quality
  - b. Trust
  - c. Choice
  - d. Justice
  - e. Access
- 6) The key Government of India initiatives for addressing safe abortions that uphold the mandates of the MTP Act 1971 are:
  - a. National Population Policy 2000
  - b. RCH II/NRHM
  - c. CAC Guidelines
  - d. All of the above
- 7) The following factors influence abortion services in the country:
  - a. Social
  - b. Economic
  - c. Policy
  - d. Physical access
  - e. All of the above

# Abortion Scenario

Abortion is an important challenge to women's health. Although abortion services in India were liberalized more than three decades ago, the access to safe services remains limited for the vast majority of women. To address this, safe abortion care is now a key component of most maternal health policies in the country.

## Public Health Perspective of Illegal and Unsafe Abortions

Prevalence of illegal and unsafe abortions in the country is because of a combination of the following factors:



### 1. Social Factors

Social factors impacting access to safe abortion services are:

- Lack of awareness that abortion is legal
- Social stigma related to abortions
- Gender discrimination and low status of women, whereby they cannot make decision about their health
- Lack of male responsibility
- Women do not go to male providers
- Provider's attitude towards women coming for abortion care

## 2. Policy Factors

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

- Legal aspects of abortion not disseminated
- Few qualified providers for safe abortion services
- Inadequate equipment and supplies
- Low use of contraceptives
- Forcing acceptance of a particular contraceptive method during abortion care
- Weak referral linkages

## 3. Economic Factors

Economic factors involve variables, such as prices and wages, which affect the individual's decision to seek health care.

Private providers who charge high fees for services also decrease access.

## 4. Physical Access Factors

Physical access barriers to safe abortion services are due to:

- Few trained providers in under-served areas
- Sites providing safe services not advertised

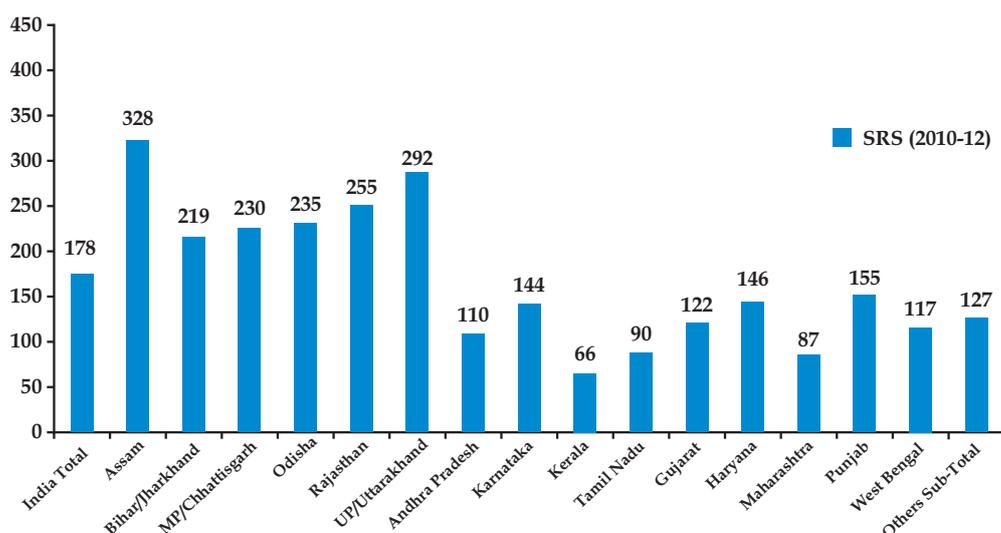
## Abortion Scenario in the Country/States

Some of the key abortion-related figures are:

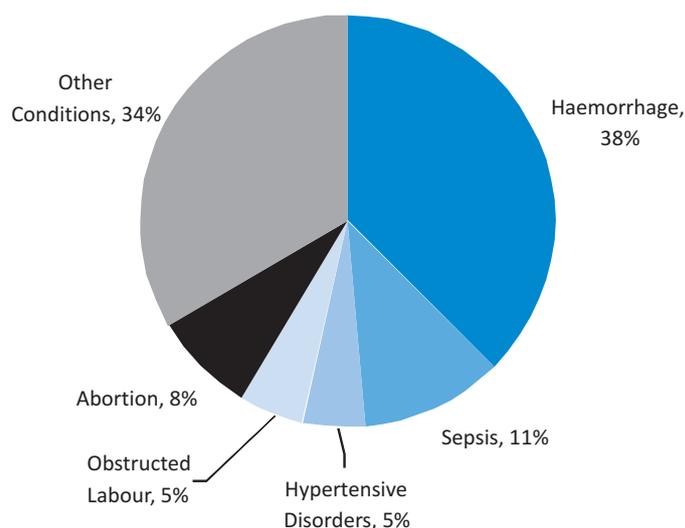
- Abortions account for 8% of the Maternal Mortality Ratio (MMR), though varies across states
- Every two hours, one woman dies of complications due to unsafe abortion. Many of those who survive suffer from chronic, debilitating diseases
- MMR in India: 178/100,000 live births (SRS 2010-12).

Given below are MMR of a few states for information and reference. As exact data on abortions is not available for most of the states, this data is based on projected figures.

## MMR Across States



## Major Causes of Maternal Mortality



Source: RGI-SRS, 2001-03

## Policies for Safe Abortion Care

Since unsafe and illegal abortions have a significant contribution to MMR, Government of India policies and strategies (NPP/RCH II) have focussed on enhancing access and availability of comprehensive abortion care services in both the public and private sector. Policies under National Population Policy (NPP) 2000 and RCH II (NRHM) programme (2005–2012), within the framework of the MTP Act, are detailed below:

### A. National Population Policy 2000

The National Population Policy 2000 was aimed at addressing the unmet need of contraception, inadequate health care infrastructure, and health care personnel to provide integrated service delivery for basic reproductive and child health care.

Some of the strategies planned under NPP 2000 to expand the availability of safe abortion care are:

- 1) **Community-level education** about the **availability** of safe abortion services and dangers of unsafe abortion.
- 2) Make safe and legal abortion more attractive by:
  - a) Increasing **geographic spread**
  - b) Enhancing **affordability**
  - c) Ensuring **confidentiality**
  - d) Providing **compassionate abortion care** (including post-abortion counselling)
- 3) **Adopt updated and simple technologies** that are safe and easy, e.g. **manual vacuum aspiration**, not necessarily dependent upon anaesthesia, or **non-surgical techniques**, which are non-invasive.
- 4) **Promote collaborative** arrangements with **private sector** health professionals and NGOs to increase the availability and coverage of safe abortion services.
- 5) **Eliminate** the current **cumbersome procedures for registration** of abortion clinics.
- 6) Simplify and facilitate the establishment of additional **training centers** for the training of providers in safe abortions.
- 7) **Ensure services** for termination of pregnancy at **primary health centers** and at **community health centers**.

## **B. RCH II/NRHM**

The initiatives for strengthening comprehensive abortion care under RCH II/NRHM fall broadly under three categories:

- I. **Establishing CAC service delivery**
- II. **Generating awareness**
- III. **Integrated strategic approach under RMNCH+A**

### **I. Establishing CAC Service Delivery**

Important steps taken to establish CAC services are:

- a. Funds to states/UTs for the operationalization of MTP services at health facilities, including drugs and equipment
- b. Capacity building of medical officers in safe MTP techniques
- c. Train ANMs, ASHAs to provide confidential counselling for MTP and promote post-abortion care and contraception

- d. Inclusion of MMA drugs in Essential Drug List (EDL) in 2011
- e. Certification of private and NGO sector facilities through District Level Committees (DLCs)
- f. A quarterly tool (format) for the monitoring of CAC service.

## II. Generating Awareness (IEC/BCC)

Following activities have been undertaken to create awareness on safe abortion care:

- a. Sensitization workshops on CAC for state and district officers in the states.
- b. Standard IEC/BCC material on safe abortion developed at central level and disseminated to the states for printing
- c. Funds to states/UTs for the planning of IEC activities through state PIPs
- d. Orientation/training of ASHAs on skills to create awareness in the community and help women in accessing services

## III. An 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 repeat unintended pregnancies and abortions.

### Initiatives under RMNCH+A

Few innovations have been undertaken to expedite the process of implementation:

- Strengthening 'Delivery Points' on priority for the provision of services



- Strengthening the quality of training by providing adequate teaching aids, teaching material and mannequins



- Conducting Maternal Death Review (MDR) to improve the quality of obstetric care and reduce maternal mortality and morbidity by focusing on analysis of each maternal death and identifying medical causes, delays and other factors that contribute to such deaths at various levels, and using this information to adopt measures to fill gaps in service delivery

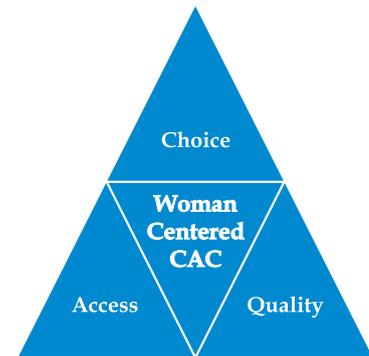
## CAC: Woman Centered approach

In 2010, the CAC Training and Service Delivery Guidelines was released by the Government of India with an aim of transforming abortion care from just being a medical procedure to a Woman Centered Comprehensive Abortion Care 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 ability to access abortion services.

### Elements of Woman Centered CAC

The three key elements of Woman Centered Comprehensive Abortion Care that would help transition abortion care to woman centered care are:

- i. Choice
- ii. Access
- iii. Quality



#### i. Choice

In its broadest sense, it means the 'right and opportunity to select between options'. There should be no interference from others to a woman's right to make choices about her body and health. The choice should be made after getting complete and accurate information and an opportunity to ask questions.

With regard to abortion, choice refers to a woman's right to determine:

- Whether to continue with or terminate a pregnancy
- Freedom to select from available abortion procedures, contraceptives, trained providers, facilities, etc.

#### ii. Access

Access to safe abortion care services means availability of services to a woman:

- As and when she needs them
- Irrespective of her economic or marital status, age, educational or social background
- Without delay because of administrative and logistic hurdles
- Close to her home



### iii. Quality

Quality of care under woman centered care means:

- Adequate time for counselling
- Privacy and confidentiality maintained
- Using internationally recommended technologies, such as MVA, EVA and MMA
- Following appropriate clinical standards and protocols for infection prevention, pain management, management of complications and other clinical components of care
- Offering post-abortion contraceptive services, including emergency contraception
- Providing reproductive and other health services, such as RTI/STIs, counselling on sexual violence, and/or special services for adolescents etc.
- Services tailored to a woman's medical and personal needs

## Summary

- Unsafe abortion is preventable. Yet, it remains a significant cause (8%) of maternal deaths in India
- Despite abortion being legal under certain conditions, a range of social, policy, economic and physical factors limit the availability and utilization of services for women in India
- Availability of trained providers, quality services at facilities and easy access closer to communities are high priority areas under the national maternal health policies to increase women's access to services
- Key elements of woman centered CAC are: Choice, Access and Quality

## Annexure 1

Meena got married at the age of 16 and had three children in quick succession, leaving her very weak. Her husband Bhola worked as a labourer. Meena conceived once again and felt very weak and tired all the time. One day, when she was sharing her experiences with Radha, a neighbour, she was told that she could terminate her pregnancy with the help of the village Dai. When Meena spoke to her husband about this conversation, he rebuked her and said that only those women who have affairs outside marriage seek such services. On insistence, Bhola permitted her to meet the Dai and find out the expenses.

He borrowed Rs. 350 and Meena was taken to the Dai. They were told that it will take only few hours to do the job. After the procedure, she looked pale and was barely able to walk. At home also, there was constant bleeding and abdominal pain. Her condition gradually deteriorated as she had high fever, her breathing was irregular and she became unconscious.

## Annexure 2

### Personal Commitment

As a trained CAC service provider, I will

.....

.....

.....

.....

.....

.....

Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

# **Chapter 2** **REPRODUCTIVE** **RIGHTS**

vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



## 2. Reproductive Rights

### Contents

Self Assessment Tool

Definition of Reproductive and Sexual Health

Sexual and Reproductive Rights

Rights-based Approach for Reproductive Health

Barriers in Promoting Sexual and Reproductive Health and Rights

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) Human rights conventions state that governments can decide how many children a woman can have - True or False
- 2) Reproductive rights for a woman means she is free to decide when and how many children she bears - True or False
- 3) Some of the barriers to accessing abortion care are (encircle all that apply):
  - a. Insistence by providers for parental consent in adolescents
  - b. Medical protocols with strict legal indications of abortion
  - c. Requiring two different providers to certify the indication for an abortion
  - d. Women giving informed consent for themselves

# Reproductive Rights

## Definition of Reproductive and Sexual Health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes.

Sexual health is the absence of illness and injury associated with sexual behaviour, and a sense of sexual well being.

## Sexual and Reproductive Rights

### What are Reproductive Rights?

Reproductive rights are the rights of both men and women to choose and control their own reproductive functions. Reproductive rights therefore, implies that people are able to have a satisfying and safe sex life that they have the capability to reproduce and the freedom to decide if, when and how to do so. They should have information and access to safe, effective, affordable and acceptable methods of family planning.

Various sexual and reproductive rights are enumerated below, along with the explanation on how respecting each of these rights can lead to an improvement in the reproductive health of individuals:

S. No.	Sexual and Reproductive Rights	Improving Reproductive Health
1.	Right to life and survival	<ul style="list-style-type: none"><li>• Prevents maternal deaths due to unsafe abortion</li></ul>
2.	Right to liberty and security of a person	<ul style="list-style-type: none"><li>• Obtains informed consent for all procedures, including sterilization, abortion and HIV testing</li></ul>
3.	Right to privacy	<ul style="list-style-type: none"><li>• Ensures privacy for all services</li><li>• Keeps information confidential</li></ul>
4.	Right to receive information	<ul style="list-style-type: none"><li>• Offers sufficient information to help men/women to make good reproductive health decisions</li></ul>
5.	Right to marry and have a family	<ul style="list-style-type: none"><li>• Prevents early or coerced marriages</li><li>• Provides access to infertility services for women and men</li></ul>
6.	Right to decide the number and spacing of one's children	<ul style="list-style-type: none"><li>• Provides access to a range of contraceptive methods</li><li>• Helps people choose and use a family planning method</li></ul>

S. No.	Sexual and Reproductive Rights	Improving Reproductive Health
7.	Right to highest attainable standard of health	<ul style="list-style-type: none"> <li>• Provides access to affordable, acceptable, and comprehensive reproductive health services so that the woman does not suffer from complications</li> <li>• Provides access to safe, legal and high-quality abortion services</li> </ul>
8.	Right to benefits of scientific progress	<ul style="list-style-type: none"> <li>• Ensures safer and less painful technologies</li> </ul>
9.	Right to non-discrimination and respect for difference	<ul style="list-style-type: none"> <li>• Offers distinctive reproductive health services to all groups, including adolescents and unmarried women</li> <li>• Offers services that meet women's and men's distinctive reproductive health needs</li> </ul>
10.	Right to be free from sexual and gender-based violence	<ul style="list-style-type: none"> <li>• All forms of sexual harassment and exploitation, including those resulting from cultural prejudice, are incompatible with the dignity and worth of the human person and must be eliminated</li> </ul>

Sources: Cook et al., 2003 and IPPF, 1996.

## Rights-based Approach for Reproductive Health

Despite all the attention given to human rights and the progress made, women continue to face discrimination in many spheres of life in relation to men. Violation of sexual and reproductive rights are directly linked to adverse public health outcomes, such as unintended pregnancies, maternal and neonatal mortality, anaemia, unsafe abortions, violence, sexually transmitted diseases and HIV/AIDS.

### Rights-based Approach in Reproductive Health

The advantage of having a rights-based approach in reproductive health is that it:

- Puts reproductive health in the broader context of social justice
- Promotes gender equality and improves the effectiveness of health interventions
- Ensures equal opportunity of services for poor, marginalized, under served, adolescents and single women
- Leads to men recognizing women's right to health

## Barriers in Promoting Sexual and Reproductive Health and Rights (SRHR)

The concept of reproductive rights requires a great deal of elaboration in the Indian context. Strict social compartments further add to the challenge of implementing human and reproductive rights. Attempts will have to continue to break regressive social mindsets to allow for 'rights' to seep in.

### *Barriers to exercising sexual and reproductive rights from the woman's perspective:*

- Lack of understanding and awareness of existing rights
- Limited decision-making power in matters of pregnancy, abortion and childbirth
- Lack of understanding of issues around consent by self/spouse/parents
- Limited participation of men in family planning and reproductive health

### *Barriers to implementing rights-based approach from the provider's perspective:*

- Lack of understanding and awareness of rights
- Lack of understanding of issues around consent by spouse/parents
- Incorrect interpretation of law, making false assumptions/judgment about sexuality and morality
- Poor quality services leads to its under-utilization
- Shortage of trained manpower pushes women to seek help from unauthorized provider
- Use of outdated and unsafe technology
- Only highly qualified professionals approved for services

## Summary

- Reproductive rights are the rights of both men and women to choose and control their own reproductive functions
- Rights-based approach in health care puts reproductive health in the broader context of social justice
- Health systems should ensure that no woman should risk her life while exercising her reproductive choices
- Providers should offer health services to all groups, including unmarried woman and adolescents, without any bias
- Lack of understanding and awareness of sexual and reproductive rights often limits women's access to information and services



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

**Chapter 3**

**LAW AND**

**ABORTIONS**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 3. Law and Abortions

## Contents

Self Assessment Tool

Introduction to the MTP Act

Salient Features of MTP Act:

- Conditions/indications for pregnancy termination
- Who can terminate a pregnancy?
- Places where pregnancy can be terminated

Salient Features of MTP Rules:

- District Level Committee: composition and site approval process
- Infrastructure requirement for MTP sites
- Experience and training required by RMP

Salient features of MTP Regulations:

- Documentation and reporting

Penalty for Violations of the MTP Act

PCPNDT Act

Summary

*MTP and 'safe induced abortion' have been used interchangeably in the whole document.*

## Self Assessment Tool

Please encircle the correct response:

- 1) Abortion is a woman's legal right in India - True or False
- 2) Any MBBS doctors can perform first trimester abortions - True or False
- 3) The District Level Committees approve the following sites to perform abortions (circle all that apply):
  - a. PHC
  - b. CHC and other government run hospitals
  - c. Private clinic
  - d. NGO or trust run clinic
- 4) There are a minimum of \_\_\_\_ (number) members and a maximum of \_\_\_\_ (number) members in the District Level Committee.
- 5) The following are mandatory documents to be maintained for each abortion procedure:
  - a. Form C - Consent Form
  - b. Form I - RMP Opinion Form
  - c. Form II - Monthly statement to CMO by the head of the institute
  - d. Form III - Admission Register
  - e. c and d
  - f. All of the above
- 6) Violation of the MTP Act can lead to:
  - a. Two years of imprisonment
  - b. Seven years of imprisonment
  - c. Two to seven years of imprisonment
  - d. None of the above

# Law and Abortions

## Introduction to the MTP Act

The Medical Termination of Pregnancy (MTP) Act was enacted in 1971. It provides the framework for provision of safe and legal abortion services or MTPs in the country.

Even though women in India do not have the right to abortion on demand, the Act allows termination of pregnancy by a Registered Medical Practitioner (RMP), up to 20 weeks gestation for a broad range of indications.

The MTP Act offers protection to a practitioner if she/he adheres to and fulfills all the requirements under the Act.

## Development and Approval Process

- **MTP Act:** Passed by both houses of Parliament and receives assent by the President.
- **MTP Rules:** Made by the Central Government and passed by the Parliament; notified in the official gazette.
- **MTP Regulations:** Made by the state government and passed by the state legislature.

## Amendments in the MTP Act and Rules

The MTP Act and Rules were amended in 2002 and 2003, respectively. The key features of the amendments are:

1. Decentralization of the MTP site approval to district level through the formation of District Level Committees (DLCs).
2. Details of composition and tenure of DLC and process of MTP site approval.
3. Change in requirement for being certified as MTP provider: a practitioner who has assisted an RMP for 25 cases of MTP must perform at least five independently. After this training the provider will be certified to provide only first trimester MTPs.
4. Infrastructure and equipment requirement for sites providing first and second trimester MTPs were defined and separated.
5. Imprisonment of two to seven years, if an uncertified provider performs the MTP procedure or if the procedure is done in an unapproved site.

## Salient Features of the MTP Act

The MTP Act defines the following:

- A. Conditions/indications for pregnancy termination
- B. Who can terminate a pregnancy?
- C. Places where pregnancy can be terminated



## A. Conditions/Indications for Pregnancy Termination

Pregnancy can be terminated under the following indications:

- Continuation of pregnancy is a risk to the life of the pregnant woman or can cause grave injury to her physical or mental health
- Substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities
- The pregnancy was caused by rape
- The pregnancy was caused due to failure of contraception in a married couple

**Sex selection is not an indication for pregnancy termination under the law**

## B. Who can terminate a pregnancy?

Only an RMP under MTP Act can terminate pregnancy. He/she should:

1. Possess a recognized medical qualification as defined in the Indian Medical Council Act, 1956
2. Have her/his name entered in the state medical register
3. Have experience or training in gynaecology and obstetrics as prescribed by the MTP Rules

## Consent and Opinion for the Procedure

### Consent for MTP Procedure

- In case of a woman over 18 years of age, married/unmarried, only her consent is required to terminate pregnancy
- In case of a minor (less than 18 years) or a mentally ill person, the consent of a guardian is required
- Guardian means a caretaker willing to be responsible for the woman

**Spousal consent is not mandatory**

### Opinion of RMP for MTP procedure

- For termination of a pregnancy up to 12 weeks, opinion of one RMP is required, for performing the MTP procedure
- For termination of a pregnancy between 12-20 weeks, opinions of two RMPs are required for performing MTP procedure

## C. Places Where Pregnancy can be Terminated

A pregnancy can be legally terminated at one of the two types of sites:

- Hospital established or maintained by the Government
- Private site approved by the Government or a District Level Committee constituted by the Government, for the purpose

## Salient Features of the MTP Rules

**The MTP Rules define:**

- A. District Level Committee: composition and site approval process
- B. Infrastructure requirement for the approval of sites
- C. Experience and training required by the RMP

### A. District Level Committee: Composition and Site Approval Process

All private sites need approval before starting abortion services. Approval of private sites is granted at the district level by the DLC.

Public sector sites do not need separate approval, provided they have the required infrastructure.

The DLC is appointed by the Government and is responsible for approval/suspension of place for performing MTPs. It is chaired by the Chief Medical Officer or District Health Officer.

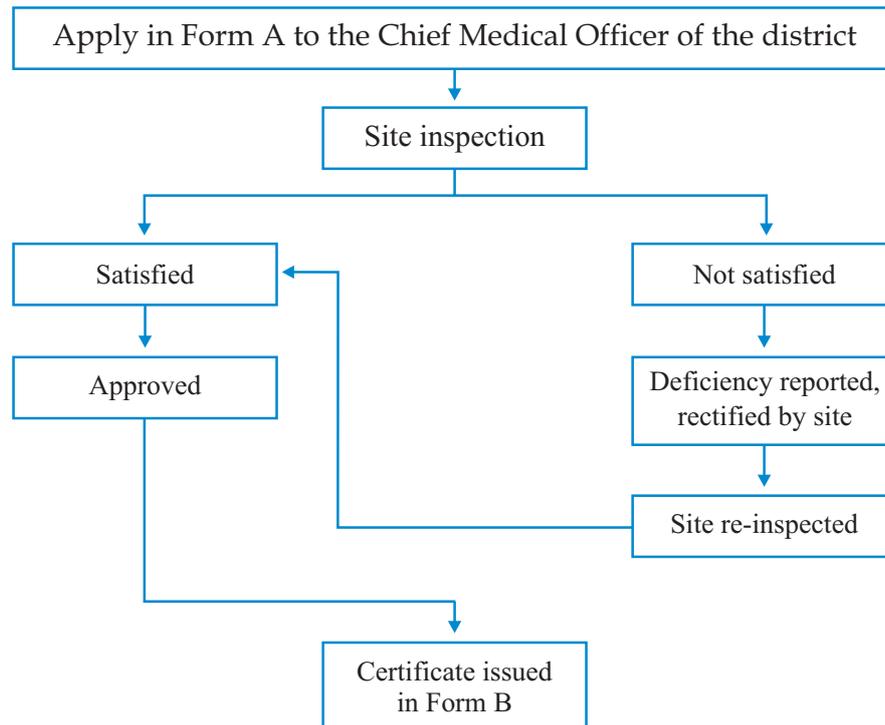


### District Level Committee: Composition

A DLC can have a minimum of three and a maximum of five members including a Chairperson. The composition of DLC should be:

- Chairperson: Chief Medical Officer or District Health Officer
- One member shall be a Gynecologist/Surgeon/Anesthetist
- Other members should be from the local medical profession, Non-Governmental Organization (NGO) and Panchayati Raj Institution (PRI) of the district
- At least one member of the committee should be a woman
- The tenure of the DLC shall be for two calendar years and the tenure of the NGO member shall not be for more than two terms (four years)

Site approval process for private sites providing abortion services:



The format used to apply for site approval is Form A (given below):

## **FORM A**

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

### FORM OF APPLICATION FOR THE APPROVAL OF A PLACE UNDER CLAUSE (B) OF SECTION 4

Category of approved place:

- A. Pregnancy can be terminated upto 12 weeks
- B. Pregnancy can be terminated upto 20 weeks

1. Name of the place (in capital letters).....

2. Address in full.....

3. Non-Government/ Private/ Nursing Home/ Other Institutions

4. State, if the following facilities are available at the place

#### CATEGORY A

- (i) Gynaecological examination/ labour table.
- (ii) Resuscitation equipment.
- (iii) Sterilization equipment.
- (iv) Facilities for treatment of shock, including emergency drugs.
- (v) Facilities for transportation, if required.

#### CATEGORY B

- (i) An operation table and instruments for performing abdominal or gynaecological surgery.
- (ii) Drugs and parental fluid in sufficient supply for emergency cases.
- (iii) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

Place : .....

Date : .....

Signature of the owner of the place.

The site approved by the committee receives the approval in Form B (given below):

### **FORM B**

[Refer 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 .....

#### **Additional information on the Rules**

- The CMO may inspect the approved place as often as may be necessary to verify that MTPs are being performed under safe and hygienic conditions.
- If the CMO has reason to believe that there has been death or injury to a pregnant woman at the place or that the termination is not being done under safe and hygienic conditions, he/she can seek any information or seize any article, medicine, admission register or other documents.
- If the CMO, after inspection, is satisfied that the facility is not being maintained properly and termination cannot be made in safe and hygienic condition, he/she shall report this matter to the District Level Committee. The committee may suspend or cancel the approval after hearing from the owner.

Approval given to the sites for performing pregnancy termination is lifelong and periodic renewal is not required unless the CMO has a reason to cancel/suspend the approval.

## **B. Infrastructure Requirement for Approval of Sites**

The MTP Rules now segregate sites that offer only first trimester (up to 12 weeks) MTPs and sites that offer MTPs up to 20 weeks.

### **Infrastructure Requirement: First Trimester MTP Site**

- Gynaecology examination/labour table
- Resuscitation and sterilization equipment
  - Drugs and parenteral fluids for emergency use, notified by Government of India from time to time

- Back-up facilities for treatment of shock
- Facilities for transportation

### **Infrastructure Requirement: Second Trimester MTP Site**

- An operation table
- Instruments for performing abdominal or gynecological surgery
- Anesthetic equipment
- Resuscitation and sterilization equipment
- Drugs and parenteral fluids for emergency use
- Facilities for transportation

The quantities of the drugs, equipment's and supplies required for CAC services at different levels of health facilities is enumerated in Annexure 1 (ref: CAC Training and Service Delivery Guidelines, GoI 2010).

## **C. Experience and Training Required by the RMP.**

Under the MTP Act, an RMP with the following training/experience can perform MTP procedures:

- Post-graduate degree or diploma in Obstetrics and Gynaecology
- Six months completed as House Surgeon in Obstetrics and Gynaecology
- At least one year experience in the practice of Obstetrics and Gynaecology at any hospital that has all facilities
- A practitioner who has assisted an RMP in 25 cases of MTP of which at least five have been performed independently in a hospital established or maintained by the government or a training institute approved for this purpose. **(Such a practitioner can only perform first trimester pregnancy termination)**

### **Medical Methods of Abortion (MMA)**

**Provider's eligibility for prescribing MMA:** Only an RMP, as under the MTP Act, can prescribe MMA drugs.

**Site eligibility for prescribing MMA:** MMA up to seven weeks of gestation can be provided by an RMP under the MTP Act, from an OPD clinic with established linkage to an approved site. However, a certificate to this effect by the owner of the approved site has to be displayed at the OPD clinic.

# Salient Features of the MTP Regulations

The MTP Regulations define the documentation and reporting to be done for all MTP procedures.

## Mandatory documentation for MTP procedures under the MTP Act:

1. **Form C (Consent Form):** To be signed by the woman herself/guardian
2. **Form I (Opinion Form):** RMP will certify this form within three hours from the termination of pregnancy
3. **Form II:** Head of the hospital or owner of the place shall send a monthly statement of cases to the CMO of the district in this form
4. **Form III (Admission Register):** An approved site will maintain case records in Form III. This Register is kept for a period of five years from the date of last entry. It should be kept in safe custody and will not be opened for inspection by any person except under the authority of law.

## Form C *[Refer 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  
present residing at (Permanent address).....  
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 my pregnancy)

Place:

Date:

Signature

**RMP OPINION FORM**  
**FORM I**  
[Refer regulation 3]

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

\_\_\_\_\_  
(Full address of the Registered Medical Practitioner)

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

\_\_\_\_\_  
(Full address of the Registered Medical Practitioner)

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

resident of \_\_\_\_\_  
(Full address of pregnant woman in block letters)

for the reasons given below\*\*.

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

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioners

Place: \_\_\_\_\_

Date: \_\_\_\_\_

\*Strike out whichever is not applicable.

\*\*of the reasons specified items (i) to (v) write the one which is appropriate.

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

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

Place: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of the Registered Medical Practitioner/Practitioners

## FORM II

[Refer Regulation 4(5)]

1. Name of the State:
2. Name of the Hospital/approved place:
3. Duration of pregnancy (give total No. only)
  - (a) Upto 12 weeks
  - (b) Between 12-20 weeks
4. Religion of woman:
  - (a) Hindu
  - (b) Muslim
  - (c) Christian
  - (d) Others
  - (e) Total
5. Termination with acceptance of contraception.
  - (a) Sterilisation
  - (b) I.U.D.
6. Reasons for termination:  
(give total number under each sub-head)
  - (a) Danger to life of the pregnant woman.
  - (b) Grave injury to the physical health of the pregnant woman.
  - (c) Grave injury to the mental health of the pregnant woman.
  - (d) Pregnancy caused by rape.
  - (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
  - (f) Failure of any contraceptive device or method.

Signature of the Officer In-charge with date

## Form III

(Refer Regulation 5)

### **Admission Register**

Name of Facility \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

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

Duly filled up Form C and Form I shall be placed in an envelope and sealed by the RMP and kept in safe custody until they are sent to the head of the hospital or the owner of the approved place.

All the records of pregnancy termination have to be maintained for MMA also (Consent Form, RMP Opinion Form, Admission Register and Monthly Reporting Form)

## Essential Protocols of Safe and Legal Abortion

An induced abortion is safe and legal only if it fulfils the following conditions:

- It is performed by a Registered Medical Practitioner as defined under the MTP Act
- It is performed at an approved site under the Act and recorded in Form III
- Other requirements of the Act such as consent (Form C), opinion of RMP (Form I), monthly reporting (Form II) etc. are fulfilled
- The pregnancy is within the gestation limit approved by the law

*The provider will get the protective cover of this legislation only when he or she fulfills the above mentioned requirements completely.*

There are situations when women present with other types of abortions at the facilities:

1. Spontaneous abortion
2. Inevitable abortion
3. Incomplete abortion
4. Threatened abortion
5. Missed abortion

Definitions of these abortions are given in Annexure 2.

### Documentation required for these abortions:

- Filling of RMP Opinion Form (Form I) is not required
- Consent has to be taken as for any other procedure and not on Form C
- Procedure not recorded in Admission Register (Form III) but in Labour/OT Procedure Register

## Penalty for Violation of the MTP Act

The following offences can be punished with rigorous imprisonment of two to seven years:-

- Any person terminating a pregnancy, who is not an RMP as under the MTP Act

- Terminating a pregnancy at a place which is not approved
- Mandatory documentation of consent, opinion, case recording and monthly reporting are not adhered to

*If termination is performed by an RMP in good faith to save a woman's life, it will not be treated as an offence even if it is done at a non-approved site or by a provider who does not have the legal requirements to perform MTP provided he/she reports it to Chief Medical Officer of the district on the same or the next working day of the termination of the pregnancy.*

## **PCPNDT Act**

The practice of sex determination, sex selection and female foeticide is a major cause for the countrywide decline in female child sex ratio.

<b>Child Sex Ratio (No. of Girl Child per 1000 Boy Child, in 0-6 yrs. Age Group)</b>	
<b>Year</b>	<b>Total</b>
1981	962
1991	945
2001	927
2011	914

The Pre-Conception Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Amendment Act 2002 prohibits sex selection, before or after conception, and regulates pre-natal diagnostic techniques to prevent their misuse for sex determination leading to female foeticide.

Under this Act, sex determination tests and disclosure of the sex of the foetus is strictly prohibited. Under the MTP Act, abortion is permitted under certain specific situations; sex selection is not one of the permissible grounds. Hence, abortion, solely for the purpose of sex selection, constitutes an offence under this Act.

The sex of the foetus can be identified with certainty using ultrasonography, only after 12 weeks of pregnancy; therefore sex-selective abortions are also usually performed during 12-20 weeks. However, any knee-jerk measures taken by the state to impose absolute restrictions on second trimester abortions by safe MTP providers in an attempt to decrease the female foeticide may drive women to go in for illegal and unsafe abortions from uncertified providers. This will contribute further to maternal morbidity and mortality and in fact, heighten the vulnerability of those very women (especially the poor, rural, of socially backward classes, adolescents etc.)

## Comparative Objectives of the PCPNDT Act and the MTP Act

	MTP Act	PCPNDT Act
<b>Objective</b>	Create a legal situation to terminate a pregnancy upto 20 weeks, on a number of therapeutic, eugenic, humanitarian or social grounds	Improve sex ratio Check female foeticide and decline in sex ratio
<b>Underlying reason</b>	Wish to terminate an unintended or unwanted pregnancy	Son/gender preference in the community, low valuation of girls, increasing dowry demands
<b>Expected outcome</b>	Reduce unsafe abortions	Improve sex ratio

### Summary

- In India, it is legal to terminate pregnancy up to 20 weeks, under special circumstances.
- Only the consent of the woman (more than 18 years) is required for MTP
- For private sites: MTP site approval is done by the District Level Committee
- There are different experience/training and site requirements for first and second trimester MTPs
- Documentation of the MTP procedure includes filling up the following forms: C (Consent Form); I (Opinion Form); II (Monthly Reporting Form); III (Admission Register).
- The MTP Act and the PCPNDT Act are two separate legislations. The objective of the MTP Act is to reduce unsafe abortion whereas the PCPNDT Act checks sex determination that leads to female foeticide and a decline in the sex ratio.

## Annexure 1

The functional equipment stock at the beginning of each month at various levels of the health facilities for providing CAC services is given below:

Sr. No.	Item	PHC/CHC*	FRU-CHC/SDH	DH/DWH
<b>1.</b>	<b>Examination room</b>			
1.1	Examination table	1	1	1
1.2	Screen/curtain for privacy	1	1	1
1.3	Cusco's speculum (medium & large)	3 (2 & 1)	4 (2 & 2)	10 (5 & 5)
1.4	Foot step	1	1	1
<b>2.</b>	<b>Procedure room</b>			
2.1	Examination/Labour table	1	1	1
2.2	Suction machine/foot pump	1	1	1
2.3	MVA Aspirator	2	3	5
2.4	Light source	1	1	1
2.5	Foot step	1	1	1
<b>3.</b>	<b>Instruments</b>			
3.1	Dilator set	1	2	3
3.2	Sim's speculum (medium & large)	2 (1 & 1)	4 (2 & 2)	5 (3 & 2)
3.3	Sponge holding forceps	2	3	5
3.4	Sharp & blunt curette	2	3	5
3.5	Ovum forceps	0	1	2
3.6	Cannulae of different sizes	2 sets	3 sets	5 sets
3.7	Bowl/kidney tray	1	3	5
3.8	Instrument tray	1	3	5
3.9	Instrument for gynae/abdominal surgery		1 set	2 sets
3.10	Instrument trolley	1	1	2
<b>4.</b>	<b>Resuscitation equipment</b>			
4.1	Oral airway	1	1	2
4.2	Face mask	1	1	2
4.3	Ambu bag	1	1	2
4.4	Oxygen cylinder with reducing valve flow meter	1	2	3
4.5	Boyle's apparatus	0	1	1
<b>5.</b>	<b>Sterilization equipment</b>			
5.1	Autoclave	1	1	2
5.2	Boiler	1	1	2
5.3	Cidex tray	1	1	2

\*CHC mentioned here is non FRU-CHC

Sr. No.	Item	PHC/CHC*	FRU-CHC/SDH	DH/DWH
<b>6.</b>	<b>Drugs &amp; parenteral fluid</b>			
6.1	Antibiotics -Tab Doxycycline	84	140	490
	Cap Ampicillin (2 may require this)	30	45	150
6.2	Analgesics -Tab Ibuprofen	54	90	315
6.3	Tab Misoprostol (200 mcg)	16	26	80
6.4	Tab Mifepristone	2	3	10
6.5	Inj. Oxytocin	10	60	120
6.6	Inj. Diazepam	2	4	10
6.7	Inj. Atropine	6	10	35
6.8	Inj. Adrenaline	1	2	5
6.9	Inj. Aminophylline	2	3	10
6.10	Inj. Sodium-Bi-Carbonate 7.5%	1	2	5
6.11	Inj. Calcium Gluconate-10%	2	3	5
6.12	Inj. Perinorm	2	5	10
6.13	Inj. Avil/Phenergan	2	3	10
6.14	Inj. Hydrocortisone	2	3	5
6.15	Inj. Frusemide	2	3	5
6.16	Inj. Dopamine	4	6	20
6.17	Inj. Xylocaine/Lignocaine (vials)	2	3	5
6.18	5% Dextrose	2	5	10
6.19	Ringer lactate	2	5	10
6.20	Normal saline	2	5	10
6.21	I/V sets	2	5	20
6.22	I/V cannula/scalp vein sets	2	5	20
6.23	Laminaria tents (sets)	0	1 set	2 sets
<b>7.</b>	<b>Supplies</b>			
7.1	Povidone iodine solution bottles	4	6	10
7.2	Bleaching powder/Hypochlorite solution	✓	✓	✓
7.3	Disposable syringes (2 ml)	24	40	140
7.4	Disposable syringes (10 ml)	12	20	80
7.5	Surgical gloves (pairs)	24	40	175
7.6	Utility gloves	2	4	10
7.7	Cotton/gauze	2 packets	3 packets	5 packets
7.8	Foley's catheter	2	3	10
7.9	Plastic gowns	2	4	4

Sr. No.	Item	PHC/CHC*	FRU-CHC/SDH	DH/DWH
7.10	Perineal sheet	2	4	10
7.11	Trolley sheet	2	4	10
7.12	Surgical masks (disposable)-number of boxes	1	1	2
7.13	Head caps (disposable)-number of boxes	1	1	2
7.14	OT Slippers	10	15	20
	<b>First trimester cases (expected)</b>	6-8 (30% MMA -2 cases)	10-15 (30% MMA -3 cases)	35 (30% MMA - 10 cases)
	<b>Second trimester cases (expected)</b>		1	5

Ref.: CAC Training & Service Delivery Guidelines, MoHFW, 2010

### Definition of Other Types of Abortions

Other types of abortions: Spontaneous, Inevitable, Incomplete, Threatened, Missed

1. **Spontaneous abortion** is defined as the natural process of loss of a pregnancy, at a period of gestation before the stage of foetal viability (20 weeks' gestation)
2. **Inevitable abortion** is a condition in which vaginal bleeding has been profuse and the cervix is dilated to the extent that abortion will invariably occur. Hence, the pregnancy will not continue and will proceed to incomplete/complete abortion
3. **Incomplete abortion** is a condition when the products of conception (POC) are partially expelled and partially retained in the uterine cavity
4. **Threatened abortion** is an occurrence of variable amount of bleeding in early pregnancy without passing of any products of conception and with a closed cervix. There are high chances of the continuation of pregnancy in this situation
5. **Missed abortion** is a condition when the products of conception are retained in uterus after fetal demise

None of these abortions come under the purview of the MTP Act.

Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

**Chapter 4**  
**COUNSELLING**

**SKILLS**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 4. Counselling Skills

## Contents

Self Assessment Tool

Qualities of a Trained Counsellor

Essential Elements of Counselling

Prerequisites for Counselling  
Role of Site Staff

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) Counselling involves ONLY giving information to a woman - True or False
- 2) Informed decision-making happens after the health care provider has explained all available options - True or False
- 3) No one else should participate in counselling without the woman's prior permission, even if it is health care staff - True or False
- 4) Counselling can be made effective by adopting 'GATHER' approach - True or False
- 5) What is the primary role of an abortion care counsellor?
  - a. To convince the woman about the correct option for dealing with unwanted pregnancy
  - b. To help her clarify her feelings, thoughts and decisions
  - c. To ensure she never has another abortion
  - d. To give advice about what the counsellor would do in her situation
- 6) Counselling is recommended only before the start of a clinical procedure - True or False
- 7) A counsellor should do all of the following, when closing a counselling session EXCEPT:
  - a. Repeat all information covered during the session
  - b. Provide written follow-up instructions, information or referrals
  - c. Explain what to expect during the clinic visit

# Counselling Skills

Counselling is a critical component in providing quality abortion care services. When a woman comes for abortion, she is likely to be under physical as well as mental stress. Therefore, effective counselling is essential to address both these aspects while providing services.

Counselling is a two-way communication between a health care worker and a woman seeking care, for the purpose of confirming or facilitating a decision by the woman, or helping the woman address her problems or concerns.

## Qualities of a Trained Counsellor

The qualities of a trained abortion care counsellor include the following:

- Warm and respectful
- Good listener
- Knowledgeable
- Non-judgmental
- Sensitive to cultural and psychological issues
- Compassionate to all women regardless of their reproductive behaviors and decisions
- Encourages women to ask questions and summarizes information in simple and nontechnical language
- Always maintains confidentiality and privacy

## Essential Elements of Counselling

To make communication effective between the health care provider and the woman, it is important to understand the essential elements of counselling enlisted below:

- I. Active listening
- II. Verbal communication
- III. Non-verbal communication



### I. Active Listening

Active listening is the key to establishing trust and rapport with the woman and is more than just hearing. The components of active listening can be summarized as 'SOLER':

**S** – Sit **squarely** in relation to the woman and at an equal level

**O** – Maintain an **open position** and an **open mind**

**L** – **Lean** slightly forward towards the woman

E – Maintain reasonable eye contact

R – Relax

## II. Verbal Communication

Verbal communication has six elements or steps. All the steps followed in the process of verbal communication can be remembered using the acronym 'GATHER':

**G: Greet** the woman and offer her a comfortable seat

**A: Ask** her menstrual history, number of pregnancies, her feelings and concerns about her decision on termination of pregnancy, reproductive goals and other relevant aspects of health

**T: Tell** accurate information about options of different abortion procedures, pain management, contraceptive methods, their benefits and contraindications

**H: Help** her to choose her own method.

**E: Explain** about the chosen method/technology in detail

**R: Refer and Return:** Refer the woman to the appropriate health center for additional health needs. Provide information on her return visit and re-supplies

Good counselling need not take a lot of time. Respect, attention to each woman's concerns and understanding her feelings and needs make all the difference.

Counsellors should use open-ended questions, along with paraphrasing, during a counselling session. Open-ended questions help in gathering information about the woman and encourage her to talk and be open about her problems. The way we ask questions can encourage or discourage the woman from engaging in conversation.

### Open-ended questions:

- Begin with how, what, when, tell me about... etc.
- Cannot be answered by just a 'yes' or 'no'

### Close-ended questions:

- Usually have a response in 'Yes' or 'No'
- Avoid asking questions beginning with 'why' as they seem judgmental



Provide referrals

### While closing a counselling session, the counsellor/provider should:

- Provide a short summary of the key information discussed
- Ask the woman if she has any questions
- Ensure that the woman understands instructions
- Provide written instructions and referrals as required

### III. Non-Verbal Communication

People often communicate thoughts and feelings through body language, gestures and postures, without speaking a single word. These can be perceived as either positive or negative forms of non-verbal communication.

#### Positive gestures:

- Pleasant facial expressions
- Maintaining eye contact
- Nodding

#### Negative gestures:

- Glancing at watch
- Yawning
- Looking elsewhere

By paying attention to both verbal and non-verbal responses, counsellors can understand the woman's feelings and emotions in a better way. It is important to confirm verbally the interpretation of any clues, to avoid miscommunication.

Apart from the communication aspects of counselling, other prerequisites of counselling are equally important to consider. The next section deals with these prerequisites, which include a proper place and time for counselling.

## Prerequisites for Counselling

### A. Appropriate Place for Counselling

An appropriate place for counselling should have the following prerequisites:

- Privacy should be maintained
- No one else should be able to hear the conversation or see the woman
- It should be comfortable
- It should be clean and well kept

The aim is to create a safe, confidential and comfortable space for the session.



### B. Appropriate Time for Counselling

A woman who seeks abortion services requires a lot of emotional and psychological support to alleviate her fear and anxiety. Therefore, it is very important to provide counselling as many times as possible, but definitely:

- a. before the procedure
- b. during the procedure
- c. after the procedure
- d. during a follow-up visit

Contraceptive counselling should be done at all available opportunities.

### **a. Pre-procedure counselling**

It focuses on providing general information to the woman and helps her clear doubts and thoughts about terminating this pregnancy. She should be provided with information that an early abortion is safe; abortion is legalized up to 20 weeks of gestation; it is available in government health facilities and therefore she should not approach an unqualified abortion provider or providers at unapproved private sites, which can pose risk to her health. At the end of the counselling session, she should be in a position to select the method for termination, give informed consent and take a decision on accepting a contraceptive method.

She should also be informed that she can become pregnant as soon as she resumes sexual activity after an abortion.

**If the woman is not able to decide on a contraceptive method, do not refuse MTP, as she may go to an unsafe/illegal abortion provider.**

### **b. During Procedure Counselling**

Counselling during the procedure helps to calm the woman and relieve her anxiety.

### **c. Post-procedure Counselling**

Key messages to be included in the post-procedure counselling are:

#### **i. Self care**

- a. Rest for a few days
- b. Change pads every four to six hours
- c. Do not have sexual intercourse until the bleeding stops
- d. Return to the health facility as advised or in case of any problem/concern

#### **ii. Danger Signs and Symptoms**

If the woman has any of following symptoms she needs to come to the health center immediately and SHOULD NOT wait:

- a. Increased bleeding or continued heavy bleeding
- b. Fever, feeling ill
- c. Dizziness or fainting
- d. Abdominal pain
- e. Foul-smelling vaginal discharge

### iii. Referral for Other Reproductive Health Aspects, if Required

Counsel woman/spouse/relatives, in case of referral to higher facility on:

- Reasons for referral
- Which facility (referral site) she has to be taken to
- What procedure will be done there and by whom

**Note: The woman should be given a referral slip and the referral should be recorded at the facility. Referral slip should have information on the clinical condition of the woman, any procedure done, drugs given, reason for referral, address and contact details of the facility referred to.**

### d. Counselling During the Follow-up Visit

- Ask the woman if she has any questions to discuss about her health or condition, or if there is any problem
- Check if she is using the contraceptive method correctly
- Address problems or side effects related to the contraceptive method or treatment

## Contraceptive counselling

The use of a contraceptive method is effective only when the user feels comfortable with the choice, has enough information on how to use the method and is aware that she could change or switch to another method if not satisfied.

Some of the elements of effective contraceptive counselling include the following:

- **Assess individual situation:** The counsellor should consider both, the woman's clinical condition and personal situation and discuss any potential barriers to the successful use of contraception in a sensitive manner
- **Availability of contraceptive methods:** It is important to determine which contraceptive methods are available and accessible to a woman, both at the facility and within her community
- **Use of the methods; effectiveness; side effects:** The counsellor should explain the characteristics, use (how it works), side effects and effectiveness of the available methods
- **Support the selected method:** The counsellors should support the woman in selecting the contraceptive method, which suits her and her partner's situation the best. It is important to help the woman make her own, informed choice

There should be no insistence for post-abortion contraception, as it can have a negative impact on the woman. In case of any pressure, a feeling of resentment about using the method may lead to a higher rate of discontinuation, possibly resulting in more unwanted pregnancies, abortions and maternal deaths. Women may avoid seeking care from the health care system and not receive much needed services for contraception and safe abortions.

## Voluntary Informed Consent

Informed consent results from communication between a woman and a provider and receiving full information on the nature of the medical method or procedure, its associated risks and benefits, and other alternatives. The woman confirms that an informed and voluntary choice has been made to receive a medical method or procedure. The woman should give consent by choice and not under pressure or coercion.

Process of counselling can be summarized in a checklist given in Annexure 1

IEC material which can be used by the counsellor/provider during counselling session or for creating awareness is given in Annexure 2

## Role of Site Staff

Service providers at the facility, who come in contact with the woman seeking abortion services, play different roles in her health care and each has a direct impact on the quality of services the woman receives. Each staff member at the facility has a role in making the environment enabling and non-threatening for the woman coming for abortion. Below are some of the possible ways of sharing counselling roles among different staff members at the health facility:

Counselling by Different Facility Staff Members	
Reception/OPD In-charge	Be polite, understanding, sensitive Maintain privacy and confidentiality
Medical Officer/Doctor	Provide counselling pre, during and post-procedure
Counsellor	Provide counselling pre and post-procedure on the options for termination of pregnancy and contraception
Nurse/ANM	Be polite, understanding, sensitive Maintain privacy and confidentiality Explain procedures Address anxieties/fears or concerns patiently Provide information and support during follow-up care
Lab Technician	Be polite, understanding, sensitive Maintain privacy and confidentiality

## Summary

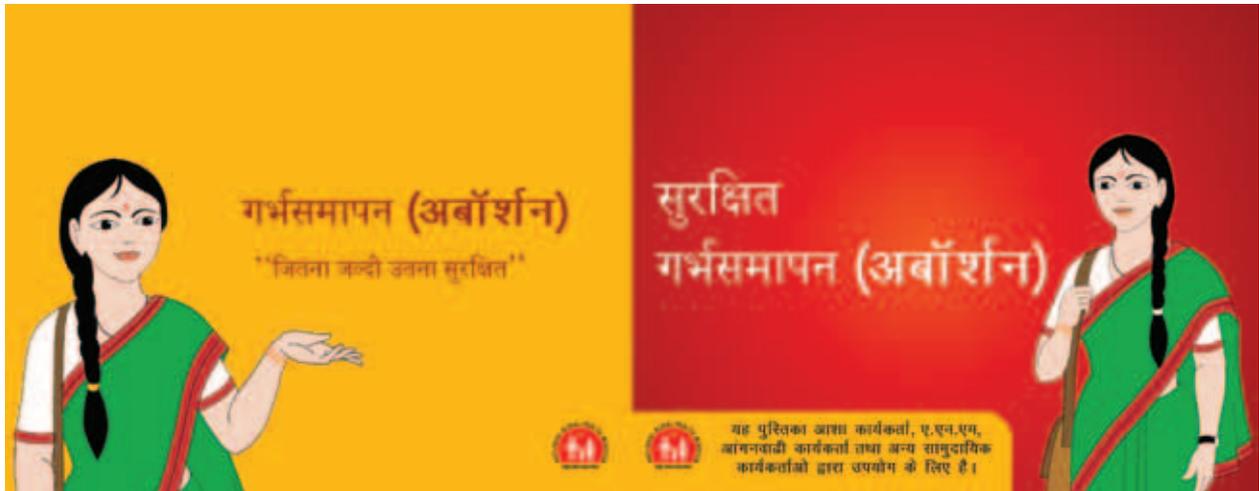
- Women respond best to non-judgmental and empathetic counselling
- Counselling should be provided before, during and after the procedure for continuum of care
- Essential elements of woman-centered counselling include: active listening, open-ended questions and attention to non-verbal communication
- A woman must be aware of the care, benefits and risk of available options for abortion and contraception before deciding on the method

## Counselling Checklist

Task	Yes	No	Comments
<b>1. Positive Rapport and Woman Centered Approach</b>			
Greets and welcomes the woman by name			
Sits facing her without barriers between them			
<b>2. Verbal Communication</b>			
Speaks in a reassuring tone			
Uses clarifying and open-ended questions			
Uses medical terms in a manner she understands			
<b>3. Non-verbal Communication</b>			
Maintains appropriate eye contact			
Shows interest and concern			
Touches the woman when appropriate			
<b>4. Empathy</b>			
Communicates openness			
Shows desire to understand woman's point of view			
Avoids judgment			
<b>5. Privacy and Confidentiality</b>			
Maintains visual and auditory privacy			
Informs her of confidentiality			
<b>6. Abortion-specific Content</b>			
Helps clarify her feelings and decisions about pregnancy and options			
Ensures voluntary and informed decision-making			
<b>7. Contraceptive counselling</b>			
Gives options for contraceptive methods and helps her choose a method based on her needs and preference			
<b>8. Referral</b>			
Refers for contraceptive and other health services, if required			

## Approved CAC Related IEC Material

### 1. ANM/ASHA Booklet



### 2. Flipbook



### 3. Leaflet

### 4. Poster



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

**Chapter 5**

# **CLINICAL ASSESSMENT**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 5. Clinical Assessment

## Contents

Self Assessment Tool

Components of Clinical Assessment

Abortion Care in Pre-existing Medical Conditions

Different Uterine Evacuation Methods

Summary

## Self Assessment Tool

Please encircle the correct response:

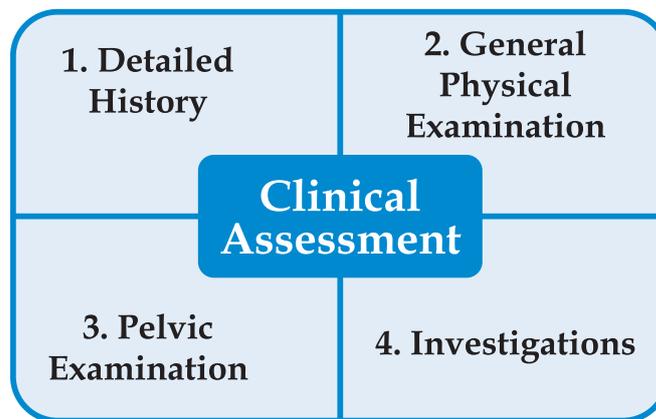
- 1) During clinical assessment, it is important to note any pre-existing condition because:
  - a. It may exacerbate or trigger complications
  - b. It may require the woman to be referred to higher center
  - c. Managing certain pre-existing conditions require advanced skills and equipment
  - d. All of the above
- 2) Accurately determining the length of pregnancy is a critical factor in both selecting an abortion method and in preventing complications - True or False
- 3) The physical examination for abortion procedure involves assessing the woman's general health and performing a pelvic examination - True or False
- 4) Ultrasound is NOT mandatory for provision of first trimester abortion care, but it may be helpful for:
  - a. Accurate gestational dating
  - b. Detecting ectopic pregnancy
  - c. Managing pre-existing conditions
  - d. All of the above
- 5) If RTI/STI is suspected at the time of the clinical assessment, the provider should:
  - a. Go ahead with the procedure and give antibiotics later
  - b. Treat an active infection before starting the procedure
  - c. Take samples for culture and wait for the reports to start antibiotics
  - d. Complete the procedure quickly before the infection spreads
- 6) Safe and appropriate methods of uterine evacuation are (tick all that apply):
  - a. Electric Vacuum Aspiration
  - b. Manual Vacuum Aspiration
  - c. Dilatation and Curettage
  - d. Medical Methods of Abortion

# Clinical Assessment

A clinical assessment, sometimes referred to as a health assessment, is a documented process that is used to evaluate, diagnose and treat individuals. In the case of abortion services, the purpose of a clinical assessment is to evaluate the woman's health status, identify pre-existing medical/surgical conditions, take necessary steps to manage these conditions, assess gestation age and help the woman in deciding from the available options of abortion technologies and contraception.

## Components of Clinical Assessment

Clinical assessment in abortion care has four components:



*Ensure privacy (auditory and visual) and maintain confidentiality throughout the process of clinical assessment*

### a) Detailed History

The process of history taking should include information on the following aspects:

- Personal history: age, religion, address
- Menstrual history: length and duration of cycle, flow (excess or normal), LMP
- Obstetric history: parity, live births, abortion (induced and spontaneous), previous caesarean section (if any), last child birth/abortion, presently lactating or not
- History of any interference/drugs taken in this pregnancy to attempt termination
- Contraceptive history: type and duration of contraceptive used
- Status of tetanus immunization: last dose received
- Psychosocial assessment – to assess family support
- History of sexual assault and domestic violence
- History of pre-existing medical/surgical conditions

- a. Hypertension
- b. Heart disease
- c. Diabetes mellitus
- d. Epilepsy
- e. Asthma
- f. Renal disease
- g. Drug allergies
- h. Bleeding disorders
- i. Current medication
- j. Previous uterine/abdominal surgery

If history of any of the above conditions is found, it may be necessary to refer the woman to an appropriate facility.

## **b) General Physical Examination**

A physical examination begins with a general health assessment, which includes the following:

- Vital signs: pulse rate, temperature, respiration, blood pressure
- Look for anaemia, jaundice, oedema, lymphadenopathy, thyroid
- Breasts for lumps, discharge from nipples
- Abdomen for masses and tenderness
- Examine CVS and respiratory system

## **c) Pelvic Examination**

A pelvic examination helps a health professional evaluate the size, position and consistency of the cervix, uterus, and adnexa. While providing abortion services, accurately determining the length of the pregnancy is a critical factor in both, selecting an abortion technology and preventing complications. In induced abortion care, miscalculation of length of pregnancy is a significant cause of complications.

### **Calculation of 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

USG is not mandatory for assessing the gestation age. However, it should be used if unable to assess the uterine size or it does not correspond to gestation age.

The woman should empty her bladder before the pelvic examination, because a full bladder may make it difficult to assess the uterine size and may mask the findings. The woman should be positioned onto the edge of the table with legs folded at the knees. Any special anatomical needs, including disability, arthritis or injuries should be attended to.

While performing the pelvic examination, explain to her what to expect during the examination. If this is her first pelvic examination, she may be anxious and it is particularly important to let her know what you are doing and reassure her.

## **Steps of Pelvic Examination:**

- i. Examination of external genitalia
- ii. Speculum examination
- iii. Bimanual examination

### **i. Examination of External Genitalia**

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

### **ii. Speculum Examination**

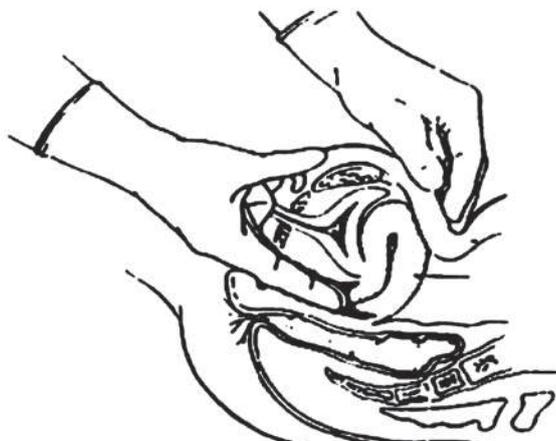
- Inspect the vagina and cervix for ulcer, foul-smelling discharge, pus and bleeding.
- Look for any local trauma/injury
- Look for foreign body in the cervical canal or vagina
- If there is any evidence of infection, practice the following:
  - In case of mild infection (vaginal discharge), start treatment before the procedure as per the protocols given by NACO (attached as Annexure 1) followed by the procedure. Post-operative antibiotics course should be prescribed
  - In case of severe infections including cervicitis and PID, refer woman to the appropriate higher center or treat the woman as per NACO guidelines and re-evaluate the woman for infection, before performing the procedure

### **iii. Bimanual examination (Per Vaginal examination or P/V)**

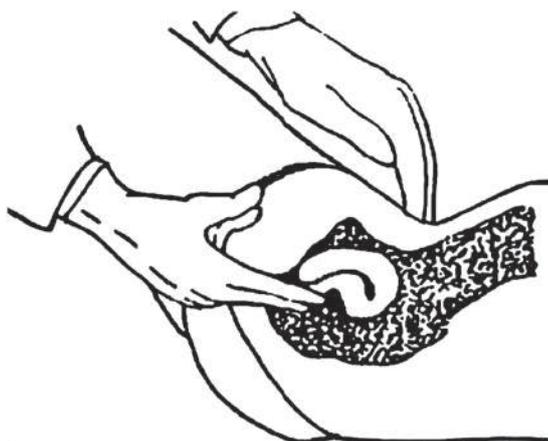
- A bimanual examination is performed to assess the size, consistency and position of the cervix, uterus and adnexa
- Insert index and middle finger of one hand gently into the vagina, and with the other hand palpating the abdomen, assess the size of the uterus
- Pregnancy as early as six weeks from LMP can be diagnosed during the bimanual examination

## Possible Position of Uterus

### A. Anteverted Uterus (Tilted Forward)



### B. Retroverted Uterus (Tilted Backward)



Possible conditions when uterine size does not correspond to the period of amenorrhea:

Uterine Size Larger than Period of Amenorrhea	Uterine Size Smaller than Period of Amenorrhea
<ul style="list-style-type: none"><li>• Full bladder</li><li>• Inaccurate menstrual dating</li><li>• Multiple pregnancies</li><li>• Associated uterine abnormalities such as fibroids</li><li>• Gestational trophoblastic disease (molar pregnancy)</li><li>• Conceived in lactational amenorrhea</li></ul>	<ul style="list-style-type: none"><li>• Inaccurate menstrual dating</li><li>• Secondary amenorrhea/irregular periods</li><li>• Lactational amenorrhea</li><li>• Ectopic pregnancy</li><li>• Spontaneous abortion</li><li>• No pregnancy</li></ul>

Detailed history, urine for pregnancy test and USG can help to differentiate between different conditions and their further management.

## d) Investigations

### Recommended:

- Haemoglobin
- Urine examination for albumin, sugar
- ABO Rh (especially in primigravida)

### Optional (only when indicated):

- Urine for pregnancy test
- HIV and HBs Ag
- Coagulation profile
- Ultrasonography

However, obtaining such tests should not hinder or delay uterine evacuation in emergency situations.

Ultrasonography is not a mandatory requirement for the provision of MTP but useful in:

1. Ruling out ectopic pregnancy
2. Detecting molar pregnancy
3. Diagnosing associated fibroids
4. Accurate gestational dating

### **Ectopic Pregnancy**

#### *Signs/symptoms during ectopic pregnancy might include:*

- Amenorrhoea (may/ may not be present)
- Irregular vaginal bleeding or spotting
- Lower abdominal pain, usually one- sided, that may be sudden, intense, persistent and cramping
- 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 products of conception after a vacuum aspiration procedure

When ectopic pregnancy is suspected, transfer the woman as soon as possible to a facility that can confirm the diagnosis and begin treatment. Uterine evacuation methods, whether vacuum aspiration or medical methods using mifepristone and misoprostol, cannot terminate an ectopic pregnancy.

# Abortion Care in Pre-existing Medical Conditions

Abortion providers encounter women with a wide variety of medical conditions, some of which can be treated at any level of facility and for some, referral to a higher level hospital setting may be appropriate.

## Abortion in Pre-existing Medical Conditions

Hypertension	<ul style="list-style-type: none"> <li>• In controlled hypertension, the woman should take her usual dose of anti-hypertensive medication on the day of the abortion procedure</li> <li>• In uncontrolled hypertension or BP &gt; than 160/100 mm, the woman should be referred to an appropriate level of health facility</li> <li>• Methergin should be avoided</li> <li>• MMA is contraindicated in hypertension</li> </ul>
Anaemia	<ul style="list-style-type: none"> <li>• If haemoglobin is between 8–11 gm%, perform the procedure with caution and then treat for anaemia</li> <li>• If haemoglobin is &lt;8gm%, bring the levels to 8gm% and then perform the procedure</li> <li>• MMA is contraindicated if Hb is &lt; 8 gm%</li> </ul>
Diabetes	<ul style="list-style-type: none"> <li>• In controlled diabetes, take the morning dose of medication, before the procedure</li> <li>• In uncontrolled diabetes, the disease should be controlled before conducting the procedure and the woman should be referred to the appropriate level of health facility for the procedure</li> <li>• MMA is contraindicated in this condition</li> </ul>
Heart disease	<ul style="list-style-type: none"> <li>• If asymptomatic, proceed with the procedure</li> <li>• If symptomatic or severe disease, the abortion procedure may be performed in an operating room after admitting the woman and monitored with the support of an anesthetist/physician</li> <li>• MMA is contraindicated in this condition</li> </ul>
Asthma	<ul style="list-style-type: none"> <li>• The woman should be not having an acute asthmatic attack prior to procedure</li> <li>• Some prostaglandins (PGF2 alpha) should not be used in asthmatics in case of post-abortal atony; PGE1 (misoprostol) can still be given</li> </ul>
Epilepsy	<ul style="list-style-type: none"> <li>• The woman should take her usual dose of anti-epileptic medication on the day of the abortion procedure</li> <li>• MMA is contraindicated in uncontrolled epilepsy</li> </ul>
Blood-clotting disorders	<ul style="list-style-type: none"> <li>• If the woman has an active clotting disorder, proceed with caution, preferably in a facility that is able to treat women with severe hemorrhage. The woman should stop the anticoagulant 48 hours before the procedure</li> <li>• MMA is contraindicated in this condition</li> </ul>

## Different Uterine Evacuation Methods

A detailed and careful clinical assessment can guide the service provider to judge suitability of the woman for a particular uterine evacuation method. The provider can thus help and support the woman in choosing the method of her choice. The different methods for abortion are:

1. Surgical abortion
2. Medical abortion

Surgical abortion is the use of transcervical procedures for termination of pregnancy. It includes:

- A. Vacuum Aspiration
  - Manual Vacuum Aspiration (MVA)
  - Electric Vacuum Aspiration (EVA)
- B. Dilatation & Curettage (this technology is not recommended)

Medical abortion/MMA is the use of pharmacological drugs to terminate the pregnancy.

### Overview and Comparison of Uterine Evacuation Methods

Feature	Electric Vacuum Aspiration	Manual Vacuum Aspiration	Medical Abortion
<b>Technique used</b>	Uterine contents evacuated through a cannula attached to an electric suction machine	Uterine contents evacuated through a cannula attached to hand held vacuum source (aspirator)	Uterine evacuation with drugs (mifepristone and misoprostol)
<b>Gestation limit of the technique</b>	Can be used upto 12 weeks of pregnancy	Can be used upto 12 weeks of pregnancy.	Can be used upto 7 weeks of pregnancy
<b>Effectiveness</b>	More than 98% effective	More than 98% effective	93-95% effective
<b>Time taken for the procedure completion</b>	5-15 minutes	5-15 minutes	May take 8-13 days
<b>POC check</b>	POC can be examined but difficult in the bottle	POC can be easily examined in the cylinder of aspirator	POC may be expelled at home
<b>Number of visits for the procedure</b>	One visit	One visit	Require minimum three visits.
<b>Risk of cervical and uterine injury</b>	Possible but rare	Possible but rare	No risk of injury to cervix and uterus since no instrumentation is done
<b>Risk of fetal malformation if pregnancy continues.</b>	None	None	Potential risk exists

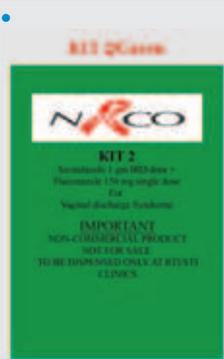
D&C is not recommended as it is more invasive, has higher risk of injury, including perforation and tissue injury, and requires longer period of recovery.

## Summary

- Ensuring privacy and confidentiality during history-taking and examination helps the woman to confide in the provider
- Four components of clinical assessment are: detailed history; physical examination; pelvic examination; investigations
- Detailed history and thorough physical examination helps to identify pre-existing medical conditions before the procedure, to guide for appropriate treatment and referral
- Recommended methods of uterine evacuation are: Vacuum Aspiration (manual and electric); Medical Methods of Abortion

## Guidelines for Treatment of Pelvic Infection

### STI/RTI Syndromic Case Management

<h4>1. Vaginal Discharge</h4>		
<p><b>Symptoms:</b></p> <ul style="list-style-type: none"> <li>Excessive vaginal discharge</li> <li>Burning while passing urine, increasing frequency</li> <li>Genital complaints by sexual partners</li> <li>Low backache</li> </ul> <p>Treat partners, if symptomatic</p>	<p>Tab Secnidazole 2 gm OD stat + Cap Fluconazole 150 mg OD stat</p>	
<h4>2. Cervical Discharge</h4>		
<p><b>Symptoms:</b></p> <ul style="list-style-type: none"> <li>Burning while passing urine, increasing frequency</li> <li>Genital complaints by sexual partners</li> <li>Low backache</li> </ul> <p>Treat partners, if symptomatic</p>	<p>Tab Azithromycin 1 gm OD stat + Tab Cefixime 400 mg OD stat</p>	
<h4>3. Lower Abdominal Pain</h4>		
<p><b>Symptoms:</b></p> <ul style="list-style-type: none"> <li>Lower abdominal pain</li> <li>Fever</li> <li>Vaginal discharge</li> <li>Menstrual irregularities such as heavy/irregular vaginal bleeding</li> <li>Dysmenorrhoea, dyspareunia, dysuria, tenesmus</li> <li>Lower backache</li> <li>Cervical motion tenderness</li> </ul> <p>Treat male partners</p>	<p>Tab Cefixime 400 mg OD stat + Tab Metronidazole 400 mg BD x 14 days + Doxycycline 100 mg BD x 14 days</p>	



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination

## Chapter 6

# **MEDICAL METHODS OF ABORTION (MMA)**



# 6. Medical Methods of Abortion (MMA)

## Contents

Self Assessment Tool

Advantages and Limitations of MMA

Eligibility Aspects of MMA

Documentation/Reporting of MMA

MMA Protocol

Management of Side Effects and Complications with MMA

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) No documentation is required in cases done with Medical Methods of Abortion since it does not involve a surgical procedure - True or False
- 2) Uterine evacuation is necessary in the case of continuing pregnancy, as there is a slight risk of birth defects after the administration of medical abortion drugs - True or False
- 3) NSAIDs cannot be used to treat pain in women undergoing MMA - True or False
- 4) Counselling prior to MMA includes a discussion of all EXCEPT:
  - a. The importance of completing the process once it has begun
  - b. Basic information about MMA
  - c. The necessity of obtaining spousal consent
  - d. Side effects and complications
- 5) Which of the following is NOT a potential side effect of MMA?
  - a. Diarrhoea
  - b. Tingly sensation
  - c. Vomiting
  - d. Fever and/or chills

# Medical Methods of Abortion (MMA)

Medical Methods of Abortion (MMA) is a non-surgical, non-invasive method for termination of pregnancy by using a combination of drugs. MMA has the potential to increase access to safe abortion services because it can be offered by providers in settings where VA or other methods of surgical abortion may not be possible.

**The requisite protocol for surgical abortions as under the MTP Act is also applicable to MMA.**

## Advantages and Limitations of MMA

Pregnancy termination by medical methods, performed by medication/drugs, offer a choice to the woman for the abortion technology. Like other available technologies, this has advantages as well as limitations of use, both of which are enlisted below:

Advantages	Limitations
Abortion can be offered at an early stage of pregnancy	At least three clinic visits required, as per protocol
Privacy is maintained	Not meant for women wanting quick abortion procedure since MMA takes longer. The mean duration of bleeding being 9.5 days
Anaesthesia is not required	Outcome is not predictable
Non-invasive. No instrument used, hence no possibility of surgical complications	MMA drugs have side effects Risk of foetal malformation if pregnancy continues
	Likelihood of misuse of drugs by untrained personnel, without knowing exact gestation age

## Eligibility Aspects of MMA

MMA should be prescribed to eligible women within seven weeks of pregnancy\* after ruling out the contraindications and taking special precautions for certain pre-existing conditions (enlisted below).

**Contraindications** to MMA include:

- Anaemia (haemoglobin <8 gm %)
- Confirmed or suspected ectopic pregnancy, undiagnosed adnexal mass
- Uncontrolled hypertension or BP > 160/100 mm Hg
- Heart problems such as angina, valvular disease, arrhythmia which can lead to sudden cardiovascular collapse

\* Mifepristone + misoprostol (1 tab mifepristone 200 mg + 4 tablets misoprostol 200 mcg each) combipack has been approved by the Central Drug Standard Control Organization (CDSCO), Directorate General of Health Services, for the medical termination of intrauterine pregnancy (MTP) for up to 63 days gestation.

- Severe renal, liver or respiratory disease
- Current long-term systemic corticosteroid therapy
- Current anti-coagulant therapy
- Inherited porphyrias
- Uncontrolled seizure disorder
- Allergic or intolerance to mifepristone/misoprostol or other prostaglandins
- Glaucoma

## Conditions for Special Precautions in MMA

Besides absolute contraindications to the use of technology of MMA, there are conditions where caution has to be exercised. Such conditions are enumerated below:

1. Pregnancy with IUCD in situ: Remove IUCD before giving drugs.
2. Pregnancy with uterine scar: Although safe, exercise caution with history of LSCS, hysterotomy or myomectomy.
3. Bronchial asthma: Misoprostol, a bronchodilator, can be used, but not other prostaglandins.
4. Pregnancy with fibroid: Large fibroid encroaching on endometrial cavity can cause heavy bleeding and can interfere with uterine contractility.
5. Women on anti-tubercular drugs: Rifampicin is a liver enzymes inducing drug, which can lead to increased metabolism and hence decreased efficacy of MMA drugs.

## Provider and Site Eligibility for Prescribing MMA

Apart from medical eligibility criteria, provider and site eligibility for prescribing MMA should also be ensured as mentioned below.

MMA is not a surgical intervention. However, it is a termination of pregnancy and therefore falls under the purview of the MTP Act 1971.

**Provider eligibility:** MMA drugs can be prescribed ONLY by an RMP, as under the MTP Act.

**Site eligibility:** MMA can be provided at the following sites:

- Primary, secondary and tertiary level public sector sites
- Private sector facilities, which have been approved by the government as certified MTP sites
- Outpatient facilities (clinics) with an established referral linkage to an MTP approved site; certificate by owner of approved site displayed, at clinic

## Documentation/Reporting for MMA

Since MMA is a method of termination of pregnancy and comes under the purview of the MTP Act, the documentation is similar to that required for the surgical methods of abortion. It is mandatory to fill and record information in the following forms for each case performed by MMA:

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

## MMA Protocol

### Drugs Used in MMA

Commonly used drugs for MMA are mifepristone and misoprostol.

**Mifepristone** is an antiprogesterone, which blocks the progesterone receptors in the endometrium, causing the necrosis of uterine lining and detachment of implanted embryo. It causes cervical softening and an increased production of prostaglandins, causing uterine contractions. Mifepristone is available as a 200 mg tablet. A small percentage of women (3%), may expel products of conception with mifepristone alone.

**Misoprostol** is a synthetic prostaglandin E1 analogue. It binds to the myometrial cells, causing strong uterine contractions, cervical softening and dilatation. This leads to the expulsion of POC from the uterus. Misoprostol has an advantage over other prostaglandins as it is well absorbed from different routes of administration; is economical; and stable at room temperatures in comparison to PGF<sub>2</sub>α derivatives. It is available as 25, 100 and 200 mcg tablets.

*Action of misoprostol through different routes of administration:*

Oral: Rapid onset but short total duration of action

Vaginal: Gradual onset but longer duration and sustained action. Misoprostol tablets on vaginal administration may not completely dissolve. As the core of the tablet is non-medicated, this does not affect its efficacy. Moistening the tablet before vaginal administration does not improve efficacy (ACOG, 2009)

Sublingual: Rapid onset of action (like oral route) and longer duration of action (like vaginal route)

Buccal: Onset and duration of action is quite similar to the vaginal route although the serum levels achieved are lower.

*Ref: Tang et al., Int J GynecolObste (2007) 99, S160 – S167*

### MMA: Schedule

The steps of the procedure are divided on the basis of the days of the visit. Typically it requires three visits (Days 1, 3 and 15) by the woman to administer drugs and confirm the completion of the abortion procedure when the MMA drugs are used.

## Drug Protocol for MMA

Visit	Day	Drugs used
First	One	200 mg Mifepristone oral; Anti D if Rh negative
Second	Three	400 mcg Misoprostol oral/vaginal/sublingual/buccal; analgesics (WHO, 2012)
Third	Fifteen	Confirm and ensure completion of procedure; offer contraceptives

## Guidelines for Providers

### First Visit/Day 1/Day of Mifepristone Administration

1. **Detailed history:** Refer to the section on history taking in Chapter 5 on 'Clinical Assessment'
2. **Counselling** including general and method-specific counselling; Refer to Chapter 4 on 'Counselling Skills' for details

#### Method-specific counselling

If the woman chooses MMA, then she should be given the following information:

- a. It is a non-invasive and non-surgical method
  - b. The process is similar to a spontaneous abortion
  - c. She needs to make a minimum of three visits to the facility (Days 1, 3, 15)
  - d. She has to follow a definite drug protocol
  - e. She may have vaginal bleeding for 8-13 days
  - f. She has to be ready for VA procedure in case of failure of the method or excessive bleeding. (soaking two or more pads per hour for two consecutive hours)
  - g. She has to stay within the accessible limits of the appropriate health care facility
  - h. She may experience side effects of the drugs, i.e. nausea, vomiting, diarrhoea, etc.
  - i. There could be teratogenic (harmful) effect on the foetus, if pregnancy continues
  - j. A small percentage of women (3%) may expel products with mifepristone alone, but total drug schedule with misoprostol must be completed
  - k. During the abortion process, it is ideal to avoid intercourse to prevent infection or use barrier methods
3. **Physical and Pelvic Examination**
    - a. Check for pallor; blood pressure; cardiovascular and respiratory system for any pre-existing disease
    - b. Carry out pelvic examination (P/S and P/V) to:
      - i. Assess the size of uterus and confirm the period of gestation
      - ii. Look for any infection
  4. **Contraceptive Options**
    - a. Oral pills can be started on the 3rd or 15th day of the protocol
    - b. IUCD can be inserted on Day 15, provided the presence of infection is ruled out
    - c. Condom can be used as soon as she resumes sexual activity
    - d. Tubal ligation can be done after the first menstrual cycle. However, if desirous of concurrent tubal ligation, surgical method of abortion is preferred

- e. Injectables can be given on the 3rd or 15th day
- f. Vasectomy, if chosen, can be done independent of the MMA procedure

5. **Investigations (Recommended)**

- a. Haemoglobin
- b. Routine urine examination
- c. Blood Group: ABO Rh especially in primigravida (Injection Anti D 50 mcg if Rh negative)

**Investigations (Optional)**

**Ultrasonography (USG):** It is not mandatory to perform an ultrasonography for all women undergoing termination of pregnancy with medical methods unless indicated (Refer Chapter 5 on 'Clinical Assessment')

- 6. **Informed consent:** Get the consent of the woman/guardian in Form C.
- 7. **Mifepristone, 200 mg orally**
  - Antibiotics: Routine use of prophylactic antibiotics is not indicated except in cases of nulliparous women or women with vaginal infections
- 8. **Give contact address and phone number** of the facility where woman can go in case of an emergency
- 9. **Complete the follow-up card:** explain the follow-up card (Annexure 1) to the woman and instruct her to note down her symptoms on it

\*First visit may sometimes not be the day of mifepristone administration. The day of mifepristone administration is taken as Day 1.

The image shows a follow-up card for medical abortion in Hindi. It includes a header 'एम.एम.ए. कार्ड' (MMA Card) with a logo. Below the header, there is a section for 'प्रक्रिया के दौरान' (During the process) with a timeline from Day 1 to Day 15. The card lists symptoms to track: 'बन्धे जाना' (Bleeding), 'साधारण रूप से खून गिरना' (Normal blood flow), 'ज्यादा खून गिरना' (Heavy bleeding), 'मतली/उल्टी होना' (Nausea/vomiting), 'दर्द/रेंठन होना' (Pain/cramps), and 'बुखार/सर्दी लगना' (Fever/cold). There are also instructions on when to seek medical help, such as 'अगर आपको निम्न से कोई भी लक्षण महसूस हो तो स्वास्थ केंद्र में डॉक्टर से तुरंत संपर्क करें:' (If you experience any of the following symptoms, contact the health center doctor immediately). The card also includes a section for 'संकेतक' (Signs) and a note at the bottom.

**Summary for First Visit (Day 1)**

Provider's task	Instructions to the woman
1. Detailed history	1. She must return for misoprostol administration after two days
2. Counselling	
3. Complete physical and pelvic examination	2. She may have pain and bleeding during these two days

4. MMA specific counselling	3. Take Ibuprofen to relieve the pain
5. Obtain informed consent	4. Avoid intercourse or use barrier method, such as condoms
6. Discuss contraceptive options	5. Keep the address or phone number of the facility in case of an emergency
7. Investigations	6. Record any experience of side effects on the follow-up card
8. Prescribe Tab Mifepristone 200 mg orally	7. A small percent (3%) of women may expel products with mifepristone alone, but the total drug dosage schedule with misoprostol must be completed
9. Complete the follow-up card with contact address and phone number for an emergency	

## Second Visit/Day 3/Day of Misoprostol Administration:

- Note any history of bleeding/pain or any other side effects after mifepristone:** few of the women will start bleeding after the administration of mifepristone
- Administer misoprostol:** Ask the woman to empty the bladder. Give/insert two tablets of misoprostol (400 mcg) orally/vaginally. Ask the woman to lie in bed for half an hour after vaginal insertion  
Home administration of misoprostol may be advised at the discretion of the provider in certain cases where the woman has an access to 24 hour emergency services
- Keep her under observation for four to six hours in the clinic/hospital:** 75% women abort within four to six hours after misoprostol administration. 30% of the remaining women abort later at home on the same day. Rest of the women mostly abort within next five days  
Mean period for bleeding is 8-13 days. Heaviest bleeding lasts on to four hours which coincides with the expulsion of POC
- Medication for pain relief:** Usually the pain starts within one to three hours of taking misoprostol, so analgesic can be taken well in time before pain becomes intolerable. The commonly used drug is Ibuprofen 400 mg. Paracetamol is not recommended for pain relief during the process of MMA. If pain does not subside on taking drugs, the possibility of ectopic pregnancy should be ruled out
- Perform a pelvic examination** before the woman leaves the clinic and if cervical os is open and products are partially expelled, remove them digitally. She should be observed for another few hours or till the expulsion of the POCs is complete
- Inform woman** about warning signs: Report to the center/provider in case of excessive bleeding/acute abdominal pain. Also tell her to:
  - Use clean sanitary napkins
  - Avoid tampons and douche
  - Report if there is no bleeding even 24 hours after taking misoprostol

- d. Be prepared for side effects such as: nausea, vomiting, diarrhoea (usually mild), headache, fever, dizziness
  - e. Return for follow-up on the 15th day
7. Keep filling the card

### Summary for Second Visit (Day 3)

Provider's task	Instructions to the woman
1. Note bleeding/pain or other side effects after Mifepristone	1. Lie in bed for 30 minutes after vaginal insertion of misoprostol
2. Give two tablets of misoprostol (400 mcg) vaginally/orally	2. She can have side effects such as nausea, vomiting, diarrhoea, headache, fever, dizziness, fatigue
3. Observe for four hours in the clinic	3. Avoid intercourse till bleeding stops
4. Prescribe drug for pain relief.	4. Use clean sanitary napkins and avoid tampons and douche
5. Bimanual examination just before discharge from the facility	5. She should report: <ol style="list-style-type: none"> <li>i. No bleeding 24 hours after misoprostol intake</li> <li>ii. Excessive bleeding, which means soaking two or more pads per hour for two hours continuously</li> </ol>
	6. Return for follow-up on the 15th day
	7. Keep filling the follow-up card

### Third Visit/Day 15/Follow-up Visit:

1. Note relevant history
2. Carry out a pelvic examination to ensure completion of abortion process
3. Reinforce contraceptive counselling and services
4. Advise USG if pelvic examination does not confirm the expulsion of POC or completion of abortion process or bleeding continues
5. Ask the woman to report back if there are no periods within six weeks

### Summary for Third Visit (Day 15)

Provider's Task	Instructions to the Woman
<ul style="list-style-type: none"> <li>• Note history</li> <li>• Pelvic examination to ensure completion of abortion</li> <li>• Reinforce contraceptive counselling and services</li> </ul>	<ul style="list-style-type: none"> <li>• Contraceptive advice as per the method chosen</li> <li>• Report back if there are no periods within six weeks of the completion of the abortion process</li> </ul>

## MMA: Effectiveness

### Effectiveness of MMA

Condition	Effectiveness*
Complete abortion	95-99%
Heavy bleeding requiring vacuum aspiration	1-2%
Incomplete abortion requiring vacuum aspiration	1-2%
Heavy bleeding requiring blood transfusion	0.1-0.2%

\*Reference: *Guidelines for Early Medical Abortion in India using Mifepristone and Misoprostol*. WHO-CCR in Human Reproduction. AIIMS and MoHFW.

## Management of Side Effects and Complication with MMA

### Side Effects

#### a. Bleeding Per Vaginum

Bleeding is usually heavier than what is experienced during a menstrual period; essentially the woman will experience symptoms resembling a spontaneous abortion. Bleeding often lasts for 8 to 13 days.

Soaking of two thick pads within one to two hours after taking misoprostol, decreasing over time is considered normal.

#### b. Abdominal Pain

When discussing abdominal pain, providers should refrain from describing cramping pain as similar to labour pains. Instead, pain can be compared to severe menstrual cramps. Sometimes it begins following ingestion of 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. Counselling and assurance help the woman experiencing persistent severe pain. However, the possibility of ectopic pregnancy should always be ruled out.

#### c. Fever, Warmth and Chills

Fever, feeling of warmth and chills are short-lived and self-limiting side effects. Treatment is generally not required but the woman should know that she may experience these symptoms.

Post-abortion infection is rare after MMA. Persistent fever (> 38° c for two readings four hour apart) may indicate infection and must be evaluated and treated accordingly.

#### d. Gastrointestinal Side Effects

Diarrhoea, nausea and vomiting are commonly reported by women following the use of misoprostol. These side effects are mild and self-limiting and pass off without any treatment. Antiemetic and anti-diarrhoeal medicines may be prescribed when needed.

#### e. Headache and Dizziness

Approximately one-fifth of women studied for MMA, reported headache and dizziness.

Headache is treated with non-narcotic analgesics and mild dizziness of short duration is managed by hydration: advising the woman to take plenty of fluids, rest and exercise caution while changing position.

### Potential Complications and Their Management:

#### i. Severe Vaginal Bleeding

Soaking two or more pads per hour for two consecutive hours needs close monitoring of the woman. In this condition, she should report to the facility. Conduct examination, including bimanual examination, to rule out incomplete abortion and assesses for hypovolemia.

Fluid replacement : IV infusion with Ringers lactate solution 30 drops per minute should be started. Simultaneously, prepare for the uterine evacuation.

In some cases, blood transfusion may be required.

#### ii. Incomplete Abortion

Women with incomplete abortion generally present with excessive/continued bleeding. Assess her vital parameters.

- a. If her condition is unstable: resuscitate and stabilize (refer to Chapter 9 on 'Complications of Abortion' for details on stabilization measures). Stabilization should be followed by examination and further management.
- b. If her condition is stable, proceed with examination:
  - If POC is felt at the os, manage with digital evacuation followed by vacuum aspiration
  - If no products are felt at the os, decide the line of management based on the clinical symptoms, pelvic examination and USG findings:
    - i) If the gestation sac is visible but is non-viable, then an additional dose of misoprostol (dosage given below) may be offered to the woman. Wait for the pregnancy to be expelled with time. The woman should be counseled to return to the clinic after one week to ensure that the abortion is complete.

**Misoprostol 600 mcg oral can be used in such cases of incomplete abortion, following MMA.**

**Current evidence does not support repeated doses of misoprostol for incomplete abortions.**

If bleeding continues even after an additional dose of misoprostol, perform vacuum aspiration.

- ii) If no gestation sac is visible on USG but bleeding continues due 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, vacuum aspiration may have to be done.

- iii) If USG shows viable gestation sac, pregnancy should be terminated by vacuum aspiration

### iii. Continuation of Pregnancy

If the pregnancy continues to grow despite taking drugs for MMA, it indicates that the drugs were ineffective. The pregnancy has to be terminated by vacuum aspiration in view of the teratogenic effect of the drugs.

### iv. Infection

Infection of uterus is rare in the process of MMA.

If the woman has symptoms such as fever, chills, foul-smelling discharge or bleeding and pain in lower abdomen, uterine infection may be suspected. Start broad spectrum antibiotics as soon as possible and remove the POCs, using vacuum aspiration.

## Summary

- Abortion can be offered at an early stage of pregnancy and with more privacy by MMA
- Counselling and ruling out contraindications is mandatory before initiating MMA procedure
- All the documentation required for surgical abortions is also required for MMA (including Forms C, I, II, III)
- The drug protocol should be strictly followed for success of MMA
- Potential side effects during the MMA process and the warning signs and symptoms should be discussed with the woman before initiating the procedure
- Once initiated, the process of abortion has to be completed by VA in case of failure of the procedure because of slight risk of teratogenic effect of the drugs

## MMA Follow-up Card

Details of the patient:

Name:.....

Phone number: .....

Residential address:

.....

.....

.....

Date of first visit: .....

Date of second visit:.....

Date of third visit: .....

In case of emergency, please contact:

Doctor: .....

Phone number: .....

Hospital address:

.....

.....

.....

This chart will help you to assess your health during the 15 days of the medical methods of abortion procedure. Put a cross (x) against any symptom that you experience each day during those 15 days.

During the Procedure		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															

## Medical Methods of Abortion

### Skills Checklist

Day 1: Skills required during first visit to clinic (mifepristone administration)	Yes	No
<b>Pre-procedure tasks</b>		
Greets the woman in a friendly, respectful manner; ensures privacy		
Confirms with her that she wants to terminate her pregnancy		
Explains what to expect during the clinic visit		
Asks if she came with someone and if she would like that person to join her in the counselling		
Asks about her general health and reproductive and medical history		
Explains which abortion methods are available, including characteristics, effectiveness and the timing/visits required		
Confirms that she is eligible for MMA (pregnancy upto seven weeks)		
Explores her views on abortion options and which abortion method is the best for her		
If the woman chooses MMA, provide more information on the method in simple terms		
Clarifies the woman's feelings on the possibility of having the abortion at home and asks what support she has at home		
Ensures that she understands: <ul style="list-style-type: none"> <li>• Common side effects and symptoms</li> <li>• Importance of attending required clinic visits</li> <li>• Warning signs indicating the need to return to the clinic</li> </ul>		
Explains how mifepristone and misoprostol will be administered and what to expect after taking it		
Explains that if the MMA should fail, vacuum aspiration will be necessary to terminate the pregnancy		

<b>Day 1: Skills required during first visit to clinic (mifepristone administration)</b>	<b>Yes</b>	<b>No</b>
Asks the woman whether she has additional questions		
Obtains written informed consent		
<b>Provides first dose for MMA</b>		
Provides mifepristone one tablet 200 mg orally		
<b>Post-procedure tasks</b>		
Explains how to take pain management medication (analgesics)		
Explains what to do in case of problems		
Explains how to record the side effects experienced, if any, on the follow-up card		
Gives the woman the address and telephone number of the clinic where she may go in case of an emergency		
Asks her to return to the clinic for the second dose after two days		
<b>Day 3: Skills required during second visit to clinic (misoprostol administration)</b>	<b>Yes</b>	<b>No</b>
<b>Pre-procedure tasks</b>		
Greets the woman in a friendly, respectful manner; ensures privacy		
Inquires about her experience after taking mifepristone (bleeding, passage of POC, discomfort, side effects). Checks the follow-up card		
Explains what to expect during this visit		
<b>Provides second dose for MMA</b>		
Administers misoprostol in clinic (per protocol) two tablets vaginally/orally		
<b>Post-procedure tasks</b>		
Asks the woman to rest in the clinic for four hours		
Observes the woman in the clinic for bleeding, cramping, expulsion of POC		

Day 3: Skills required during second visit to clinic (misoprostol administration)	Yes	No
If the woman leaves the clinic before she aborts, gives her instructions and supplies (pain medication, written instructions) for aborting at home		
Explains how to record her experience of any side effect on the follow-up card and reminds her of the address and contact number of the clinic to visit in case of an emergency		
Records the date of misoprostol administration and counsels the woman to come for a follow-up visit on day 15		
Reviews after-care instructions and provides information on warning signs which indicate the need to return to the clinic or seek medical assistance		
Asks the woman if she has any additional questions and clarifies them		
Day 15: Skills required during third visit to clinic (Follow-up visit)	Yes	No
Greet the woman in a friendly, respectful manner; ensure privacy		
Inquire about her experience of the abortion process, ask her if she saw the expulsion of any POC and feels that the abortion is complete. Ask whether she is still having symptoms of pregnancy		
Explain what to expect during this follow-up visit		
<b>Assessment to ensure abortion is complete</b>		
<p>Assess the completeness of the abortion by:</p> <p>Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping, any visible parts of POC expelled)</p> <p>Conducting a physical examination (pelvic examination to assess the size and consistency of the uterus and opening of the cervical os)</p> <p>Advising/performing an ultrasound, for the presence of gestation sac, if it is still unclear whether the abortion is complete</p>		
If the abortion is not complete, discuss treatment options: expectant management, additional misoprostol administration or vacuum aspiration		

Day 15: Skills required during third visit to clinic (Follow-up visit)	Yes	No
If the pregnancy is continuing: <ul style="list-style-type: none"> <li>• Discusses need for vacuum aspiration to terminate it</li> <li>• Arranges to complete the procedure by VA</li> </ul>		
If the abortion is complete: Provides information about return to fertility Explains risks of repeated induced abortions Counsels regarding contraceptive methods desired by the woman		
Asks the woman if she has any additional questions and clarifies them		
Tells her that she can come back to the clinic whenever she has any problem		

Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

**Chapter 7**

# **INFECTION PREVENTION**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 7. Infection Prevention

## Contents

Self Assessment Tool

Cycle of Disease Transmission

Universal Precautions

Steps of Instrument Processing

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) Through which infection-transmission routes do blood-borne diseases commonly spread in the clinic setting:
  - a. Contact with infected bed linen
  - b. Injuries from sharp instruments such as needles and blades
  - c. Blood contact with workers' gowns or lab coats
  - d. Splashes of blood on intact skin
  
- 2) Which of the following is NOT a proper procedure for managing occupational exposure to blood and body fluids:
  - a. Immediately flush area with clean water
  - b. If exposure caused bleeding wound, allow to bleed briefly
  - c. Prevent the employee from working until HIV status is known
  - d. Give post-exposure prophylaxis when available
  
- 3) Universal precautions are mandatory while handling which of following body fluids:
  - a. Saliva and vomitus
  - b. Semen, vaginal secretions
  - c. Peritoneal fluid/pleural fluid/CSF
  - d. Both b and c
  - e. a, b, and c
  
- 4) After use needles should be:
  - a. Recapped and stored
  - b. Put in yellow bags and send for incineration
  - c. Destroyed in needle destroyer and placed in puncture-proof container
  - d. Made non reusable by disfiguring/bending them
  
- 5) Which of the following infections cannot occur due to injury by sharps:
  - a. Hepatitis A
  - b. Hepatitis B
  - c. Hepatitis C
  - d. HIV

- 6) Concentration of Sodium Hypochlorite used for decontamination of reusable items is:
- a. 0.1%
  - b. 1.0%
  - c. 5%
  - d. 0.5%
- 7) Which is NOT true about the decontamination soak (encircle all that apply):
- a. Makes cleaning easier
  - b. Use of chlorine solution assists with disinfection
  - c. Makes items safe to handle with bare hands

# Infection Prevention

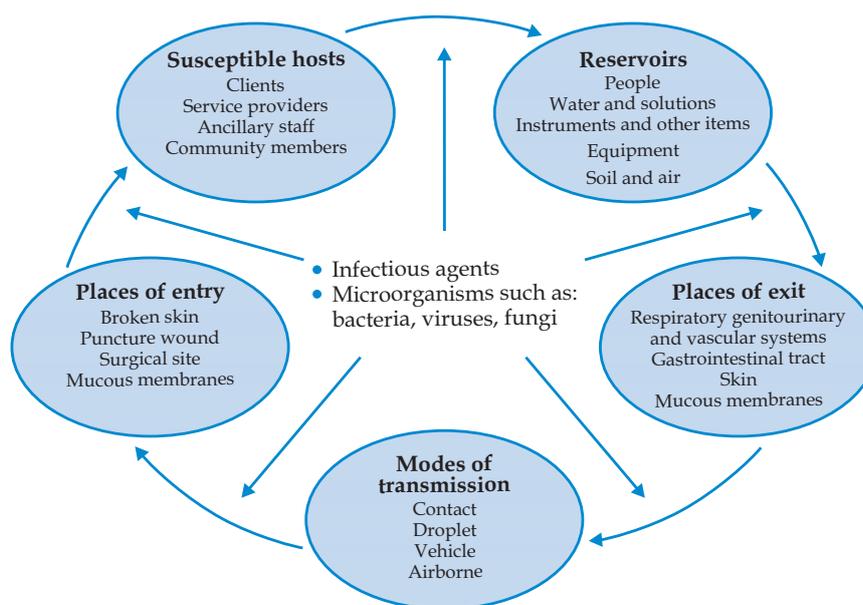
Health care facilities are primary settings for infection transmission because of the presence of numerous types of infectious agents. Health care workers are exposed to infections and contaminated materials during their daily work, while patients are exposed to these infections when they receive health care services.

There is a great need to practice infection prevention protocols by all health care providers to minimize the risk of transmission of any infection including HIV/AIDS, Hepatitis B and C to service provider, patients and visitors; to prevent spread of antibiotic resistant micro-organisms; and to reduce the overall cost of health care services.

To understand how infection spreads, it is first important to understand the cycle of disease transmission.

## Cycle of Disease Transmission

The term 'disease' refers to conditions that impair normal tissue function.



**Infectious Agent:** Infectious agents are bacteria, virus, fungi, and parasites.

**Reservoir:** A place within which micro-organisms can thrive and reproduce. For example, microorganisms thrive in human beings, animals, and inanimate objects such as water, equipment, soil, air.

**Portal of Exit:** A place of exit providing a way for a micro-organism to leave the reservoir. For example, nose (respiratory system) or mouth (gastrointestinal tract) when someone sneezes or coughs; genitourinary tract; vascular system and skin.

**Mode of Transmission:** Method of transfer by which the organism moves or is carried from one

place to another. It could be through droplets in the air, physical contact with the infected person/item or airborne.

**Portal of Entry:** An opening allowing the micro-organism to enter the host. Portals include body orifices, mucus membranes, surgical sites or breaks in the skin.

**Susceptible Host:** A person who gets infection. It could be service provider, client or community members.

It is important to understand how these infections can be prevented. Universal precautions are meant to reduce the risk of transmission of blood-borne and other pathogens from both recognized and unrecognized sources.

## Universal Precautions

Universal Precautions are so called because they should be practiced by all the health care workers against all body fluids, wet surfaces and during contact with all clients at all times. They are the basic level of infection control measures, which are to be used, as a minimum, in the care of all patients. They are also called Standard Precautions.

**THE TWO CARDINAL RULES OF UNIVERSAL PRECAUTIONS ARE :**

1. All patients/persons are potentially infectious
2. There is no reason to treat individuals with known blood-borne diseases differently

**Note:** Universal precautions should be followed for all clients and workers, regardless of their presumed infection status or diagnosis

### Components of Universal Precautions

- A. Hand washing
- B. Personal protective barriers
- C. Aseptic techniques
- D. Handling of sharp items
- E. Environmental cleanliness
- F. Waste management plan
- G. Proper instrument processing (discussed in section on 'Steps for Instrument processing')

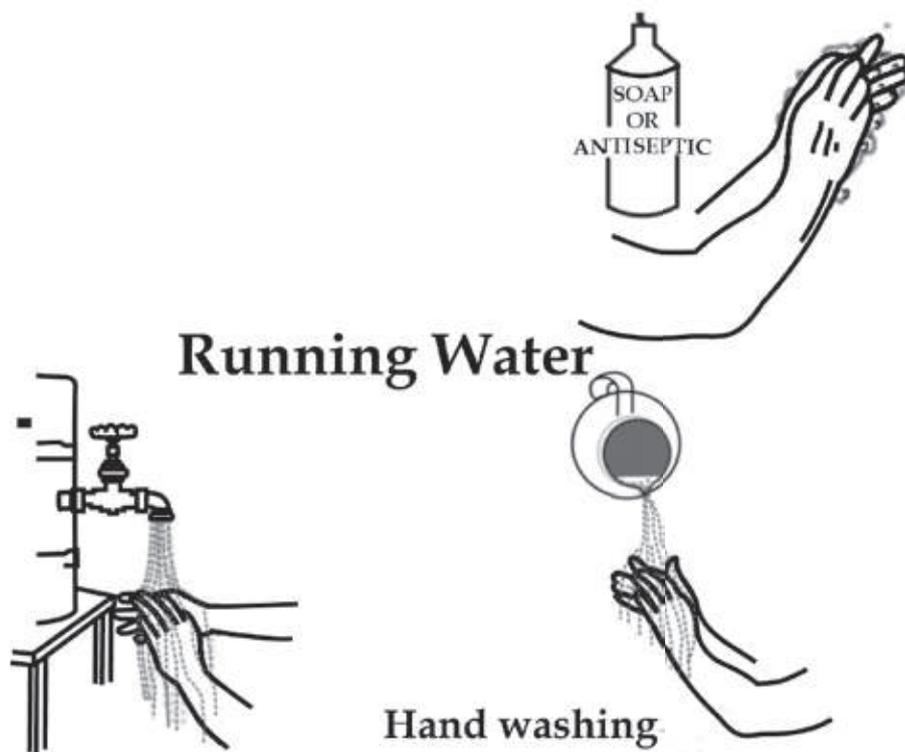
#### A. Hand Washing

Hand washing is a simple, cost effective and important (though often neglected) practice to prevent infection.

How often should hands be washed?

- Before and after examining/contact with each patient or their surroundings
- Before and after any procedure
- After contact with contaminated objects/tissues, even if gloves are worn while handling them

Use soap and clean, running water for hand washing. When running/tap water is not available, a bucket with tap or assistance from another person in pouring the water through a mug is advocated.



*\*Steps of hand washing are given in Annexure 1.*

## **B. Personal Protective Barriers**

Following are the barriers used for protecting the providers/health workers during the procedure:

- Gloves
- Face mask
- Eye-cover
- Gown
- Cap
- Footwear/cover



The gloves should be:

- Changed:
  - After each client contact
  - After contact with a potentially contaminated item
  - Before touching sterile instruments
  - Between rectal and vaginal examinations of the same woman
- Worn while drawing blood, starting an intravenous line or at any time when blood vessels are accessed
- Removed, disposed of immediately after a procedure followed by hand washing

*Steps for putting on and removing surgical gloves are given in Annexure 2.*

*Three types of gloves are used in the clinical practice:*

1. Surgical: used for the procedures and handling blood
2. Utility: used by paramedics mainly to handle the instruments (esp. sharps), linen, cleaning etc.
3. Examination: used for taking intravenous samples; in OPD while performing bimanual examination of non-pregnant women; touching intact skin and mucosa

## **C. Aseptic Techniques**

Please refer to step 3 on page 103 in chapter 8 on 'Vacuum Aspiration'.

## **D. Handling Sharp Items**

Sharps have the highest potential to spread infection by transferring the micro-organisms directly into the blood. It is vital that sharp items used during the procedure be handled with great care to avoid chances of injury by them.

The health care workers can be careful with the sharp items by:

- Avoiding the recapping or bending of needles after use
- Making needles unusable after single use by burning them in a needle destroyer/hub cutter
- Putting all needles in a puncture proof container after use
- Putting all the syringes in 1% hypochlorite solution for half an hour before disposing
- Wearing utility gloves when disposing of sharps containers

In spite of best efforts, if accidentally exposed to needle pricks or cuts:

- Allow the exposed area of the skin to bleed briefly

- Immediately flush with clean, running water
- Wash wound and skin thoroughly with soap and water
- Do not press, suck or squeeze
- Give post-exposure prophylaxis if available as soon as possible but not later than 72 hours of injury

### Post Exposure Prophylaxis

Zidovudine (300 mg BD) and Lamivudine (150 mg BD) should be started within 72 hours of the exposure and continued for four weeks.

## E. Environmental Cleanliness

Health care workers should follow the following cleanliness protocols at all the facilities:

- Wear utility gloves while cleaning
- Use a damp/wet cloth for dusting to reduce the spread of dust and micro organisms
- Wash room surfaces from top to bottom so that dirt falls on the floor
- Use 0.5% chlorine solution\* for decontamination and cleaning. Use 1% solution for disinfecting waste and managing spills
- Health facility should be cleaned at the beginning, middle and end of each day and as needed

*\*Chlorine is highly effective against HIV and HBV and is a cost effective disinfectant.*

### Cleaning Schedule: Client Care Areas

At the beginning of each day	Clean horizontal surfaces operating/procedure tables, examination couches, chair, trolley tops or Mayo stands, lamps, counters and office furniture with a cloth dampened with water; and clean floor with a mop dampened with water to remove dust and lint that have accumulated overnight
Between clients	Clean operating/procedure tables, examination couches, chairs, trolley tops or Mayo stands, lamps and any other potentially contaminated surface in operating theaters and procedure rooms with a cloth dampened with a disinfectant cleaning solution  Clean visible soiled areas of floor, walls or ceiling with a mop or cloth dampened with a disinfectant cleaning solution
At the end of each clinic session or day	Wipe down all surfaces, including counters, tables, sinks, lights, doors, handle plates and walls with a cloth dampened with a disinfectant cleaning solution or spray the solution on to the surface using a spray bottle and wipe them down. Remember to wipe from top to bottom. Pay particular attention to operating/procedure tables, making sure to clean the sides, base and legs thoroughly. Rinse sinks with clean water after cleaning  Clean the floors with a mop soaked in a disinfectant cleaning solution
Each week	Clean ceiling with a mop dampened with a disinfectant cleaning solution

### Preparation of 0.5% chlorine solution

#### *a. Calcium Hypochlorite or Chlorinated lime:*

If using bleaching powder: Use the formula –  $(0.5/\% \text{ active chlorine in powder}) \times 1000 =$  gm of powder/litre of water. So, for the bleaching powder with 35% available chlorine, the formula will be:

$$(0.5/35) \times 1000 = 14.3/15 \text{ gm/litre of water}$$

**Dissolve three teaspoons of bleaching powder (15 gm of calcium hypochlorite) in one liter of water. Increase quantity of chlorine in same proportion to prepare larger quantities of solution.**

#### *b. Sodium Hypochlorite:*

If using liquid hypochlorite solution/bleach: mix one part of the solution to 9 parts of water to make 0.5% chlorine solution (if solution has 5.0 % active chlorine available) OR one part of liquid bleach to six parts of water (if solution has 3.5% active chlorine available).

*For spill of blood or body fluid on the ground/any surface, follow the rules below:*

A spill kit should be readily available at all the times, containing necessary items.

Most experts recommend the following (though some differ in duration of contact and concentration):

- Cover spills of infected or potentially infected material on the floor with paper towel/blotting paper. Pour disinfectant (5% Phenol or freshly prepared 1% hypochlorite solution)
- Leave for at least 10 minutes for contact
- Then wipe with gauze or cloth with gloved hands
- The gauze or cloth used to wipe is discarded as biomedical waste

For highly infectious spills use 10% bleach solution.

## **F. Waste Management Plan**

It is important to dispose of all kinds of waste properly; improper disposal of biomedical waste poses health risk to the community. **Proper disposal of infectious waste is crucial in maintaining environmental cleanliness. All healthcare facilities in the country are covered under BMW Management and Handling Rules (1998), hence it is mandatory to manage waste as per the guidelines of the local authorities.**

All waste in a health facility can be divided into:

1. **General waste** is the waste that poses no risk of injury or infections. This is similar in nature to household trash. Examples include paper, boxes, packing materials, bottles, plastic containers and food-related trash. It should be stored in black bins, which will be taken away by the municipality.

2. **Biomedical waste:** Material generated in the diagnosis, treatment or immunization of clients, including blood, blood products and other body fluids, as well as material containing fresh or dried blood or body fluids, such as bandages or surgical sponges and organic waste such as human tissue, body parts, placenta and products of conception.

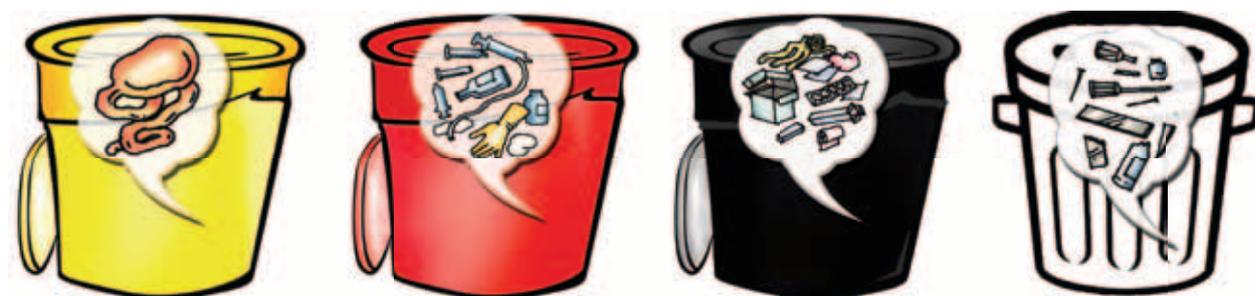
There are four steps in the waste management plan:

1. Segregation
2. Collection and storage
3. Transportation
4. Disposal of waste

## 1. Segregation

Most health facilities use color coded bags or containers to collect different types of waste. Find below the illustration showing the type of waste and the container for its collection.

### Waste Segregation



- **Black bin:** for general waste such as packaging material, cartons, fruit and vegetable peels, syringe and needle wrappers, medicine covers
- **Puncture-proof container:** for sharps such as needles, blades, broken glass etc.
- **Yellow bin:** for anatomical waste such as placenta, body parts etc.
- **Red bin:** for infected plastics, syringes, dressings, gloves, masks, blood bags, urine bags

## 2. Collection and Storage

- Always collect the waste in covered bins
- Fill the bins up to the three-fourth level. Never overfill the bins
- Clean the bins regularly with soap and water/disinfect the bins regularly
- Never store waste beyond 48 hours

## 3. Transportation

- Always carry/transport the waste in closed containers
- Never transport the waste in open containers or bags, it may spill and lead to spread of infection
- Never transport waste through crowded areas

## 4. Disposal of Waste

Burning solid infectious waste in an incinerator is the best option.

If incinerator is not available, burying solid infectious waste on-site in a deep burial pit, as long as it is secured with a fence or wall and away from any water source, is the next best option. The waste should be covered with 10 to 30 centimeters (4 to 10 inches) of soil at the end of each day. Never put any waste in an open pile.

Liquid infectious waste, after disinfecting with chlorine solution, should be poured down the drain connected to an adequately treated sewer or pit latrine. Burial with other infectious waste is an acceptable alternative.

Anatomical waste in a yellow bag is to be disinfected with bleach solution and then either sent for incineration or deep burial. First trimester products of conception should be poured down a drain or buried with other liquid infectious waste, after disinfecting with chlorine solution. For second trimester POC, since the placenta and other foetal parts are already formed, they should be disposed in yellow bag.

Plastics should be autoclaved or decontaminated and then shredded.

Sharps are to be disinfected with chlorine solution and dumped in the sharps pit.

Chart on hospital waste management is given in Annexure 3

## Steps for Instrument Processing

All instruments which are to be reused for the procedures should be processed following the steps given below:

- I. Instrument soak/Decontamination
- II. Cleaning
- III. Sterilization/HLD
- IV. Storage or immediate use

### I. Instrument Soak/Decontamination

There is a need for decontamination of instruments by soaking in 0.5% Chlorine solution for 10 minutes before cleaning because:

- a. Use of chlorine solution assists disinfection, protects from HIV, HBV
- b. It removes tissue and body fluids, prevents them from drying

Remember: Items after soaking are still not safe to handle with bare hands.

#### Care to be taken during decontamination:

- Always use gloves
- Draw solution into cannula and aspirator and flush each of the used cannula
- Disassemble instruments before soaking

- Soak all instruments and gloves immediately after use
- Remove metal instruments from the chlorine solution after 10 minutes to avoid corrosion

## II. Cleaning

- Wash all surfaces of instruments in warm water and detergent
- Use a soft brush; nothing sharp or pointed should be used
- Clean until no blood or tissue is visible

## III. Sterilization/High Level Disinfection (HLD)

Sterilization is a process that destroys all micro-organisms (such as bacteria, viruses, fungi and parasite/protozoa) including bacterial endospores whereas HLD is a process that destroys all micro-organisms excluding bacterial endospores, which cause tetanus and gas gangrene.

### *Sterilization options:*

- Autoclave at 121°C/250°F for 30 minutes with pressure of 106 kPa/15 lbs/in<sup>2</sup>
- Soak in 2% Gluteraldehyde for 10 hours

### *High Level Disinfection options:*

- Rolling boil for 20 minutes
- Soak in 2% Gluteraldehyde for 20 minutes
- Soak in 0.5% chlorine solution for 20 minutes

### **Care to be taken during the step of sterilization/HLD:**

#### *a. For autoclave:*

- Disassemble the instrument fully
- Wrap separately parts of the aspirator and cannula in paper/linen
- Adjust the temperature and pressure carefully

#### *b. For HLD using Gluteraldehyde/Chlorine solution:*

- Instruments to be fully immersed
- Instruments must be rinsed with sterile water before use
- Solution to be changed as per recommendations

#### *c. For HLD by boiling:*

- Do not add fresh instruments while boiling
- Count the time from when water is on a rolling boil
- Boiler should be covered

## IV. Storage or Immediate Use

Store instruments in an environment that preserves the level of desired processing. Instruments not used immediately can be stored as mentioned below:

- Store HLD instruments in a covered HLD tray. If not used, HLD again after 24 hours
- Store autoclaved instruments in drums placed in a dry place. If not used, autoclave after seven days

**Care to be taken during storage:**

- Always mark the date of the sterilization/HLD
- Storing items even when slightly wet invites microbial growth

*Chart on instrument processing options for MVA equipment is given in Annexure 4*

### Summary

- All patients irrespective of their status should be considered as potentially infected and universal precautions should be followed
- Universal precautions include: hand washing; protective personal barriers; aseptic techniques; proper handling of sharps; environmental cleanliness; waste management plan; and instrument processing
- Steps of waste management are: segregation; collection and storage; transportation; and disposal
- Steps of instrument processing are: decontamination soak; cleaning; sterilization/HLD; storage

# STEPS FOR ROUTINE HAND WASH

Wet hands with warm water, apply soap and lather well  
Rub each area together for at least 6 times (15-20 seconds)



**1** Palm to palm



**2** Between fingers



**3** Palm to back of hand



**4** Base of thumbs



**5** Back of fingers



**6** Rotational rubbing of fingers



**7** Rinse hands and air dry

## Ensure following before hand wash:

- ✓ Nails should be trimmed
- ✓ All ornaments (rings, bangles, watch) should be removed

**Hand washing with running water is mandatory before and after every procedure**

# Putting On and Removing Surgical Gloves

## Steps for putting on surgical gloves



**1** Surgical hand wash



Prepare for putting on gloves **2**



**3** Pick 1<sup>st</sup> glove by cuff



Slip hand into glove by holding cuff **4**



**5** Pick 2<sup>nd</sup> glove by slipping fingers under cuff



Put 2<sup>nd</sup> glove by steady pull, adjust both gloves **6**

To autoclave, keep the gloves straight with folded hand cuff in a paper or linen



## Steps for removing surgical gloves



**1** Rinse gloved hands in bleach solution



Holding near cuff, pull 1<sup>st</sup> glove partly **2**



**3** Holding near cuff, pull 2<sup>nd</sup> glove partly



Pull off both gloves completely **4**



Process the gloves in bleach solution for disposal or reuse **5**

Don't rollback the gloves while autoclaving



# Hospital Waste Management

## Waste segregation to be done at source



Human tissue, placenta, products of conception, used swabs/gauze/bandage, other items contaminated with blood



Used mutilated catheters, IV bottles and tubes, syringes, disinfected plastic gloves, other plastic material



Kitchen waste, paper bags, waste paper/thermocool, disposable glasses and plates, leftover food



All needles/sharps/IV cannulae/broken ampules/blades in puncture proof container

**Puncture proof container**

## Waste Disposal

- Incinerate or deep burial of solid waste
- Drain liquid waste in sewer or in pit toilet after chemical treatment

- Shred and disinfect before disposal
- Disposal in municipal waste or send for recycle

→ Municipal waste

- Disinfect with bleach
- Dump in pit for sharps

### Dos and Don'ts

- ✓ Never put waste in an open pile
- ✓ Deep burial to be done away from source of water
- ✗ Don't mix infectious waste with non-infectious waste
- ✗ Don't chemically treat incinerable waste

## Instrument Processing options for MVA Plus aspirator and Easygrip cannula

Mentioned below are suitable options and behaviours to be necessarily followed for reusing MVA Plus aspirator and Easygrip cannulae. Standard operating protocols for instrument processing are to be carefully followed. Using chemicals and processing methods other than the ones mentioned here can be harmful.

### Essential elements of Infection Prevention:

- ✍ Washing hands before and after contact with the woman.
- ✍ To treat blood and other body fluids of all women as infectious.
- ✍ Personal protective barriers (like - gloves, gown, face mask and shoes) are to be used if there are chances of coming in contact with the blood and other body fluids.
- ✍ No touch technique to be used. Tips of the instruments should not touch any contaminated surfaces including woman's vaginal walls before being inserted into the uterus.

All the instruments should be kept wet before cleaning for reuse. 0.5% Chlorine solution can be used for this purpose.

Instrument processing options	MVA plus 	EGC 
<b>Sterilization</b>		
1. Steam autoclave the disassembled aspirator/cannula wrapped in paper/linen for 30 minutes at 121 degree centigrade (250 degree F) and pressure of 106 K Pa (15 lbs/inch <sup>2</sup> )	✓	✓
2. Fully immerse aspirator/cannula in 2% glutaraldehyde solution for 10 Hrs.	✓	✓
<b>High-level Disinfection (HLD)</b>		
1. Rolling boil the disassembled aspirator/cannula for 20 minutes.	✓	✓
2. Fully immerse the disassembled aspirator/cannula in 2% glutaraldehyde solution for 20 minutes.	✓	✓
3. Fully immerse the disassembled aspirator/cannula in 0.5% chlorine solution for 20 minutes. Daily prepare a fresh solution.	✓	✓
<b>Storage</b>	<ul style="list-style-type: none"> <li>• Immediately use aspirator/cannula after processing</li> <li>• Store HLD processed aspirator/cannula in dry and covered HLD tray for not more than 24 hours</li> <li>• Store sterilized aspirator/cannula in sterilized drum for not for more than 7 days</li> </ul>	



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

**Chapter 8**  
**VACUUM**  
**ASPIRATION**  
**(VA)**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 8. Vacuum Aspiration (VA)

## Contents

Self Assessment Tool

Indications and Contraindications for Vacuum Aspiration (VA)

MVA Equipment and Procedure:

- a. Parts and Features of MVA Kit (Aspirator and Cannula)
- b. Pain Management Plan
- c. Steps for Performing MVA Procedure
- d. Solving Instrument Related Problems

Electric Vacuum Aspiration (EVA):

- a. Parts and Features of EVA Equipment
- b. Pain Management Plan
- c. Steps for Performing EVA Procedure
- d. Solving Instrument Related Problems

Post-procedure Care

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) Safe methods for first trimester abortion are:
  - a. D & C
  - b. MVA
  - c. EVA
  - d. b and c
  
- 2) MVA aspirator and cannula:
  - a. Should be used only once
  - b. Do not have to be sterilized before each procedure
  - c. Should not be processed immediately after use
  - d. Can be boiled as well as autoclaved
  
- 3) Which of the following CANNOT be associated with vacuum aspiration?
  - a. Vagal reaction
  - b. Pelvic infection
  - c. Migraine headaches
  - d. Uterine/cervical injury
  
- 4) Signs that indicate that a woman is ready for discharge are:
  - a. Her vital signs are normal
  - b. Bleeding and cramping have decreased
  - c. She is conscious
  - d. All of the above
  
- 5) A follow-up visit for abortion care should be scheduled:
  - a. After the woman has her first menstrual cycle
  - b. Within one to two weeks of the procedure
  - c. Only for women with severe complications
  - d. Only at the same facility where the woman received abortion care

- 6) Which of the following is a possible reason for POC not being visible during post-procedure tissue inspection:
  - a. Ectopic pregnancy
  - b. Non pregnant uterus
  - c. Uterine anomaly
  - d. All of the above
  
- 7) Which of the following are signs of completion of the VA procedure:
  - a. Gritty sensation inside the uterine cavity through the cannula
  - b. Cervix gripping over the cannula
  - c. Red or pink foam without tissue passing through cannula
  - d. All of the above

# Vacuum Aspiration (VA)

Vacuum Aspiration can be performed using either MVA or EVA. The primary difference between the two vacuum aspiration options is the source of the vacuum: Manual Vacuum Aspiration (MVA) uses a hand-held, portable aspirator, whereas Electric Vacuum Aspiration (EVA) employs an electrically operated device which is referred to as the EVA or suction machine.

## Indications and Contraindications for VA

Indications	Contraindications
<ul style="list-style-type: none"> <li>Termination of pregnancy upto 12 weeks uterine size according to examination or LMP</li> <li>Treatment of incomplete abortion upto 12 weeks LMP</li> <li>Missed abortion upto 12 weeks LMP</li> <li>Molar pregnancy (Hydatidiform Mole)</li> </ul>	<ul style="list-style-type: none"> <li>Termination of pregnancy of uterine size/ gestation age more than 12 weeks</li> <li>Incomplete abortion of uterine size more than 12 weeks</li> <li>Acute cervicitis/PID</li> <li>Multiple fibroids</li> <li>History of bleeding disorder</li> <li>Suspected uterine perforation</li> </ul>
Caution to be used in pre-existing medical conditions	

## MVA Equipment and Procedure

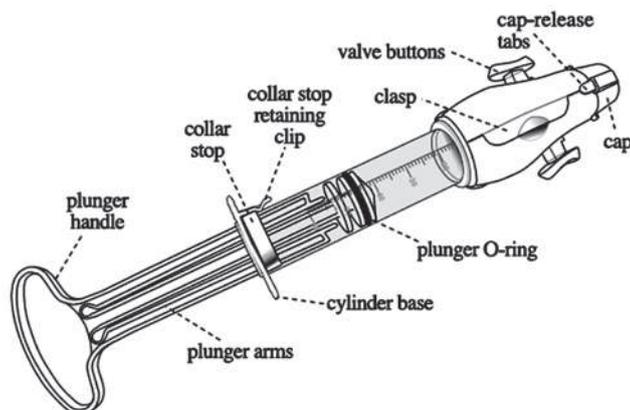
### Parts and Features of MVA Kit (Aspirator and Cannula)

#### Manual Vacuum Aspirator

MVA aspirator has the following parts: cylinder, plunger, valve assembly, cap, liner, collar stop, O-ring.



Parts of  
MVA Aspirator



Assembled MVA Aspirator

### Functions of different parts of the aspirator are:

- **60 cc cylinder:** holds the products of conception for up to 12 weeks gestation
- **Plunger:** is pulled out to create vacuum
- **Collar stop with retaining clip:** prevents the plunger from coming out of the cylinder
- **Valve assembly:** includes hinged valve with cap, removable liner and valve buttons. It controls the release of the vacuum. The advantage of double valve aspirator is that it can be used for pregnancy termination upto 12 weeks.

### Steps to disassemble and reassemble the MVA Aspirator

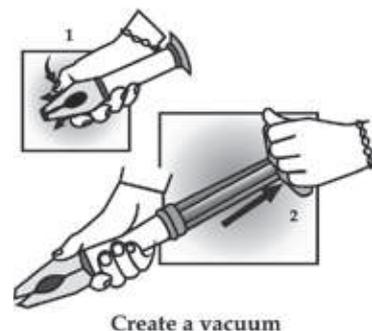
Disassembling the MVA Aspirator	Reassembling the MVA Aspirator
<ol style="list-style-type: none"><li>1. Pull apart the cylinder and plunger from the valve assembly</li><li>2. Press cap-release tabs to remove cap in the valve assembly unit</li><li>3. Open hinged valve by pulling open the clasp</li><li>4. Remove valve liner</li><li>5. Disengage collar stop by sliding under retaining-clip. Pull plunger completely out of cylinder</li><li>6. Displace O-ring by pressing its sides and rolling it down into groove below*</li></ol> <p><i>*Sharp objects should never be used to remove the O-ring, as it can damage the ring.</i></p>	<ol style="list-style-type: none"><li>a. Place valve liner in the valve by aligning ridges</li><li>b. Close valve; ensure it snaps into place.</li><li>c. Put the cap onto end of valve assembly unit</li><li>d. Push cylinder straight upto the base of valve</li><li>e. Place O-ring into groove near tip of plunger</li><li>f. Spread one drop of lubricant around O-ring with finger</li><li>g. Press plunger arms, push them straight into cylinder</li><li>h. Insert collar stop tabs into holes in cylinder</li><li>i. Move plunger in and out to lubricate</li></ol>

It is important to use only one drop of lubricant because over-lubrication can interfere with vacuum capability. Silicon oil and non-petroleum based lubricants such as K-Y Jelly and Glycerol can be used as lubricants.

### Charging the Aspirator

- Begin with open valve buttons, plunger all the way in
- Push valve buttons down and forward until they lock
- Pull plunger back until both its arms catch on the wide sides of cylinder

*Note that the charged aspirator should never be grasped by the plunger arms because this can eject its contents.*



## Check Aspirator for Vacuum

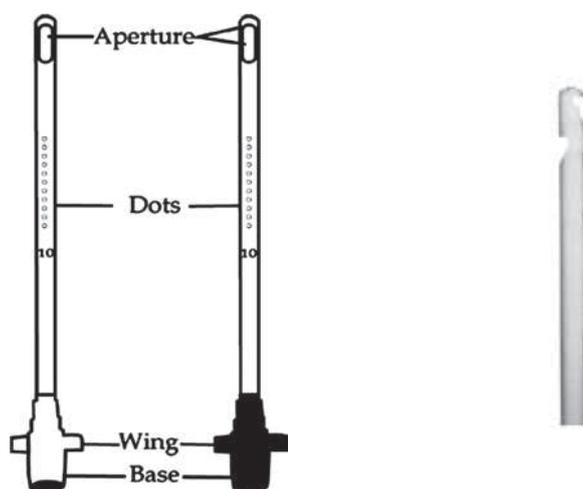
Charge the aspirator. Leave it charged for a minute. Press the valve buttons to release vacuum. A rush of air indicates vacuum was created. The aspirator retains the vacuum until it is 80% that is 50 ml full after which the contents should be emptied and the vacuum recreated.

The various reasons of vacuum failure in the aspirator could be:

1. Aspirator is not properly assembled
2. O-ring not properly positioned
3. Cylinder not firmly seated on valve assembly

The MVA aspirator needs to be **replaced** if the cylinder is cracked; if there are mineral deposits that inhibit plunger movement; if the valve is cracked, bent or broken; if the plunger arms do not lock; or if the aspirator no longer holds vacuum.

## Cannula



Easy Grip Cannulae

- Have permanently affixed base with wings
- Available in different sizes from 4 to 12 mm
- The sizes 4, 5, 6, 7 and 8 have two opposing apertures and sizes 9, 10 and 12 have one larger, single-scoop aperture
- Dots on each cannula: The first dot is located 6 cm from the tip of the cannula and the remaining dots are at 1 cm interval from it (the dots help in measuring the length of the uterine cavity)
- Each cannula is sterilized with ethylene oxide (ETO) before packaging and will remain sterile for three years from the date of sterilization or when opened, whichever is earlier
- Cannulae can be reused after sterilization/HLD

## Selection of Cannula

The size of the cannula to be used during the procedure depends on the uterine size, period of gestation and amount of dilatation required to aspirate the POCs. The suggested number of the cannula as per the uterine size is:

### Use of Cannula According to Uterine Size

Uterine size	Suggested cannula size
4-6 weeks LMP	4-6 mm
7-9 weeks LMP	6-8 mm
10-12 weeks LMP	8-10 mm

**It is important to use a cannula appropriate to the size of the uterus and amount of cervical dilatation required. Using a cannula that is too small/big may result in retained tissue or loss of vacuum.**

The cannula needs to be replaced if it is cracked, twisted or bent, especially near the tip or if the tissue cannot be removed from its body while cleaning.

If routine protocols of maintenance of equipment are followed, cannula can be reused upto a minimum of 50 times and aspirator upto 200 times.

## Pain Management Plan

Managing pain appropriately during the MVA procedure is an important component of high quality abortion care. Each woman's response to pain varies. The goal is to reduce pain and anxiety, make her as comfortable as possible and minimize medication induced risks and side effects. The plan should be based on the woman's individual needs and preferences and decided by the woman and provider.

Sources of pain during VA could be psychological (anxiety, fear, and apprehension heighten the sensitivity to pain); during cervical dilatation; during the movement of the cannula against the uterine walls; and the uterine contractions.

Pain management during the VA procedure has two components:

1. Non pharmacological:
  - Providing psychological support
  - Explaining each step to the woman in advance
  - Performing the procedure gently and smoothly
  - Encouraging the woman to relax and breathe deeply

2. Pharmacological (use of medication):

The following drugs can be used for pain management:

- Anxiety: Anxiolytics, General anaesthesia
- Cervical dilatation: Local anaesthesia, Analgesics
- Uterine cramping: Analgesics

The following table shows the specific drugs that can be used for pain management, the dosage, duration of effect and the side effects of the drugs:

Source of pain and its management	Dose and timing	Duration of effect	Side effects
<b>Anxiety</b> 1. Anxiolytics i.e. Diazepam 2. General anaesthesia	Diazepam 10 mg orally one hour prior to procedure or 2-5 mg IV 20 minutes prior to procedure	4-6 hours	<ul style="list-style-type: none"> <li>• Disorientation</li> <li>• Dizziness</li> </ul>
<b>Cervical dilatation</b> 1. Lignocaine/Local Anaesthesia 2. Analgesics (NSAID): Ibuprofen	10 ml of 1% lignocaine  400-800 mg one hour prior to the procedure	60-90 minutes  4-6 hours	<ul style="list-style-type: none"> <li>• Dizziness</li> <li>• Seizures</li> <li>• Gastritis</li> </ul>
<b>Uterine cramping</b> 1. Analgesics: Ibuprofen	400-800 mg one hour prior to the procedure	4-6 hours	<ul style="list-style-type: none"> <li>• Gastritis</li> </ul>

**A Paracervical block, using local anaesthesia is very effective. It ensures that the woman is responsive during the procedure, recovers early and reduces hospital stay.**

Precautions during paracervical block:

- Always aspirate before injecting
- Maximum dose not to exceed 4.5 mg/kg or 200 mg
- In case of mild reaction (itching, rashes etc.) give 25-50 mg of Diphenhydramine IV or IM.

**Recommended pain management for VA procedure: verbal reassurance; paracervical block and oral analgesics**

## Steps for Performing MVA Procedure

1. Prepare instruments
2. Prepare the woman
3. Perform cervical antiseptic preparation
4. Administer paracervical block
5. Dilate cervix
6. Insert cannula
7. Suction of uterine contents
8. Inspect tissue
9. Concurrent procedures
10. Instrument processing

## Steps of MVA Procedure

### Step 1: Prepare instruments

- Check that the aspirator retains vacuum as described earlier
- Check the availability of all appropriate sized cannula, as per uterine size

### Step 2: Prepare the woman for the procedure

- Ensure the woman has given her consent in Form C
- Ensure pain control medication is given at the appropriate time
- Ask the woman to empty her bladder
- Clean and drape the parts including the vaginal walls
- Perform bimanual examination to confirm position and size of the uterus

## Cervical Priming

It is not mandatory to perform pre-procedure cervical priming for all women.

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

*The commonly used method is* Tablet misoprostol 400 mcg administered orally or vaginally three to four hours before the procedure.

### Step 3: Perform cervical antiseptic preparation

- Cervix should be cleaned twice with povidone iodine swab under direct vision
- Follow 'No-Touch' technique while handling the instruments

Antiseptic cervical preparation is needed because resident vaginal flora can easily be introduced while inserting the cannula into the uterus during the procedure. The cervix and the vagina must be cleaned with povidone iodine (2.5%) prior to inserting any instrument. Leave for one to two minutes before processing. Iodophores such as povidone iodine require contact time to act.

Never use spirit/alcohol for vagina as it is painful for the woman; it dries and damages the mucous membrane, which may support the infection process.

## 'No-touch' Technique

The tips of instruments that enter the uterus should not touch any other surface, including gloved finger tips or vaginal walls. This is important because infection can start when vaginal or other flora is introduced into the uterus during the procedure.

#### Step 4: Administer paracervical block

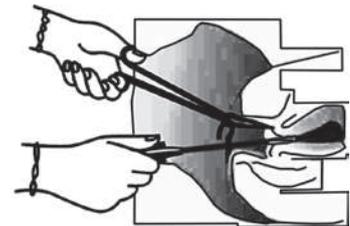
- Use Lignocaine one per cent (10 ml). Give the paracervical block using a 22-24 gauge needle. There is increasing evidence to show that pre-testing before the administration of local anaesthesia need not be mandatory
- Apply slight traction with the vulsellum/allis forceps to identify the area between the smooth cervical epithelium and the vaginal tissue. Insert the needle just under the epithelium to a depth of 2-3 mm at four and eight o'clock positions and inject 2-4 ml of Lignocaine at each site
- Always aspirate before injecting. If any blood is visible in the syringe, do not inject. Instead, move to a different injection site, and aspirate again before injecting
- Proceed with MVA after allowing 2-4 minutes for the local anaesthetic to be effective

#### Step 5: Dilate cervix

- Use progressively increasing sizes of cannula/dilator to dilate cervix so that cannula fits snugly in the os to hold vacuum

#### Step 6: Insert cannula

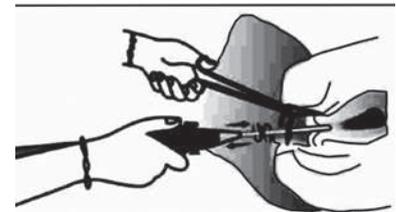
- Rotate the cannula while gently applying forward pressure
- Insert cannula slowly beyond the internal os



Insert cannula into uterus

#### Step 7: Suction of uterine contents

- Attach charged aspirator to cannula
- Release valve buttons to start suction and observe the POC flowing into the cylinder
- Gently rotate cannula 180 degrees in each direction
- Use a gentle 'in and out' motion
- Do not withdraw cannula opening beyond external os before the aspiration is complete



Suction of uterine contents

#### Signs of procedure completion

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

*When the procedure is complete*, push buttons down and forward to close valve. Disconnect cannula from aspirator.

## Step 8: Inspect tissue

- Empty contents of aspirator into a container through a strainer
- Look for POC with light underneath: villi and decidua should be visible
- Evaluate the amount of POC based on estimated length of pregnancy

If the aspirated contents do not conform to the estimated duration of pregnancy, consider the following:

1. Ectopic pregnancy
2. Incomplete abortion
3. Uterine anatomical variation preventing evacuation of POC
4. Wrong dates

*If the procedure is apparently complete*, wipe the cervix with a swab to assess bleeding and perform bimanual examination to check uterine size and firmness, if required.

## Step 9: Concurrent procedures

Tubal ligation or IUCD insertion procedures can be done along with the MVA procedure if the woman requests for it. **However, accepting a concurrent contraceptive method should not be a prerequisite to providing MVA services.**

**The POCs are to be disposed in the yellow bag or poured into the drain after disinfection.**

## Step 10: Instrument Processing

- Immerse the aspirator in chlorine solution/bleaching solution after rinsing and disassembling.
- Refer to Chapter 7 on 'Infection Prevention' for further details

## Solving Instrument Related Problems

**Vacuum can decrease unexpectedly during the procedure in case of the following problems:**

1. Aspirator is full of POC/blood
2. Cannula is withdrawn out of cervical opening
3. Cannula aperture is clogged

*Resolving these problems:*

1. If the aspirator is full with POC/blood:
  - Close valve buttons
  - Detach cannula and leave it in uterine cavity
  - Open valve buttons; press plunger arms to empty the aspirator
  - Recharge aspirator
  - Reattach aspirator to cannula and continue evacuation

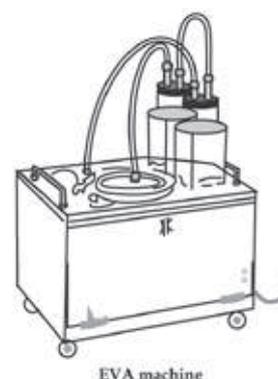
2. If the cannula is accidentally withdrawn out of the cervical opening:
  - Remove cannula and aspirator; without touching vaginal walls
  - Detach and reinsert the cannula into the uterine cavity
  - Empty aspirator and recharge it
  - Re-attach aspirator to cannula and continue evacuation
3. If the cannula aperture gets clogged:
  - Close valve buttons and withdraw aspirator and cannula out of uterus
  - Remove tissue clogging the cannula aperture using tissue/artery forceps
  - Re-insert cannula and continue evacuation

## Electric Vacuum Aspiration

EVA uses an electric pump or suction machine attached to a cannula to evacuate uterine contents. EVA is typically used in centralized settings with higher case loads.

### Parts and Features of EVA Equipment

The EVA equipment consists of an electrically operated suction machine and a set of Karman cannulae. Karman cannulae are available in all sizes for the purpose of uterine evacuation. Cannulae are either available with or without adapter for connecting to the suction tube. The cannula without the adapter can be directly fitted into the tube.



### Pain Management Plan

Pain management plan for EVA procedure is same as for MVA procedure.

### Steps for Performing EVA Procedure

The basic steps of performing MTP with EVA are very similar to MVA.

Steps 2 to 6 are same for both EVA and MVA.

Step 7: Evacuation of the uterine contents: insert the cannula (pre-attached to the suction tube) in the uterine cavity. Switch on the suction machine to build up the suction levels to 25–26 inches/600–660 mm Hg. It provides a constant level of vacuum after it has reached the desired level for sucking out the uterine content.

### Solving Instrument Related Problems

1. Vacuum pressure is not built upto the optimum level: This could be because the connection between the cannula and suction tube is loose; suction jar is filled with POC; or the jar lid is not snugly fit.

2. The cannula is accidentally withdrawn out of the cervical opening: In this case, switch off the suction machine, reinsert the cannula into the uterine cavity, switch on the machine, build the suction levels and continue evacuation.
3. The cannula aperture gets clogged: Switch off the suction machine, pull out the cannula from the uterine cavity, remove tissue clogging the cannula using tissue/artery forceps, reinsert cannula, switch on the machine and continue evacuation.

After the procedure has been completed, it is important to ensure post-procedure care to the woman.

## Post-procedure Care

Elements of post-procedure care:

1. **Physical monitoring:** this includes taking her vital signs, evaluating abdominal pain and evaluating bleeding per vaginum, which should decrease over time
2. **Provide emotional support:** this includes giving verbal reassurance to the woman, alleviating her anxiety after the procedure
3. **Contraceptive counselling:** woman may be re-counseled for regular contraceptive methods to prevent future unwanted pregnancies if she has not already accepted a method of contraception
4. **Addressing other health issues:** anaemia, Reproductive Tract Infections (RTIs), HIV, violence, cancer screening
5. **Providing discharge instructions:** These are:
  - Antibiotics: give broad spectrum antibiotics for five days. Providing antibiotics to women undergoing VA reduces chance of infection
  - Pain management: give analgesics, NSAID
  - Uterine cramping may occur over the next few days, similar to that of a normal menstrual period
  - Resume normal diet on the same day
  - Restrict activity for next three days
  - Avoid intercourse until a week or till bleeding stops
  - A normal menstrual period should begin within the next four to six weeks
  - Report back to the provider, if experiencing any of the symptoms listed below

For most women, the in-facility recovery period will last 30 minutes to an hour if done under local anaesthesia or may require longer when sedation or general anaesthesia is used.

**Conditions requiring immediate attention post-procedure are:**

- Abnormal vital signs (tachycardia, hypotension)
- Dizziness or fainting (including transient vasovagal reaction)

- Excessive vaginal bleeding (retained POC, uterine atony, cervical laceration or uterine perforation)
- Severe abdominal pain or cramps: may be a sign of uterine perforation

### **Conditions requiring attention during recovery period:**

It is essential to know about symptoms and signs of complications during recovery period:

- fever
- chills
- fainting
- vomiting
- distended
- tender abdomen
- foul-smelling discharge per vaginum
- cramping
- bleeding more than normal menses
- delay in resumption of menstruation (more than six weeks)

## **Follow-up Care**

After a VA procedure, the follow-up visit should be scheduled within next one to two weeks. Ensure the following are assessed during the follow-up visit:

- Physical status and vital signs
- Fever
- Bleeding per vaginum
- Determine whether symptoms of pregnancy, such as nausea and breast tenderness, have decreased or continued, in order to rule out continuing pregnancy
- Her fertility goals and need for contraception (provide counselling and contraceptive method if not already accepted)
- A pelvic examination should be done to rule out any continuation of pregnancy/sepsis/incomplete abortion, if required

## Summary

- Vacuum Aspiration (MVA and EVA) is a safe technology for uterine evacuation upto 12 weeks LMP
- An accurate clinical assessment, counselling and informed consent is a must before VA procedure
- Ideal pain control during VA is a combination of verbal reassurance, oral analgesic (30-60 minutes before the procedure) and paracervical block
- VA procedure should be performed as per the protocol
- Evacuated tissue should be inspected for chorionic villi
- Follow-up visit should take place within one to two weeks after a VA procedure

## Uterine Evacuation Procedure with MVA Aspirator

### Skills Checklist

Skill	Yes	No
1. <b>Prepares instruments</b> • Checks vacuum retention of aspirator		
2. <b>Prepares the woman</b> • Ensures informed consent; Asks woman to empty her bladder		
3. <b>Performs cervical antiseptic preparation</b> • Follows no-touch technique • Performs pelvic examination to confirm assessment findings		
4. <b>Administers paracervical block</b> • Injects 2-5 ml lignocaine at 4 and 8 o'clock positions, after aspirating • Uses positive, respectful, supportive reassurance		
5. <b>Dilates cervix</b> • Gently dilates cervix until cannula fits snugly		
6. <b>Inserts cannula and attach aspirator</b>		
7. <b>Suctions uterine contents</b> • Rotates cannula 180 degrees in each direction and uses an 'in and out' motion		
8. <b>Inspects tissue</b> • Empties aspirator into container and looks for POC		
9. <b>Completes concurrent procedures</b> • Assesses bleeding • Provides contraception		
10. <b>Instrument processing</b>		

Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

# **Chapter 9** **COMPLICATIONS** **OF ABORTIONS**

vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 9. Complications of Abortions

## Contents

Self Assessment Tool

Complications During Abortion Procedure

Management of Abortion Complications

Management Options at Different Levels of Health Facilities

After Care of Complications

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) Retained products of conception/incomplete abortion:
  - a. Is indicated by vaginal bleeding and pain abdomen
  - b. Can lead to infection
  - c. Is treatable by vacuum aspiration
  - d. All of the above
  
- 2) Continuing pregnancy:
  - a. Is the same as failed abortion
  - b. Is common following surgical abortion especially MVA
  - c. After MMA, has no possibility of congenital malformations in the foetus
  - d. Is unheard of with dilatation and curettage (D&C)
  
- 3) A condition that occurs due to inability of the uterus to contract is:
  - a. Disseminated Intravascular Coagulopathy (DIC)
  - b. Asherman's Syndrome
  - c. Uterine atony
  - d. Uterine perforation
  
- 4) Managing abortion complication entails:
  - a. Staff knowing how to recognize and treat a complication
  - b. Referral for conditions that cannot be fully treated on site
  - c. Both a and b
  
- 5) After-care for women with complications includes providing:
  - a. Close monitoring
  - b. Information about follow-up
  - c. Counselling on medical and emotional consequences
  - d. All of the above

- 6) Abortion procedures performed by trained providers:
  - a. Rarely result in complications
  - b. Still can lead to infection and/or retained POC
  - c. Quite often leads to infertility
  - d. Both a and b

# Complications of Abortions

Providers encounter two types of abortion complications during service provision: complications that occur while the provider is him/herself performing the procedure and complications due to procedures done outside the facility by someone else. All complications should be managed as per standard protocols.

## Complications During Abortion Procedure

When performed by a trained provider, an abortion procedure rarely results in immediate or delayed complications. In many cases, complications can be avoided by accurately estimating the duration of pregnancy; by ensuring that the woman has passed urine before examination as well as before procedure; and by being alert in lactating women. When dealing with complications, a provider must be well prepared to diagnose them and provide treatment quickly or make referrals to an appropriate facility after stabilizing the woman.

Possible complications **during an abortion procedure** could be:

- a. Haemorrhage
- b. Perforation of uterus
- c. Shock
- d. Anaesthetic complications

Possible complications **after the abortion procedure** (these can present when a procedure has been conducted by the provider him/herself or by another provider):

- i. Shock
- ii. Secondary haemorrhage
- iii. Infection/sepsis
- iv. Continuation of pregnancy

**Sequelae (long term complications):**

- a. Continuation of pregnancy
- b. Asherman's syndrome
- c. Pelvic Inflammatory Disease (PID)

# Management of Abortion Complications

## a. Haemorrhage/Excessive Vaginal Bleeding

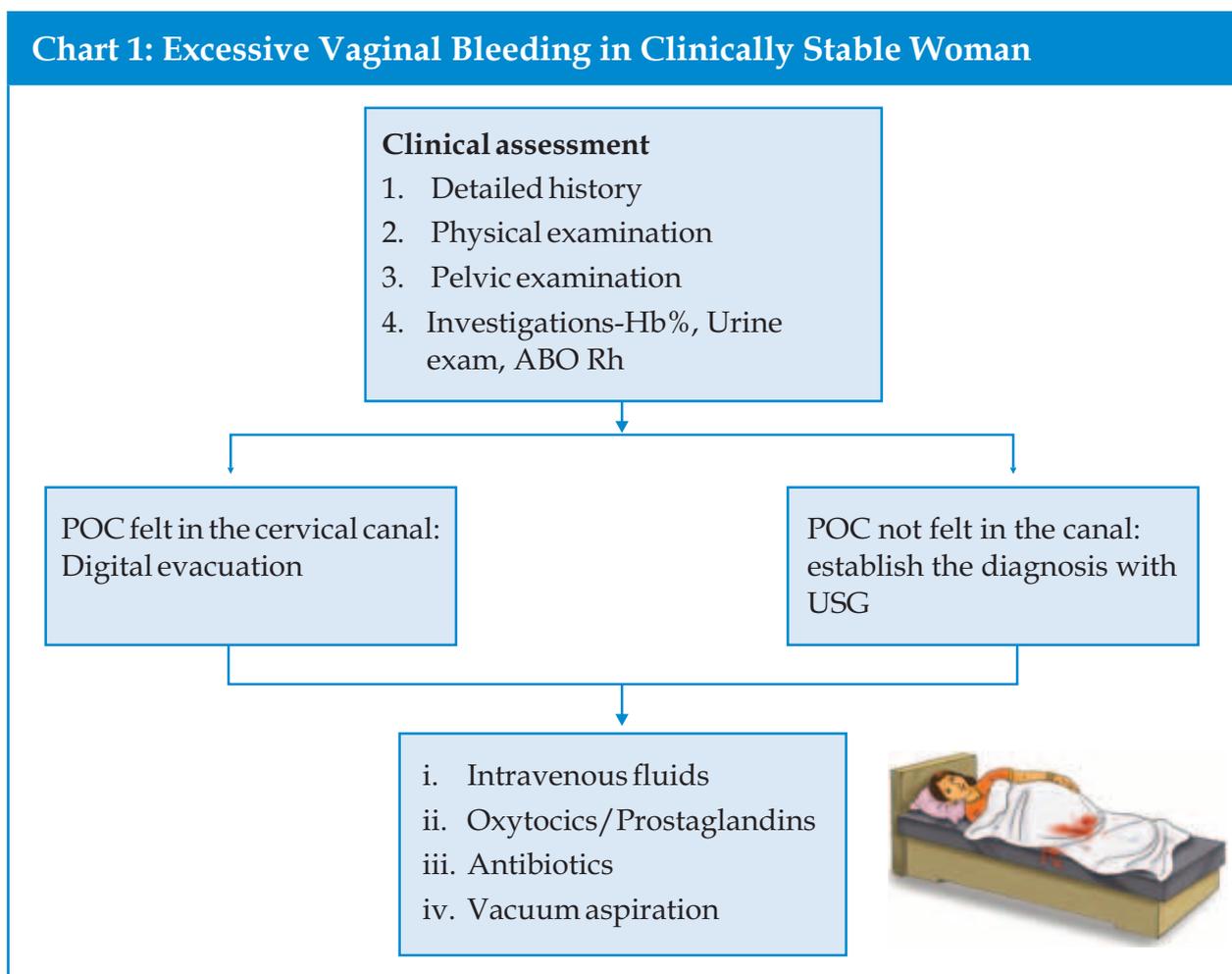
The main causes of excessive vaginal bleeding are:

- Retained products of conception
- Trauma/lacerations of cervix
- Trauma to uterus, including perforation
- Uterine atony

Though most of the women presenting with excessive vaginal bleeding will be clinically stable, we should, however, not delay the treatment, because the condition can worsen anytime, if left untreated.

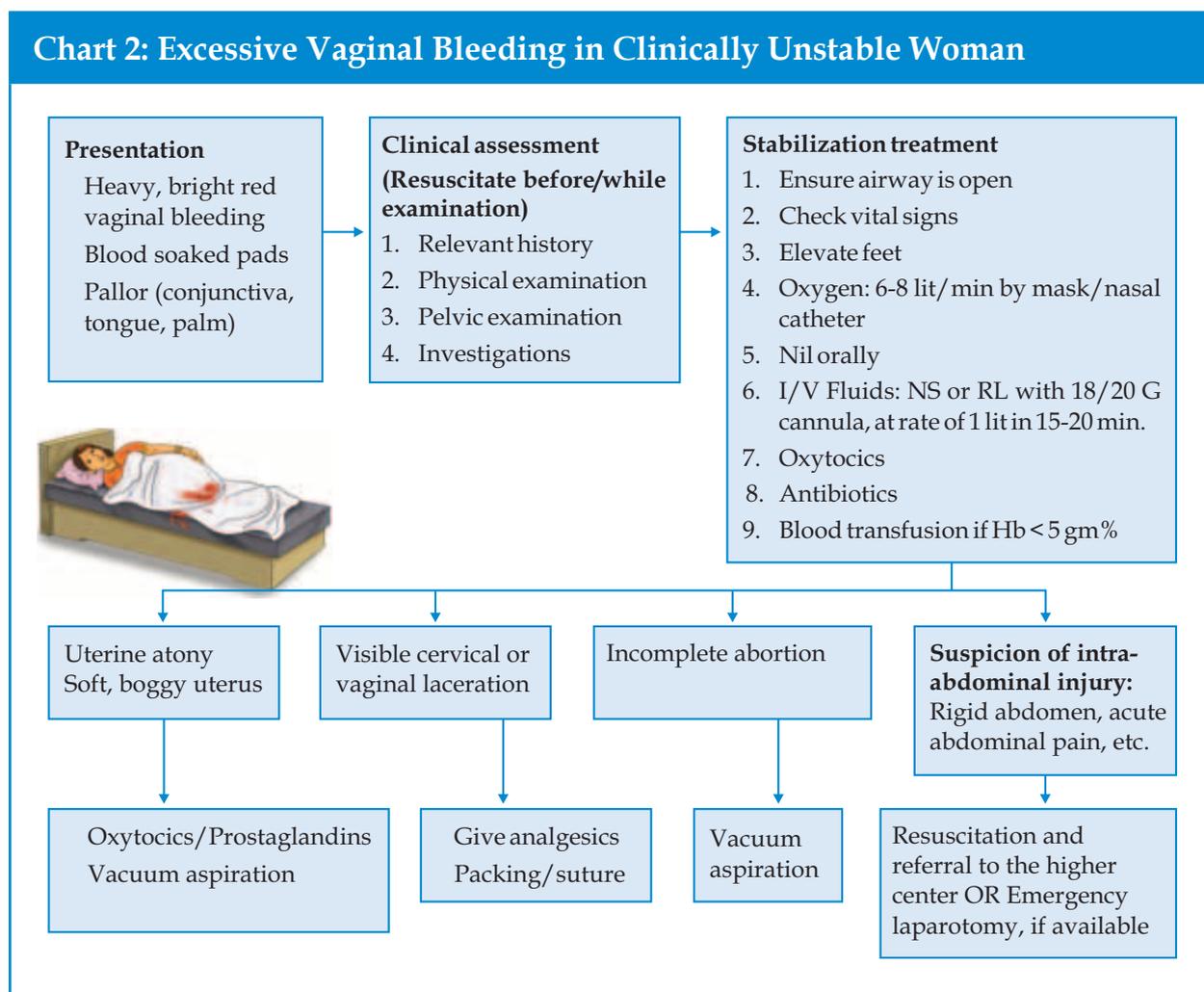
### (i) Excessive Vaginal Bleeding with Clinically Stable Woman

For management of clinically stable woman with excessive vaginal bleeding, refer to Chart 1 below:



## (ii) Excessive Vaginal Bleeding in Clinically Unstable Woman

If the woman is clinically unstable following excessive vaginal bleeding, refer to Chart 2 below for further management:

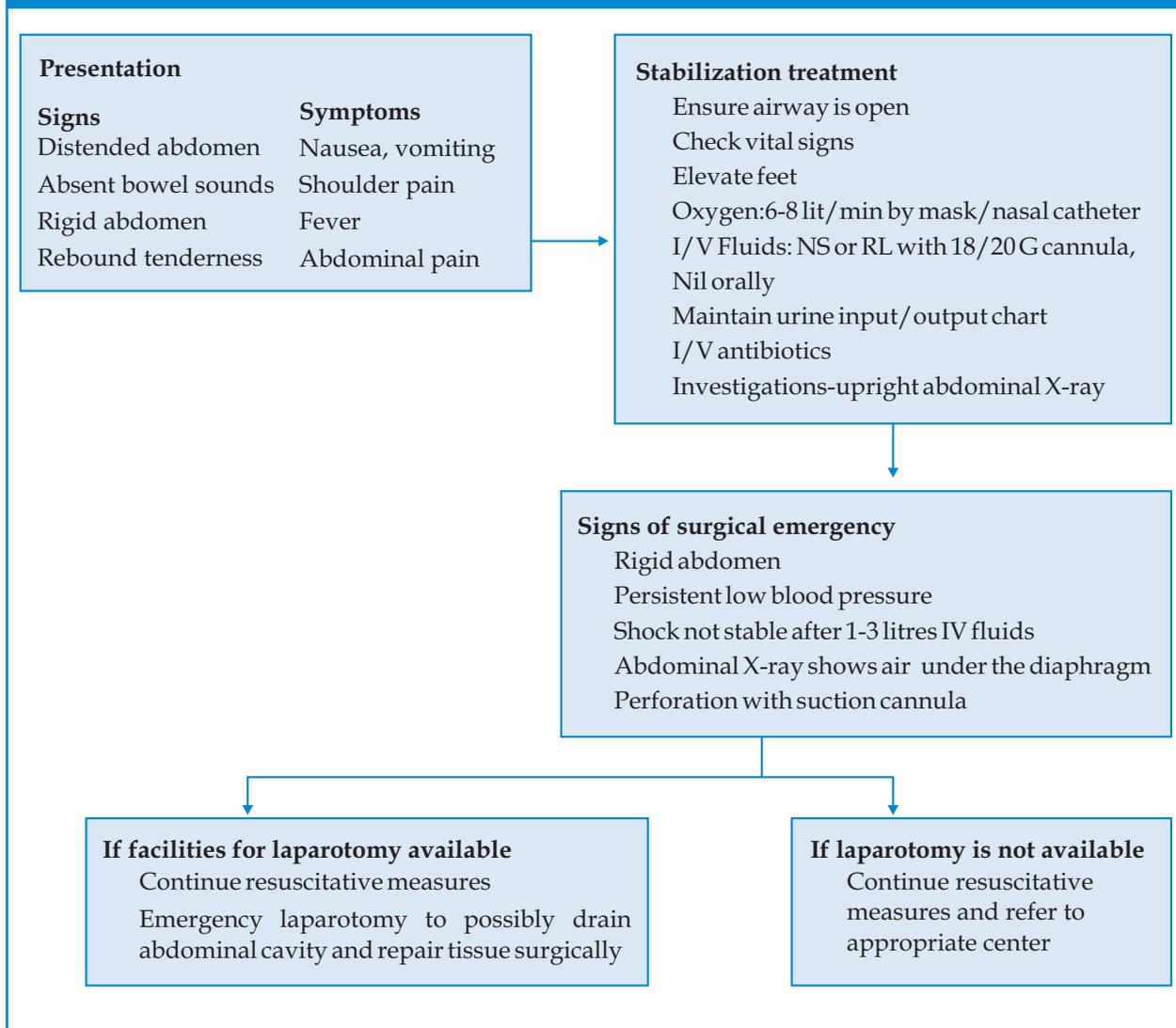


**(iii) If the excessive vaginal bleeding is associated with shock, refer to Chart 5 on the management of shock.**

## B. Uterine Perforation

Uterine perforation usually presents itself with signs of distended abdomen, rigid abdomen and sometimes pain in the shoulder. Management of uterine perforation can be done as per protocols given in Chart 3:

### Chart 3: Uterine Perforation



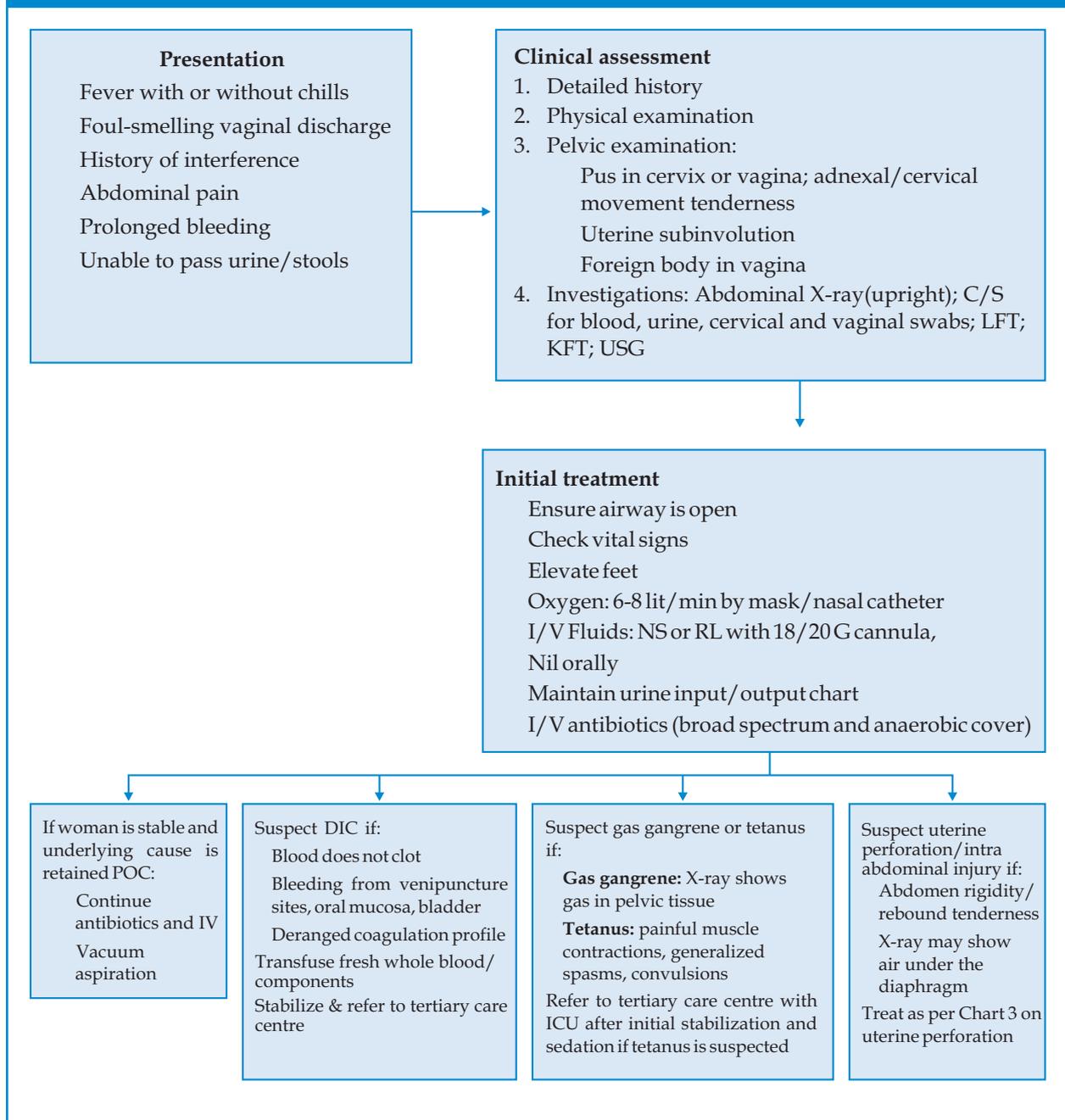
### C. Infection/Sepsis

Unsafe abortion has a high risk of complications from infection; both from the pathogens (micro-organisms) introduced during the procedure into the uterus and from retained products of conception. Localized infection can quickly lead to more generalized sepsis and septic shock, which can be fatal.

Common symptoms of post-abortion sepsis include fever, abdominal pain and foul-smelling discharge from the vagina.

**Management of sepsis can be done as per the protocol shown in Chart 4:**

## Chart 4: Sepsis



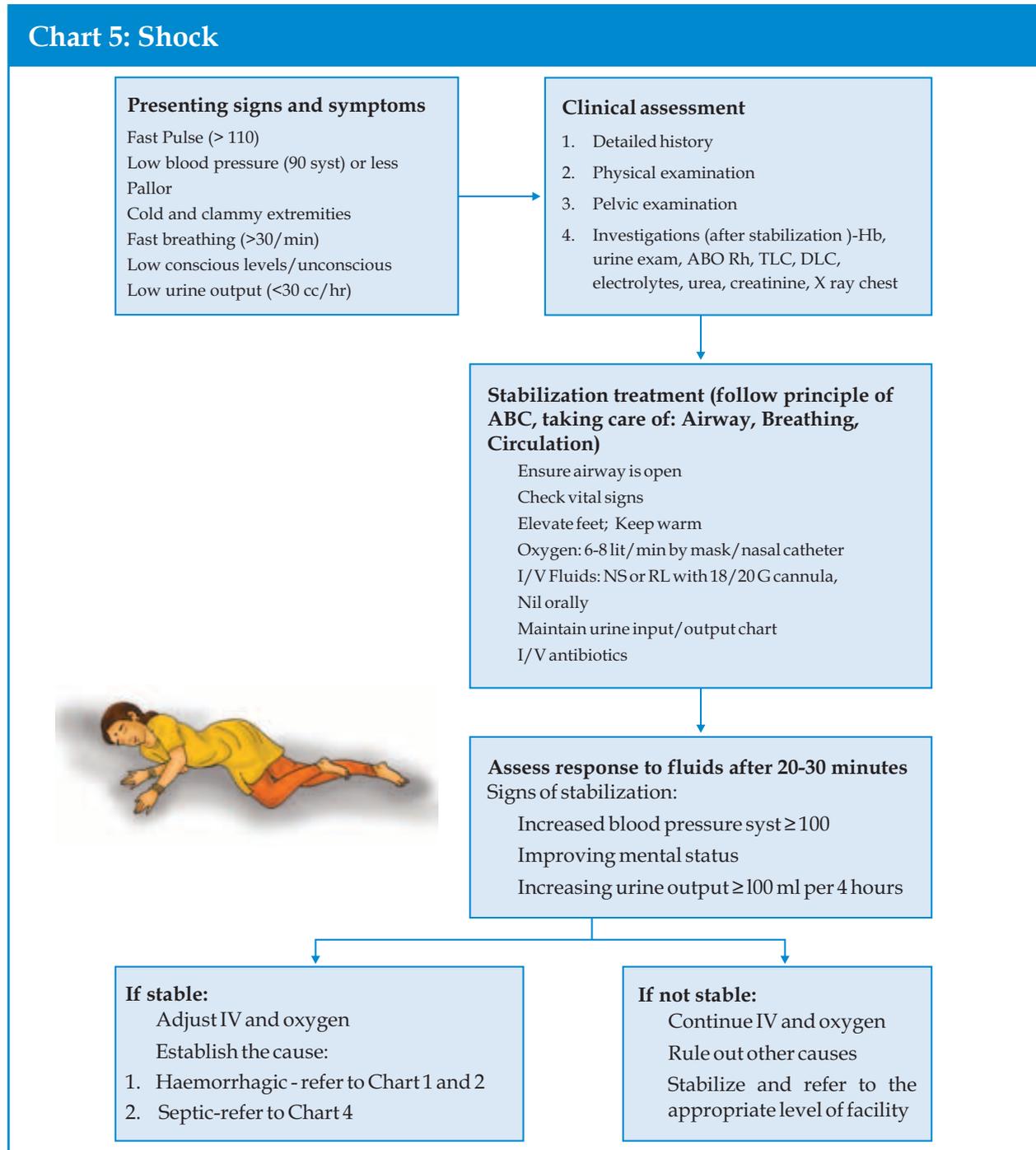
## D. Shock

Shock is a life threatening condition and requires immediate and intensive treatment to save the woman's life. In case of abortion care, shock is usually caused by:

- i. Haemorrhage (haemorrhagic, hypovolaemic shock) due to incomplete abortion
- ii. Sepsis (septic shock) due to infection following either tissue trauma or incomplete abortion
- iii. Vasovagal reaction due to rapid cervical dilatation

Shock can progress from early and mild stage to late and severe condition, hence treatment should be promptly provided. The woman should be quickly stabilized followed by establishing the diagnosis and managing accordingly.

Manage the woman as per protocols given under Chart 5:



## Sequelae Following Abortion Procedure:

- a. **Continuation of pregnancy:** if the menstrual cycles are not resumed within four to six weeks of the abortion procedure or the pregnancy signs and symptoms persist even after the procedure, continuation of pregnancy should be suspected. Vacuum aspiration should be offered to terminate the pregnancy.
- b. **Asherman's syndrome:** women with this condition present with amenorrhea due to formation of adhesions within the uterine cavity. She should be referred to appropriate level of health care for treatment.
- c. **Pelvic Inflammatory Disease:** It could be a consequence of infection either during or after the procedure and can sometimes lead to infertility or increased risk of ectopic pregnancy.

## Management Options at Different Levels of Health Facilities

All the potential complications cannot be managed at all levels of health facilities. It is best to stabilize the woman and refer her to the appropriate level of care for further treatment.

The chart below shows management protocols for different levels of facilities

### Management Options at Different Levels of Facilities

At Primary Level (PHC and CHC level by Doctor, Nurse, ANM)	At Secondary/Tertiary Level Hospital (District Hospital and Medical College)
<ul style="list-style-type: none"> <li>• Initial clinical assessment of woman coming with abortion complications</li> <li>• Initiation of resuscitation/stabilization treatments including antibiotic therapy, intravenous fluid replacement and oxytocics</li> <li>• Diagnosis of the type of abortion complication</li> <li>• Investigations- haemoglobin, blood grouping and cross matching</li> <li>• Preparation for definitive treatment or referral to an appropriate facility for further management and care</li> <li>• Uterine evacuation</li> </ul>	<ul style="list-style-type: none"> <li>• All services provided at the primary level</li> <li>• Blood cross matching and transfusion, USG, X ray abdomen and other relevant investigations</li> <li>• Laparotomy and indicated surgery</li> <li>• Treatment of severe complications (bowel injury, tetanus, renal failure, gas gangrene etc.)</li> <li>• Treatment of Disseminated Intravascular Coagulopathy (DIC)</li> </ul>

## After Care of Complications

A woman who has experienced abortion complications should be:

- Given physical and emotional support
- Advised about medications to be taken, contraception and follow-up visit
- Counseled about her condition and any resulting life changes required
- Given written instructions for care after discharge, according to her individual need and clinical status

### Summary

- Complications such as sepsis, haemorrhage and tissue injury are responsible for maternal morbidity and mortality related to abortion care
- Universal stabilization measures should be provided to all cases of abortion complications and definitive management should be started immediately after establishing the diagnosis
- Since primary level facilities cannot treat all types of abortion complications, timely referral after stabilizing the woman helps in the definitive treatment



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

**Chapter 10**  
**POST ABORTION**  
**CONTRACEPTIVE**  
**CHOICES**

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination



# 10. Post-abortion Contraceptive Choices

## Contents

Self Assessment Tool

Contraceptive Counselling:  
a. Importance of Contraceptive Counselling  
b. Barriers to Contraception

Eligibility for Contraceptive Methods

Misconceptions about Contraceptive Methods

Emergency Contraception

Summary

## Self Assessment Tool

Please encircle the correct response:

- 1) All women receiving abortion care services should use contraception immediately afterwards  
- True or False
- 2) One of the reasons of contraceptive failure is that counsellors do not adequately explain to women how to use the method - True or False
- 3) Free and informed choice means that a woman chooses a method voluntarily that is, without anyone forcing her to use a particular method - True or False
- 4) Including partners in contraceptive counselling can increase the effectiveness of the counselling and method use - True or False
- 5) In abortion care facilities where contraceptive services are not offered, what are the key points counsellors must tell every woman receiving abortion care (tick all that apply)?
  - a. She could become pregnant even before the first menstrual cycle after abortion procedure
  - b. Women who have an abortion procedure do not need contraception till they have had three normal menstrual cycles
  - c. Where and how she can obtain contraceptive services and methods
  - d. There are very few contraceptive methods that can be used after an abortion
- 6) Insertion of IUCD is not recommended in which of the following conditions:
  - a. Past history of ectopic pregnancy
  - b. Pus like discharge from the cervix
  - c. Both a and b
- 7) Which of the following methods would not be appropriate for a woman with pelvic infection?
  - a. Condoms
  - b. Oral Contraceptive Pills
  - c. Female sterilization
  - d. Hormonal Patches

# Post-abortion Contraceptive Choices

Since ovulation can occur soon after an abortion, contraception should be provided immediately after the procedure to help the woman prevent or delay pregnancy.

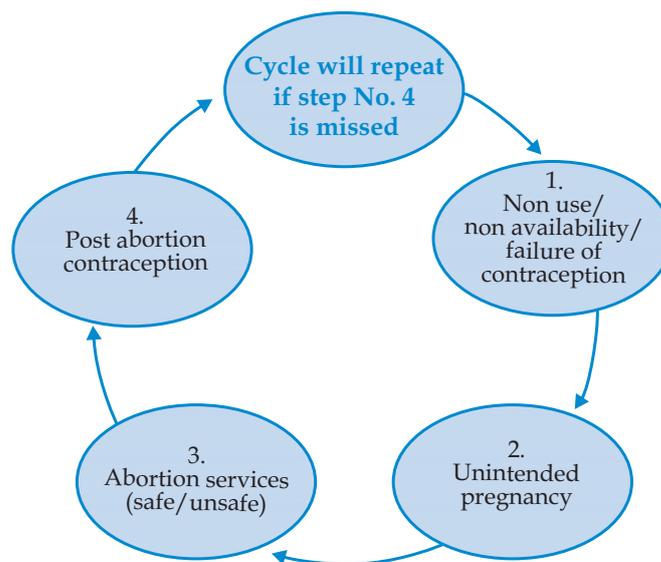
## Contraceptive Counselling

Contraceptive counselling and provision of a suitable contraceptive method is an important component of CAC services.

### Importance of Contraceptive Counselling

A large number of women seek unsafe abortions in order to 'get out' of an unintended pregnancy and use it as a method of contraception. This is a powerful indication that women need more control over their fertility through safer and healthier ways. Providing contraceptive counselling and services as a part of abortion care can improve contraceptive acceptance and help break the cycle of repeat unintended pregnancies and their consequences, as shown in the diagram below.

#### Break Cycle of Unintended Pregnancy



A woman undergoing an abortion should be offered contraceptive counselling on a range of contraceptive methods available, so that she can choose a contraceptive method to control her future fertility from the basket of choices offered to her.

### Barriers to Contraception

Acceptance and uptake of contraception may be affected due to:

- a. Barriers in the health systems
  - lack of opportunities to make contraception a part of routine abortion care
  - requirement of multiple visits for abortion care

- b. Gaps in the woman’s knowledge level and support required:
- lack of awareness on the part of the woman that fertility can return immediately after an abortion
  - lack of awareness about complications due to repeated abortions
  - little societal support to the woman after an abortion procedure

## Eligibility for Contraceptive Methods

In general, all modern contraceptive methods can be used immediately following a first trimester abortion. After an abortion, when providing contraception to a woman, her eligibility for each method must be considered. Ensure:

- There are no severe complications requiring further treatment
- The woman receives adequate counselling and gives informed consent
- The provider screens the woman’s eligibility for a particular contraceptive method

## Contraceptive Methods Available

### Temporary methods:

- Barrier methods such as condoms (male and female)
- Hormonal methods such as oral contraceptive pills, progestin-only injectables
- Intrauterine Contraceptive Devices (IUCDs)



IUCD and injectables come under Long Acting Reversible Contraception (LARC)



### Permanent methods:

- Male sterilization
- Female sterilization



## Details of all Contraceptive Methods:

Method	Timing after First Trimester Abortion	Advantages	Remarks
Condoms (Male)	As soon as the woman resumes her sexual activity	<ul style="list-style-type: none"> <li>• Prevent STIs, including HIV/HBV</li> <li>• Safe. No hormonal side effects</li> <li>• Can be used without seeing health care provider</li> </ul>	<ul style="list-style-type: none"> <li>• Latex condoms may cause irritation to some people</li> <li>• May make sex less enjoyable for either partner</li> </ul>

Method	Timing after First Trimester Abortion	Advantages	Remarks
		<ul style="list-style-type: none"> <li>• Usually easy to obtain and sold at many places</li> <li>• Enables a man to take responsibility for preventing pregnancy</li> <li>• Effective immediately</li> <li>• Can be easily discontinued</li> </ul>	<ul style="list-style-type: none"> <li>• Small possibility of condom slipping off or breaking during sex, if not properly used or stored</li> <li>• Failure rate is 2/100 women*</li> </ul>
Female Condoms	As soon as the woman resumes her sexual activity	<ul style="list-style-type: none"> <li>• Prevent STIs, including HIV/HBV</li> <li>• Safe. No hormonal side effects</li> <li>• Effective immediately</li> <li>• It empowers woman to make her choice</li> <li>• 40% stronger than latex used in male condoms</li> </ul>	<ul style="list-style-type: none"> <li>• May make sex less enjoyable for either partner</li> <li>• Difficult to insert and remove</li> <li>• More expensive than male condoms</li> <li>• Failure rate is 5/100 women users*</li> </ul>
Oral Contraceptive Pills	May be given immediately after abortion (using vacuum aspiration or on Day 3 of medical methods of abortion)	<ul style="list-style-type: none"> <li>• Highly effective</li> <li>• Can be started immediately</li> <li>• Can be provided by health workers other than doctors</li> <li>• Does not interfere with intercourse</li> </ul>	<ul style="list-style-type: none"> <li>• Requires continued motivation and daily use</li> <li>• Re-supply must be available</li> <li>• Effectiveness may be lowered if woman using Rifampin, Dilantin, and Griseofulvin</li> <li>• No protection against STIs/HIV/HBV</li> <li>• Failure rate is 0.3/100 women users*</li> </ul>
Progestin-only Injectable DMPA, NET-EN	<ul style="list-style-type: none"> <li>• May be given immediately after abortion (using vacuum aspiration or on Day 3 of medical methods of abortion)</li> <li>• May be appropriate for use if the woman wants to delay choice of a longer-term method</li> </ul>	<ul style="list-style-type: none"> <li>• Highly effective</li> <li>• Can be started immediately, even if infection is present</li> <li>• Does not interfere with intercourse</li> <li>• Not user-dependent, except for remembering to come for injection every two or three months, depending on the type of injection</li> <li>• No supplies needed by user</li> </ul>	<ul style="list-style-type: none"> <li>• May cause irregular bleeding, spotting, amenorrhea</li> <li>• Excessive bleeding may occur in rare instances</li> <li>• Delayed and unpredictable return to fertility after stopping use</li> <li>• Must return for injections every two or three months or as advised</li> <li>• No protection against STIs/HIV/HBV</li> <li>• Failure rate is 0.3/100 women users*</li> </ul>

Method	Timing after First Trimester Abortion	Advantages	Remarks
IUCD	IUCD can be inserted after abortion (using vacuum aspiration or after confirmation of completed medical methods of abortion, provided the risk or presence of infection is ruled out)	<ul style="list-style-type: none"> <li>• Highly effective</li> <li>• Effective immediately</li> <li>• Long-term contraception; effective for five to ten years, depending on the type of IUCD (IUCD 380A for 10 years and IUCD 375 for 5 years)</li> <li>• Immediate return to fertility following removal</li> <li>• Does not interfere with intercourse</li> <li>• No regular supplies needed by user</li> </ul>	<ul style="list-style-type: none"> <li>• May increase menstrual bleeding and cramping during the first few months</li> <li>• No protection against STIs/HIV/HBV</li> <li>• Trained provider needed for insertion and removal</li> <li>• Failure rate is 0.6/100 women users*</li> </ul>
Female Sterilization	Female sterilization procedures are usually performed immediately after a surgical abortion. If there is infection or severe blood loss is experienced, female sterilization should not be performed	<ul style="list-style-type: none"> <li>• Permanent method, highly effective</li> <li>• Does not interfere with intercourse</li> <li>• No long-term side effects</li> <li>• Immediately effective</li> </ul>	<ul style="list-style-type: none"> <li>• Adequate counselling and fully informed consent are required before female sterilization procedure</li> <li>• Slight possibility of surgical complication</li> <li>• Requires trained staff and appropriate equipment</li> <li>• No protection against STIs/HIV/HBV</li> <li>• Failure rate is 0.5/100 women users*</li> </ul>
Male sterilization (No-scalpel Vasectomy)	This procedure can be done independent of the abortion procedure	<ul style="list-style-type: none"> <li>• Very effective</li> <li>• Permanent</li> <li>• No interference with sex</li> <li>• No repeated clinic visits required</li> <li>• No apparent long-term health risks</li> <li>• Enables a man to take responsibility for preventing pregnancy</li> <li>• Supplies required till azoospermia is confirmed</li> </ul>	<ul style="list-style-type: none"> <li>• Not immediately effective. First 20 ejaculations after vasectomy may contain sperms. The couple must use another contraceptive method for at least the first 20 ejaculations or the first three months whichever is earlier</li> <li>• Semen analysis should be done after 3 months to confirm azoospermia</li> <li>• No protection against sexually transmitted diseases including HIV/ HBV</li> <li>• Failure rate is 0.1/100 women*</li> </ul>

Method	Timing after First Trimester Abortion	Advantages	Remarks
Natural Family Planning Methods: Fertility Awareness based/ Standard Days Method	Effective only after menstrual cycles are regular	<ul style="list-style-type: none"> <li>No supplies required</li> <li>Under control of couple</li> </ul>	<ul style="list-style-type: none"> <li>Effective after cycles regularize</li> <li>Effective only in women with regular cycles between 26-32 days</li> <li>Have high failure rates (3 to 5/100 women users) so should not be the method of choice</li> </ul>

\*Failure rates are first year pregnancy rates.

All the above mentioned methods may not be available in the public health delivery system.

## Contraceptive Options for Special Conditions

The table below gives contraceptive options for women with some special conditions, during abortion care:

Woman's Clinical Situation	Potential Contraceptive Method for Use	Contraceptive Method to be Avoided
Reproductive Tract/ pelvic infection (confirmed or presumptive diagnosis)	<ul style="list-style-type: none"> <li>Provide a short-term method (condoms or hormonal) and follow-up later for long term method</li> </ul>	<ul style="list-style-type: none"> <li>Delay female sterilization or IUCD insertion until infection is either ruled out or fully resolved</li> </ul>
Trauma to genital tract; uterine perforation; vaginal or cervical trauma; chemical burns	<ul style="list-style-type: none"> <li>Provide a short-term method (condoms or hormonal) and follow-up later for long term method</li> </ul>	<ul style="list-style-type: none"> <li>Delay female sterilization until trauma is healed</li> <li>Delay IUCD insertion until uterine perforation or other trauma has healed</li> <li>Injuries that affect the vagina or cervix may limit the use of female barrier methods and spermicides</li> </ul>
Haemorrhage and severe anaemia	<ul style="list-style-type: none"> <li>Provide a short-term method (condoms or hormonal) and follow-up later for long term method</li> </ul>	<ul style="list-style-type: none"> <li>Delay female sterilization and IUCD until the condition is resolved because of the risk of further blood loss</li> </ul>
Second trimester abortion	<ul style="list-style-type: none"> <li>Oral contraceptive pills</li> <li>Barrier methods (condoms)</li> <li>Female (only minilap) sterilization</li> <li>IUCD</li> </ul>	

Woman's Clinical Situation	Potential Contraceptive Method for Use	Contraceptive Method to be Avoided
HIV positive cases	<ul style="list-style-type: none"> <li>• Condoms (male or female) with or without spermicide should be used during each act of intercourse</li> <li>• Other methods along with condoms can also be used</li> </ul>	
Adolescents	<ul style="list-style-type: none"> <li>• Condoms</li> <li>• Hormonal contraceptive methods</li> <li>• Dual contraception recommended</li> </ul>	

## Misconceptions about Contraceptive Methods

Unfortunately, sometimes health workers themselves may be misinformed about certain methods or may have different religious or cultural beliefs pertaining to contraceptive methods which may have an impact on their work.

When a woman mentions a rumour/misconception, always listen carefully. Don't laugh. Explain the facts with visual aids. Use strong scientific facts about contraceptive methods to counter misinformation. Always tell the truth. Never try to hide side effects or problems that might occur with various methods.

### Misconceptions and Facts about Condoms

1.	<p>Misconception</p> <p>Fact</p>	<ul style="list-style-type: none"> <li>• If a condom slips off during sexual intercourse, it might get lost inside woman's body</li> <li>• A condom cannot get lost inside the woman's body because it cannot pass through the cervix. If the condom is put on properly, it will not slip off</li> </ul>
2.	<p>Misconception</p> <p>Fact</p>	<ul style="list-style-type: none"> <li>• There is a danger of condom breaking or tearing during intercourse</li> <li>• Condoms are made of thin but very strong latex rubber and they undergo extensive laboratory tests for strength. A condom is more likely to break if the vagina is very dry, or if the condom is old (past the expiration date)</li> </ul>

### Misconceptions and Facts about OCPs

1.	<p>Misconception</p> <p>Fact</p>	<ul style="list-style-type: none"> <li>• I need to take the pill only when I sleep with my husband</li> <li>• A woman must take the pill every day in order not to become pregnant</li> </ul>
2.	<p>Misconception</p> <p>Fact</p>	<ul style="list-style-type: none"> <li>• I am still protected from pregnancy when I stop taking the pills if I have been using it long enough</li> <li>• Pills protect against pregnancy only if they are taken every day</li> </ul>

3.	Misconceptions Facts	<ul style="list-style-type: none"> <li>The pill is dangerous and causes cancer</li> <li>Numerous studies have disproved this misconception. The pills have been safely used by millions of women for over 30 years. Infact, studies show that the pills can protect women from some forms of cancer, such as those of the ovary, endometrium</li> </ul>
4.	Misconception Fact	<ul style="list-style-type: none"> <li>Women who take the pill for several years need to stop them to give the body a 'rest period'</li> <li>A 'rest period' from taking pills is not necessary and a woman may use OCPs for as many years as she wants to prevent a pregnancy</li> </ul>
5.	Misconception Fact	<ul style="list-style-type: none"> <li>The pills can't be used following an abortion</li> <li>OCPs are appropriate for use immediately post-abortion (spontaneous or induced), in either the first or second trimester, and should be initiated within the first seven days post-abortion, or any time the provider can be reasonably be sure that the woman is not pregnant</li> </ul>
6.	Misconception Fact	<ul style="list-style-type: none"> <li>The pills cause infertility or makes it difficult for a woman to become pregnant once she stops using it</li> <li>Studies have clearly shown that the pills do not cause infertility or decrease a woman's chances of becoming pregnant once she stops taking it</li> </ul>

**In brief, the pills:**

- Must be taken every day, whether or not a woman has sex that day
- Do not make women infertile
- Can be started immediately after abortion procedure
- Offers protection against few forms of cancers

## **Myths and Misconceptions about the Intrauterine Contraceptive Device (IUCD)**

1.	Misconception Fact	<ul style="list-style-type: none"> <li>The thread of the IUCD can trap the penis during intercourse</li> <li>The strings of the IUCD are soft and flexible, cling to the walls of the vagina and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string that can be grasp with a forceps)</li> </ul>
2.	Misconception Fact	<ul style="list-style-type: none"> <li>A woman who has an IUCD cannot do heavy work</li> <li>Using an IUCD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores and the use of an IUCD</li> </ul>

3.	Misconception Fact	<ul style="list-style-type: none"> <li>• The IUCD might travel inside a woman’s body to her heart or her brain</li> <li>• There is no passage from the uterus to the other organs of the body.</li> </ul>
4.	Misconception Fact	<ul style="list-style-type: none"> <li>• The IUCD causes ectopic pregnancy</li> <li>• There is no evidence that the use of an IUCD increases the risk of an ectopic pregnancy.</li> </ul>
5.	Misconception Fact	<ul style="list-style-type: none"> <li>• An IUCD cannot be inserted after an abortion</li> <li>• With appropriate technique, the IUCD may be inserted immediately after an abortion (spontaneous or induced) following first as well as second trimester abortions, if the uterus is not infected, or during the first seven days post-abortion (or anytime you can be reasonably sure the woman is not pregnant)</li> </ul>

**In brief, intrauterine contraceptive devices:**

- Do not travel to the heart or brain
- Can be inserted immediately after abortion procedure
- Do not cause discomfort or pain for the woman/man during sex
- Do not increase the risk of ectopic pregnancy

## Misconceptions and Facts about Female Sterilization (Tubectomy)

1.	Misconception Fact	<ul style="list-style-type: none"> <li>• A woman who has been ligated loses all desire for sex (becomes frigid)</li> <li>• Tubal ligation has no physiological effect on sexual desire of the woman other than that of preventing the egg from being fertilized by sperm. The ovaries will still release eggs and produce hormones, and the woman will still menstruate, but she is no longer at the risk of getting pregnant</li> </ul>
2.	Misconception Fact	<ul style="list-style-type: none"> <li>• A woman who has been ligated becomes sick and is unable to do any work</li> <li>• A woman who has been ligated can resume regular activities as soon as she is free from post-surgical discomfort. It does not affect her ability to work or make her weak or ‘sick’</li> </ul>
3.	Misconception : Fact :	<ul style="list-style-type: none"> <li>• A woman who undergoes ligation has to be hospitalized</li> <li>• Usually there is no need for hospitalization for the woman undergoing tubal ligation. The woman can go home after at least four to six hours of the procedure, when the vital signs are stable and she is fully awake, has passed urine, and can walk, drink or talk. The woman must be accompanied by a responsible adult while going home</li> </ul>
4.	Misconception : Fact :	<ul style="list-style-type: none"> <li>• Ligation may cause early menopause</li> <li>• Ligation will not hasten menopause. A ligated woman will continue to ovulate and menstruate (although she will no longer get pregnant) until she naturally reaches menopause</li> </ul>

### In brief, female sterilization:

- Does not make the woman weak
- Does not cause heavier bleeding or irregular bleeding or early menopause
- Does not change woman's sexual behavior or sex drive

## Myths and Misconceptions about Vasectomy

1.	Misconception	<ul style="list-style-type: none"><li>• Vasectomy is the same as castration</li></ul>
	Fact	<ul style="list-style-type: none"><li>• Vasectomy is not castration. In vasectomy, the vas deferens are cut and tied so that sperm cannot mix with the semen. The semen ejaculated during sexual intercourse no longer contains sperm and will no longer make a woman pregnant</li></ul>
2.	Misconception	<ul style="list-style-type: none"><li>• A man who submits to vasectomy has his manhood taken away. Worst of all, he will no longer enjoy sex</li></ul>
	Fact	<ul style="list-style-type: none"><li>• Vasectomy does not interfere with any other physiological functions; or cause any other types of change. After a vasectomy, a man will continue to produce male hormones, and be 'masculine'. Many men enjoy sex more after a vasectomy because they no longer need to worry about getting their partner pregnant</li></ul>
3.	Misconception	<ul style="list-style-type: none"><li>• Sperm that is not ejaculated during intercourse will collect in the scrotum and cause the scrotum to burst or will cause other problems in the body</li></ul>
	Fact	<ul style="list-style-type: none"><li>• Sperm that is not ejaculated is absorbed by the body. It cannot collect in the scrotum or cause harm to a man's body in any way</li></ul>

### In brief, vasectomy:

- Does not decrease sex drive
- Does not cause a man to grow fat or become weak, less masculine or less productive

## Emergency Contraception

Emergency Contraception (EC) is a unique option that can be used by women to prevent an unwanted pregnancy in the first five days after unprotected sexual intercourse, contraceptive accidents or due to unexpected circumstances.

The term 'emergency contraception' is used because it conveys the important message that the treatment should be an action taken in an emergency and not be used as an ongoing contraceptive method, and it avoids giving the mistaken impression that use of the method is limited to the morning following every unprotected sex (morning after pill).

## When can Emergency Contraception be Used?

Emergency contraception can be used in the following situations:

1. When contraceptive method has failed or has been used incorrectly (explained below)
2. Sex occurs unexpectedly and without contraceptive protection.
3. A woman is raped or forced to have sexual intercourse

Failure of contraception or incorrect use can happen in one of the following ways:

- A condom breaks, slips or there is leakage
- A woman has missed three or more combined oral contraceptive pills in a row
- A woman is more than two weeks late for her repeat contraceptive injection (DMPA and one week late for norethindrone enanthate)
- Partial or complete expulsion of an IUCD
- Miscalculating or failure to abstain from sexual intercourse during the fertile period
- Failed coitus interruptus when ejaculation occurred inside the vagina or on the external genitalia

## Methods Used for Emergency Contraception

- Emergency Contraceptive Pills (ECPs) are hormonal contraceptives which can be used up to 72 hours (three days) after an unprotected sexual intercourse. These are of two types:
  - a. Progesterone only pills
  - b. Oestrogen-Progesterone combination pills
- Copper releasing IUCDs. These can be used up to 120 hours (five days) after an unprotected sexual intercourse

## Dose and Regimen of Emergency Contraceptive Pills

Type of pills	Dosage
Progestin-only pills	<ul style="list-style-type: none"><li>• 1 tablet of 1.5 mg levonorgestrel single dose</li></ul>
Low dose pills	<ul style="list-style-type: none"><li>• 4 stat + 4 (after 12 hours of the first dose)</li></ul>

## Mechanism of Action of EC

The mechanism of action in a particular case depends on the time of the menstrual cycle when emergency contraceptive pills are used:

- Prevent implantation by altering the inner lining of uterus (endometrium) and making it unsuitable for implantation

- Prevent fertilization
- Thicken cervical mucus
- Alter transportation of the sperm, ovum and embryo
- Interfere with corpus luteum function and luteolysis

Emergency contraceptive pills do not interrupt or abort an established pregnancy. They can only help prevent an unwanted pregnancy before it has been implanted in the uterus.

## Advantages of Emergency Contraceptive Pills

- Are safe, effective, easy to use and easily available
- Can be taken at any time during a menstrual cycle after an unprotected intercourse
- Do not require a physical examination
- Can be obtained over-the-counter from a chemist's shop without prescription
- Can be used by women with contraindications of oral contraceptive pills such as history of heart disease, migraine and liver problems

For women who are unclear of their pregnancy status and take ECP while pregnant, the emergency pills will neither harm the foetus nor would it terminate the pregnancy.

## Contraindications of Emergency Contraceptive Pills

There are no known medical contraindications to use emergency contraceptive pills. They should not be used in women with confirmed pregnancy.

## Efficacy of Emergency Contraceptive Pills

Condition	Status of ECP Use	% of Probable Pregnancy
If 100 women had unprotected intercourse during the second or third week of their menstrual cycle	No ECP use	8 would become pregnant
	Used ECPs	1 would become pregnant

Even if ECPs are correctly used, 15-25% woman may still become pregnant.

## Who can Provide Emergency Contraception?

Emergency contraceptive pills can be provided safely by clinical and non-clinical trained personnel of service delivery systems such as:

- Doctors
- Nurses and midwives
- Pharmacists, chemists

- Paramedics
- Health and family welfare assistants
- Depot holders
- Community health workers
- Other clinically trained personnel

There is evidence supporting over-the-counter use by women. Well informed women can themselves buy the pills over-the-counter from a chemist/ drug store without any prescription.

## Misconceptions about EC

1. ECPs can cause abortion:
  - No. ECPs will not disturb an established pregnancy
2. ECPs is contraindicated in many medical conditions:
  - No medical condition rules out use of ECPs. Even medical conditions that rule out continuing use of oral contraceptives, do not apply to ECPs
3. ECPs when taken once during the cycle will give protection for full cycle:
  - ECPs do not provide continuing protection from pregnancy. Therefore it is important to start an ongoing method of contraception after ECP use

## How to Manage Failure of ECPs

If the woman has not had periods for a week or more after the expected date, there is a possibility that she may be pregnant.

*Advise a pregnancy test to confirm the pregnancy.*

If she is pregnant, she should be counseled regarding the available options for safe abortion services such as manual vacuum aspiration (MVA), electric vacuum aspiration (EVA) or medical methods of abortion (MMA). She should be helped to choose the most appropriate option for her and told where she can get these services.

If she wants to continue with the pregnancy, she should be reassured that ECPs do not harm the foetus.

## Summary

- Prompt return of ovulation can lead to the possibility of unwanted pregnancy very soon after an abortion (even before the first post-abortion menstruation)
- Counsellor should explain the characteristics, use, side effects, effectiveness and availability of the contraceptive methods and let her know where she can obtain them
- Commonly held misconceptions about contraceptive methods are a barrier to their acceptance in the community
- Emergency contraceptive pills help women avoid unwanted pregnancy in cases where regular contraceptive methods have failed or incorrectly used or under special situations such as rape or forced sex



Abortion scenario

Reproductive Rights

Law and Abortions

Counselling Skills

Clinical assessment

Medical Methods of Abortion

Infection Prevention

Vacuum Aspiration

Complications of Abortions

Post Abortion Contraceptive Choices

Second Trimester Pregnancy Termination

## Chapter 11

# **SECOND TRIMESTER PREGNANCY TERMINATION**



# 11. Second Trimester Pregnancy Termination

## Contents

Self Assessment Tool

Legal Requirements for Second Trimester Abortion:

- Site/Provider Eligibility
- Documentation/Reporting

Methods for Second Trimester Pregnancy Termination

Post-procedure Care

- Immediate Care
- Contraceptive Options
- Follow-up Care

Summary

## Self Assessment Tool

Please encircle the correct response/Fill in the blanks:

- 1) Second trimester abortions can be legally performed up to \_\_\_\_\_ weeks gestation in India
- 2) Any private sector health facility can provide second trimester abortions - True or False
- 3) RMP Opinion Form (Form I) is to be signed only by the provider performing the second trimester abortion - True or False
- 4) D & E is a surgical method of second trimester abortion and should be used only up to \_\_\_\_\_ weeks of gestation
- 5) Often women coming for second trimester termination have the following indications :
  - a. Have a foetus with a congenital anomaly
  - b. Have a uterus with structural abnormality
  - c. Are a victim of rape/incest
  - d. a and c
- 6) One of the contraceptive methods that should NOT be provided immediately following second trimester abortion is:
  - a. IUCD insertion
  - b. Minilap tubectomy
  - c. Injectables
  - d. Laproscopic tubal ligation

# Second Trimester Pregnancy Termination

Second trimester pregnancy termination is associated with higher risk of complications leading to morbidity and mortality. However, some women are not able to come for the services in the first trimester because of the following reasons:

- Eugenic: foetal congenital anomalies not compatible with life are diagnosed late in gestation
- Medical: worsening medical disease in the woman
- Social: unmarried, adolescent and other marginalized women report late in the pregnancy
- Pregnancy following rape or sexual violence
- Conception during lactational amenorrhea where pregnancy goes unnoticed

Thus, it is essential that second trimester abortion services are available and accessible as an essential component of comprehensive reproductive health care.

## Legal Requirements for Second Trimester Abortion

The sites and providers' eligibility to provide second trimester abortions is different from first trimester abortions under the law, because of higher risk of complications in the former.

### Site/Provider Eligibility

#### Eligibility criteria: provider

- Experience and training requirement as under the MTP Rules (for more details, refer to Chapter 3 on 'Law and Abortions').
- Opinion recorded by two RMPs as under MTP Act, in Form I



#### Eligibility criteria: Site/facility

- Public sector facilities: secondary level (FRUs, SDH, DH) and tertiary level (medical colleges) which have the required facilities
- Private sector facilities: approved by the government as certified MTP sites for second trimester abortion



*Indications for termination in the second trimester are the same as for first trimester.*

*Pregnancy termination following sex selection is not allowed under the law.*

For more details on the training requirements for providers, infrastructural requirements for sites/health facilities and indications to provide second trimester pregnancy termination, refer to Chapter 3 on 'Law and Abortions'.

## Documentation/Reporting

It is mandatory to fill and record information in the following forms for each second trimester termination case performed, as per the MTP regulations:

- Form C – Consent Form
- Form I – Opinion Form (signed by two RMPs, as under the MTP Act)
- Form II – Monthly Reporting Form (to be sent to the district authorities)
- Form III – Admission Register for case records



## Methods for Second Trimester Pregnancy Termination

Second trimester pregnancy terminations should be done as an indoor procedure. Availability of blood for transfusion (if required) should be ensured.

### Clinical Assessment of the Woman

The woman should be thoroughly assessed before starting the procedure. The components of clinical assessment include:

1. Detailed history taking
2. Physical examination for the general condition of the woman
3. Pelvic examination
4. Investigations (Recommended)
  - **Haemoglobin**
  - **Routine Urine Examination**
  - **Blood Group: ABO Rh**
5. Ultrasonography (optional)

*Refer to Chapter 5 on 'Clinical Assessment' for more details.*

## Second Trimester Pregnancy Termination Methods

There are different methods of termination used for second trimester pregnancy:

- A. Medical
  1. Mifepristone and misoprostol regime
  2. Misoprostol alone regime
  3. Extra amniotic ethacridine instillation supplemented by oxytocin
  4. Mechanical methods supplemented by oxytocics
- B. Surgical
  1. Dilatation and Evacuation (D&E)
  2. Hysterotomy

## A. Medical Methods

Before starting the procedure, ensure that the consent has been taken for the procedure as well as for surgical termination in case of the failure of the medical method. It is preferable to get pre-anesthetic check-up done for the woman before starting the medication for termination.

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

- i. Cervical priming
- ii. Inducing uterine contraction

### 1. Mifepristone and Misoprostol regime

Mifepristone and misoprostol for termination of second trimester pregnancy is not yet approved by DCGI. However, WHO recommends this method as the safest method for second trimester termination (WHO; 2012).

**Cervical priming:** Under this regime, cervical priming is done by Mifepristone.

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

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

#### Regime: Mifepristone - Misoprostol

200 mg oral mifepristone  
↓ 36-48 hours later  
800 mcg vaginal or 400 mcg oral misoprostol  
↓ followed by  
400 mcg vaginal or sublingual misoprostol every 3 hours  
Total: up to 5 doses (including the first dose of misoprostol)

WHO, 2012

Refer to Chapter 6 on Medical Methods of Abortion, for details on different routes of administration for misoprostol.

## Monitoring of the Woman During the Procedure

Record the woman's vital signs every four hours until she starts getting strong uterine contractions, at which point her vital signs should be checked every two hours.

After the foetus is expelled, the maternal side of the cord should be clamped and the foetus should be wrapped in a cloth or paper sheet. After expulsion of the placenta, examine the foetus and placenta to confirm that expulsion is complete.

## 2. Misoprostol Alone Regime

### Cervical Priming and Inducing Uterine Contractions

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

#### Regime: Misoprostol Alone

400 mcg vaginal misoprostol  
↓ followed by  
400 mcg vaginal/sublingual misoprostol every three hours, up to maximum of five doses\*  
WHO, 2012

\* Discontinue misoprostol if expelled before maximum number of doses.

## 3. Extra amniotic Ethacridine Instillation Supplemented by Oxytocin

This method is no longer in use because of non-availability of ethacridine lactate in the market.

## 4. Mechanical Methods Supplemented by Oxytocics

Under this method, commonly used devices for cervical priming are:

- a. Laminaria tent
- b. Catheter

**Laminaria tent:** It is made of hygroscopic material, which swells up by absorbing cervical and vaginal secretions. It gradually dilates and softens the cervix and also stimulates uterine contractions. In clinical practice, it has been observed that the maximum dilatation with laminaria tent is achieved in six to eight hours of its insertion.

Disadvantage of using laminaria tent is that it can lead to infection, particularly if it is introduced without proper aseptic care and kept in for too long.

**Catheter:** Foley's catheter is used for cervical dilatation in some cases, to be supplemented later by oxytocics. Remember to instill 5-10 ml of saline in the balloon of the catheter, to prevent its slipping out of cervical canal.

### Potential Problems during Second Trimester Termination by Medical Methods

- a. If membranes rupture during the process before cervix is sufficiently dilated: vaginal route for misoprostol may be less desirable and sublingual or buccal routes may be used instead
- b. If the placenta is not expelled within half an hour of the fetal expulsion, one of the following can be used:
  - i. Repeat the dose of misoprostol
  - ii. 20 units of oxytocin in 500-ml, 5% Dextrose or Ringer Lactate at rate of 50 ml/h
  - iii. Cord traction method: While awaiting placental expulsion, periodically use the forceps to grasp the base of the cord and apply slight tension on the cord, avoiding the tearing of the cord

- c. If fetal expulsion does not occur within 24 hours from the initial dose, re-evaluate the woman and identify the cause through examination and USG. Rule out the following:
  - i. Rupture of the uterus
  - ii. Wrong dates and diagnosis
  - iii. Abdominal pregnancy

Once the above conditions are ruled out, decide the line of management. If the woman is haemodynamically:

- **Stable** - Wait for 24 hours and then individualize the treatment. Either repeat the same regime or terminate surgically. There are no studies that directly compare repeating the same regime to changing to a different regime
- **Unstable** - Stabilize and terminate the pregnancy surgically

## B. Surgical Methods

1. Dilatation & Evacuation
2. Hysterotomy

### 1. Dilatation and Evacuation (D&E)

With the advent of medical methods of abortion, D&E is used rarely for termination of second trimester pregnancies. The gestation limit for this method is less than 15 weeks (WHO, 2012).

D & E should be done at an appropriate level of health care facility by a gynaecologist.

The D&E method involves priming the cervix and then evacuating the uterus with a combination of suction and ovum forceps.

#### Dilatation/Cervical Priming Options

- Administering 400 mcg misoprostol vaginally or sublingually approximately four hours before the procedure OR
- Inserting laminaria tent, six to eight hours before the procedure
- Dinoprostone gel (esp. in cases of previous LSCS)

#### Evacuation

- Evacuation should only be started after sufficient dilatation has been achieved so that cannula of size 12–14 mm can pass through the cervix
- Perform evacuation using suction and ovum forceps

**Inspect all the evacuated fetal parts to ensure completion of the procedure.** Identify fetal parts (extremities, thorax/spine, calvarium and placenta). If there is any doubt, use ultrasound to confirm complete evacuation.

## 2. Hysterotomy

Hysterotomy is a mini-caesarean section and is performed in case of failure in the induction of abortion by other methods or excessive bleeding during the procedure, as life-saving measure.

### Disposal of Foetus and Placenta

Consider local tissue disposal regulations, and infection prevention practices while developing disposal protocol. It is to be disposed off in yellow bag like other human tissue disposal.

If the foetus is given to the woman, it should be placed in a sealed, wrapped container. The woman and her family should be informed that the container should not be opened and should be carefully buried as soon as possible.

Never dispose off the foetus till the signs of life exist.

## Post-procedure Care

### Immediate Care

- Observe vital signs
- Observe bleeding per vaginum
- Inspect all the parts of the expelled/evacuated foetus
- Provide discharge instructions

After a second trimester abortion, a woman should remain in the health care facility for at least four hours so that health care team can ensure that she is well enough to return home.

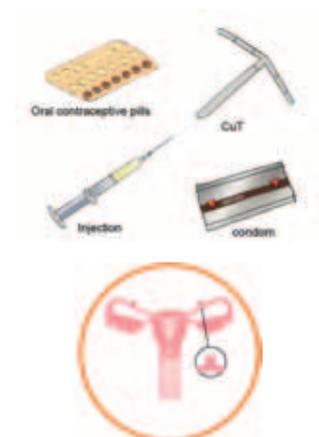
### Before discharge every woman should be informed that:

1. She will experience some bleeding per vaginum for few days to weeks and that this is normal
2. 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 health facility/provider
3. She may have some abdominal cramping which is normal. If her cramping increases rather than decreasing, or if she has a fever or severe abdominal pain, she should contact the health facility/provider
4. She should return for a follow-up visit within two weeks of the procedure.
5. It is recommended that she should not have sexual intercourse until complications, if any, are resolved and her chosen contraceptive method becomes effective
6. She should know signs and symptoms of potential complications (such as excessive bleeding per vaginum; acute pain abdomen; fainting etc.) so that she can contact the provider if she experiences any of them

## Contraceptive Options

All methods of contraception can be started immediately after an uncomplicated second trimester abortion. Either on-site or through referral, the woman should be offered contraceptive counselling and the method of her choice. Contraceptive options possible after second trimester abortion are:

- Condoms
- Oral contraceptive pills (OCPs)
- Injectables
- IUCD
- Minilap tubectomy



Tubectomy

Laparoscopic ligation should not be done\*

*\*If laparoscopic ligation is done following second trimester abortions, there are chances of injury to the fallopian tubes as the tubes are oedematous then and possibility exists of slipping of the rings from the tubes, leading to the failure of the tubal ligation procedure.*

For more details, refer to Chapter 10 on 'Post-abortion Contraceptive Services'.

## Follow-up Care

Every woman who has a second trimester abortion should be scheduled for a follow-up visit within two weeks after the procedure or earlier if she experiences any warning signs and symptoms.

During the follow-up visit:

- Review woman's medical records
- Perform a physical examination
- Conduct a pelvic examination, if indicated
- Review her contraceptive decisions
- Provide related services indicated/ desired such as cervical cancer screening, anaemia, RTI/ STI etc.
- Record follow-up visit in the register

## Summary

- The MTP Act, 1971 allows second trimester abortions upto 20 weeks
- The MTP Rules specify the provider and site requirement for second trimester termination
- There can be many social and economic pressures that push a woman to seek an abortion in the second trimester, though second trimester abortions have a higher risk of complications
- Second trimester pregnancy termination can be done with medical or surgical methods
- Most contraceptive methods can be started immediately after second trimester termination
- Follow-up visit within two weeks of procedure is most appropriate
- Sex selection is not an indication for second trimester pregnancy termination under the law



