सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Climate setting
Abortion scenario
Reproductive Rights
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Medical Methods of Abortion
Infection Prevention
Vacuum Aspiration
Complications of Abortions
Post Abortion Contraceptive Choices
Second Trimester Pregnancy Termination

Trainer's Manual

Comprehensive Abortion Care

April 2014

Maternal Health Division
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In collaboration with:

Ipas HEALTH ACCESS RIGHTS INDIA

Anuradha Gupta, IAS
Additional Secretary &
Mission Director, NRHM
Telefax : 23062157
E-maii : 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.

lt 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. ln 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

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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

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Acknowledgement

The Comprehensive Abortion Carc (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, lpas.

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 thc 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.

Manisha

(Dr. Manisha Malhotra)

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 Gonandotropin
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,** Professsor, 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

Comprehensive Abortion Care Certification Training Schedule

Week 1	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
9.30 am – 1.00 pm	Registration Pre-test Introduction of participants	MTP OPD Understanding functioning of OPD	MTP OPD Skills demo on clinical assessment	MTP OPD Skills demo on clinical assessment	MTP OPD Skills demo on clinical assessment	MTP OT Observe cases
1.00 – 2.00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
2.00 – 3.00 pm	Objectives of the training Expectations	Clinical Assessment	Counselling	Vacuum Aspiration	MVA Demonstration on pelvic model	Infection Prevention
3.00 – 3.15 pm	Tea	Tea	Tea	Tea	Tea	Tea
3.15 – 4.15 pm	Abortion Scenario	Law and Abortions	Counselling	Post Abortion Contraceptive Choices	Practice MVA procedure on model	Practice MVA procedure on model
4.15 – 4.30 pm	Plan for next day	Plan for next day	Plan for next day	Plan for next day	Plan for next day	Plan for next day
Week 2	**Day 7**	**Day 8**	**Day 9**	**Day 10**	**Day 11**	**Day 12**
9.00 – 1.00 pm	MTP OT/OPD assist in MTP Cases, post-procedure care	MTP OT/OPD Skills demo on instrument processing and assist in cases	MTP OT/OPD assist in MTP Cases, post-procedure care	MTP OT/OPD Assist/ perform cases, post-procedure care	MTP OT/OPD Assist/ perform cases,	MTP OT/OPD Assist/perform cases, post-procedure care Complete the record book
1.00 – 2.00 pm	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
2.00 – 3.00 pm	Medical Methods of Abortion	Reproductive Rights	Complications of abortions	Practice counselling skills	Practice MVA procedure on model	Certificate distribution
3.00 – 3.15 pm	Tea	Tea	Tea	Tea	Tea	Tea
3.15 – 4.15 pm	Practice counselling skills	Practice MMA counselling skills with peer	Practice MVA procedure on model	Practice MVA procedure on model	Practice MVA procedure on model	
4.15 – 5.00 pm	Plan for next day	Plan for next day	Plan for next day	Plan for next day	Plan for next day, Post-test	

Contents

Climate setting
Abortion scenario
Reproductive Rights
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Counselling Skills
Clinical assessment
Medical Methods of Abortion
Infection Prevention
Vacuum Aspiration
Complications of Abortions
Post Abortion Contraceptive Choices
Second Trimester Pregnancy Termination

Chapter 1

CLIMATE SETTING

1. Climate Setting

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards, team activity chart, copies of pre-test

Session Plan

S. No.	Sub-Session	Methodology	Time (60 minutes)
1.	a. Welcome b. Pre-test	Presentation Pre-test	10 minutes
2.	Introduction of the Participants	Group activity	15 minutes
3.	Share Expectations	Brainstorming Presentation	5 minutes
4.	Goal and Objectives	Brainstorming Presentation	10 minutes
5.	Training Logistics	Discussion	5 minutes
6.	Group Norms	Brainstorming Presentation	5 minutes
7.	Activity Teams	Team formation Activity sheet Presentation	5 minutes
8.	Summary	Presentation	5 minutes

1a. Welcome

1b. Pre-Test

Time: 10 minutes

Methodology: Presentation (Slide 1.1)

Greet the participants and introduce yourself. Facilitate the completion of the Pre-Test (Annexure 1). Explain that this session is about getting started on our journey for the next few days.

This session consists of essential action taken at the beginning of any training program. It helps in opening communication channels between the participants and trainers and creates a positive environment for participation and learning.

Share the session objectives with the participants.

Slide 1.1: Session Objectives

1. Identify the names of fellow participants and trainers
2. Share expectations from the training program
3. Get familiar with the goal, objectives and schedule of the training
4. Gain clarity regarding the administrative and logistic arrangements of the training
5. Contribute towards creating an enabling training environment

2. Introduction of the Participants

Time: 15 minutes

Methodology: Group activity (Slide: 1.2)

Tell the participants that we will now have a round of introductions in a way that will help us appreciate each other as individual human beings.

Note: The person facilitating this introduction should also participate.

Give instructions for the game or activity you choose to do. For example:

Use any quick idea to divide the group of trainers and participants in pairs. Possible ideas include:

a. *Cut pictures (6" X 6") from old magazines or newspapers and cut them into halves in advance. Depending on the number of participants in the group, distribute these pieces randomly. Let the participants go around and find their match and pair up with the person. Take care to count the number of participants and take only as many pictures as needed before you mix and distribute.*

b. *Use popular idioms, advertisement tag lines, songs or rhymes and write a part each on two separate strips of paper. (Ba Ba black sheep..... have you any wool)*

In case of odd numbers, one set could be a triad of three persons.

Once the participants and trainers have paired up, give a set of interesting questions to ask each other (as in Slide: 1.2). Limit these to only four questions.

Ask the pairs to interact with each other and find the answers to the questions. Ask them to introduce their partner in this activity. It is not necessary to repeat the whole conversation. Monitor time closely. After this activity, tell the participants they have only touched the tip of the iceberg and would continue on the journey of discovery and learning together.

Slide 1.2: Introduction Points

- Name
- Place of posting
- Experience with the provision of abortion care or related complication.
- Interests/hobbies, food preferences, favourite movies/actors, their greatest accomplishments

3. Share Expectations

Time: 5 minutes

Methodology: Brainstorming; Presentation (Slide: 1.3)

Ask the participants to share their expectations from this training. Write them on the flip chart or VIPP cards and paste them for all to see. There is no need at this point to get into any detailed discussion on any of the expectations.

Slide 1.3: Expectations

Expectations of the participants from the training

4. Goal and Objectives

Time: 10 minutes

Methodology: Brainstorming; Presentation (Slides: 1.4, 1.5, 1.6 [a, b], 1.7)

Present the goal and objectives of the training

Read aloud and give a few minutes to reflect. Ask if the participants have any questions.

Slide 1.4: Goal of the Training

To build competencies of service providers in clinical and technical procedures and enhance their knowledge and skills on all aspects of Comprehensive Abortion Care (CAC) for providing high quality services.

Slide 1.5: Objectives of the Training

- Understand the key elements in 'Comprehensive Abortion Care' approach
- Acquire knowledge and skills to practice updated, safe abortion technologies, infection prevention measures and effective counselling
- Establish quality abortion services at your health facilities as per the CAC Training and Service Delivery Guidelines, MoHFW, 2010
- Obtain certification as a trained MTP provider under the MTP Act

Share the course content and the requirements to get certified as MTP provider.

Slide 1.6(a): Course Content

Non-clinical topics (for both doctors and nursing staff)

- Abortion scenario in India
- Reproductive rights of the woman
- Laws related to abortion (MTP Act)
- Counselling skills
- Post-abortion contraceptive methods
- Disassembly and assembly of the parts of an MVA aspirator
- Infection prevention and instrument processing
- Operationalizing CAC service delivery post-training

Slide 1.6(b): Course Content

Clinical topics

- Clinical assessment before the MTP procedure
- Methods of first trimester abortion:
  - Medical Methods of Abortion (MMA)
  - Manual Vacuum Aspiration (MVA)
  - Electric Vacuum Aspiration (EVA)

- Pre and post-procedure care
- Managing abortion complications
- Methods of second trimester abortion (only for gynecologists)

Pre and post-tests will be conducted at the beginning and end of the training respectively.

A test using the self-assessment tool will be conducted at the beginning of each session.

The participants should be able to obtain the answers for all the questions in the self-assessment tool during the course of each session. They may seek clarification at the end of the session for the remaining doubts.

Slide 1.7: Clinical Competency Requirement

During the duration of the training program, you have to:

- Acquire competency in assessing uterine size by bimanual examination
- Observe at least 10 MTP cases
- Assist at least 10 MTP cases
- Perform at least 5 MTP cases independently under supervision (as per the MTP Rules)

The cases recorded in the notebook should be signed by the trainer who has supervised those cases. The cases should be an optimal mix of MTPs by MVA and EVA

A certificate will only be issued after the participant demonstrates the critical skills as per the `Skills Checklist' for surgical and medical methods, given in Chapter 7: 'Medical Methods of Abortion' and Chapter 9: 'Vacuum Aspiration' respectively.

Refer to the expectations from the earlier activity written on the Flip chart and discuss to what extent the expectations will be met.

5. Training Logistics

Time: 5 minutes

Methodology: Discussion (Slide: 1.8)

Share important instructions regarding accommodation, venue for training and protocols to be followed for reimbursements. If necessary, invite the official/staff person who can adequately respond to the logistics and administrative queries of the participants. After the session is completed, assign time for individual problems and doubts.

Slide 1.8: Training Logistics

- Venue for:
  - Theory sessions
  - Hands-on practice
- Accommodation
- Reimbursements

6. Group Norms

Time: 5 minutes 

Methodology: Brainstorming; Presentation (Slide: 1.9)

Brainstorm with the participants to arrive at a consensus for adopting a set of group norms. Write these on a flip chart and leave it on the wall for the rest of the training period. Some of the examples of the group norms are given below:

Slide 1.9: Group Norms

- Be punctual/follow time schedule
- Participate actively
- Encourage and support one another
- Listen to others
- Be sensitive to others
- Stay focused on the topics being covered
- One person should talk at a time
- Mobile phones on silent/vibration mode

Parking Lot: *Paste a flip chart on the wall titled 'Parking Lot'. Explain that if ideas come up during discussions which are either outside the agenda or cannot be discussed at that point, they will be written on this chart. Coordinators or trainers should refer to the chart periodically and find time to address those issues during relevant sessions or breaks.*

7. Activity Teams

Time: 5 minutes 

Methodology: Team formation; Activity sheet; Presentation (Slide: 1.10)

Tell the participants that throughout the training, they would be sharing responsibilities along with the training team to maintain a relaxed and conducive learning environment.

Divide participants into three activity teams. Each team needs to choose a name they like and sign up on the `Activity Sheet'. Ensure that teams rotate the tasks every day.

Recap, Evaluation/Feedback, and Energizers are the suggested team roles.

To encourage their full involvement and active participation, rotate tasks among teams on each day of the training program. Each team should include participants from different facilities. It is the responsibility of each team to determine team leadership; some teams prefer to appoint a leader for the entire training, some rotate leadership while others choose not to appoint a leader.

Role of Each Team

1. Recap Team

This team creatively present synthesis of learning from the previous day, looking at methodology as well as content related to comprehensive abortion care. The team also raises issues that need clarification or reinforcement.

The facilitator/trainer who takes the first theory session of each day will need to devote 10 to 15 minutes prior to the session for these daily start-up activities.

2. Evaluation/Feedback Team

This team collects informal feedback from all the participants, collates them and makes necessary recommendations to the training team at the end of each day.

The facilitator/trainer who takes the last theory session of each day will need to devote 10 to 15 minutes prior to the close of the day for this activity.

3. Energizer Team

This team facilitates creative warm-ups and energizers to begin each day, after each break and as needed. Facilitators/trainers who take theory sessions each day will need to devote time periodically prior to/in between the sessions for these energizing activities.

The table below indicates the schedule of team activities for the first three days, which can be replicated for the subsequent days.

Slide 1.10: Activity Sheet			
Day	**Recap**	**Evaluation/Feedback**	**Energizers**
1/4/7/10	Team 1	Team 2	Team 3
2/5/8/11	Team 3	Team 1	Team 2
3/6/9/12	Team 2	Team 3	Team 1

8. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 1.11)

Discuss the answers of the pre-test before summing up the session.

Slide 1.11: Summary

It is mandatory to have a devoted time for climate setting at the beginning of each training program to:

- Know fellow participants and trainers
- Understand the goal and objectives of the training program
- Understand the session plan and schedule of the training program
- Understand the requirements for clinical competency during the training program
- Know the administrative and logistic arrangements during the training program

Annexure 1

CAC Training Program

Pre/Post-test Questionnaire

Name: (optional): .....

Name of training center: .....

Dates of training: from .....(dd/mm/yy) to .....(dd/mm/yy)

A. Please mark your response with a '✓' in the appropriate column:

Sr. No.	Statement	True	False
1.	A woman 18 years and above does not need her husband's or guardian's consent for MTP		
2.	MVA aspirator should not be boiled or autoclaved as it may get damaged		
3.	MVA aspirator can be used to take endometrial biopsy		
4.	Under the MTP Act amendments 2002, MTP can be performed up to 24 weeks of pregnancy with the opinion of two doctors		
5.	To avoid repeated abortions, doctors should insist on women accepting IUCD or sterilization before performing MTP		
6.	When combination of mifepristone and misoprostol is used for medical methods of abortion, there is potential risk of fetal malformation if pregnancy continues		
7.	Decontamination of used instruments by soaking in 0.5% bleach solution is essential before cleaning		
8.	The instruments soaked in 2% Cidex for disinfection should be washed with tap water before use during the procedure		

B. Please encircle your response from the options given in the brackets:

9. For making 0.5% bleach solution (1 teaspoon/2 teaspoons/3 teaspoons) bleaching powder is added to one litre of water

10. MVA can be used to terminate pregnancy for a maximum gestation period up to (8 weeks/10 weeks/12 weeks)

11. Cannula up to maximum size of (8 mm/10 mm/12 mm) can be fixed to a double-valve MVA aspirator

12. In India, medical methods of abortion using mifepristone and misoprostol is approved for use up to (49 days/56 days/70 days) of pregnancy

13. Documentation is not required for MTPs performed by Medical Methods of Abortion (MMA) (True/False)

14. An emergency contraceptive pill is 85% effective in preventing pregnancy if used within (3 days/5 days/7 days) of unprotected intercourse

15. Continuation of pregnancy after taking emergency contraceptive pill has a risk of deformities in growing fetus (Yes/No)

16. The percentage of xylocaine used for local anaesthesia in MVA procedure is (1-2%/5%)

17. Deaths from unsafe abortions account for (8/13/20)% of MMR

C. Answer the following questions by encircling the most appropriate answer. Only one answer is correct for each question:

18. Counselling means:
    a. Facilitating decision-making
    b. Giving information
    c. Motivating the woman
    d. Giving advice

19. Fertility of a woman after an abortion can return:
    a. As early as 2-3 weeks
    b. Only after the first menstruation
    c. Within 2-6 months
    d. After 6-8 months

20. The following techniques help improve the trainees' performance:
    a. Practice on models and live cases
    b. Using skills checklists
    c. Role play
    d. All of the above

Key to Pre/Post-test:

1) True	2) False	3) True	4) False
5) False	6) True	7) True	8) False
9) 3 teaspoons	10) 12 weeks	11) 12 mm	12) 49 days
13) False	14) 3 days	15) No	16) 1-2%
17) 8%	18) a	19) a	20) d

Climate setting
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Second Trimester Pregnancy Termination

Chapter 2

ABORTION SCENARIO

2. Abortion Scenario

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Presentation	10 minutes
2.	Public Health Perspective of Illegal and Unsafe Abortions	Story Brainstorming Presentation	15 minutes
3.	Abortion Scenario in the Country/States	Discussion Presentation	5 minutes
4.	Policies for Safe Abortion Care	Discussion Presentation	10 minutes
5.	CAC: Woman Centered Approach	Discussion Presentation	10 minutes
6.	Personal Commitment	Discussion	5 minutes
7.	Summary	Presentation	5 minutes

2. Abortion Scenario

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) CAC Training and Service Delivery Guidelines published by the Government of India, recommends 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

Key to Self Assessment Tool:

1) False	2) False	3) True	4) 8
5) a, c, e	6) d	7) e	

1a. Self Assessment Tool
1b. Introduction to the Session

Time: 10 minutes

Methodology: Presentation (Slide: 2.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss correct responses with them. Share the objectives of the session, laying emphasis on the fact that abortion is an important challenge to women's health. To address this, safe abortion care is now a key component of most maternal health policies.

Slide 2.1: Session Objectives

- Understand the magnitude of the problem of unsafe and illegal abortions in India from a public health perspective
- Know abortion related data in the Indian context
- Understand the activities under the policy framework for CAC
- Know the elements of Woman Centered Comprehensive Abortion Care
- Write a 'Power Statement' for commitment to CAC

2. Public Health Perspective of Illegal and Unsafe Abortions

Time: 15 minutes

Methodology: Story; Brainstorming; Presentation (Slides: 2.2, 2.3 [a, b])

Ask one of the participants to read out the story. Project the slide with the story.

Slide 2.2: Story

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 laborer. 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. Meena's condition gradually deteriorated as she had high fever, her breathing was irregular and she became unconscious.

To initiate the analysis of Meena's story, ask the participants to enlist various factors which lead to such a situation, as in the story. Note down their responses and place them under four heads as in Slide 2.3 (a):

Slide 2.3(a): Factors Influencing Abortion Services

Ensure that factors enlisted in slides 2.3 (b) are covered in the discussion:

Slide 2.3(b): Factors Influencing Abortion Services

Social Factors

- Lack of awareness that abortion is legal
- Social stigma
- Gender discrimination and low status of women
- Lack of male responsibility
- Women do not go to male providers
- Provider's attitude

Economic Factors

- Poverty
- Private providers charge high fee

Policy Factors

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

Physical Access Factors

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

3. Abortion Scenario in the Country/States

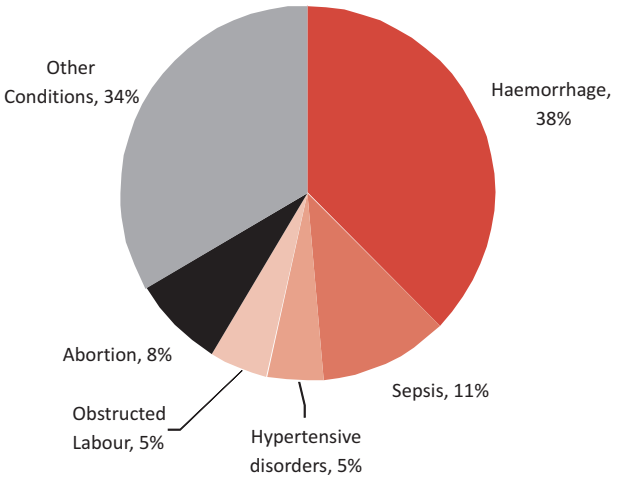
Time: 5 minutes

Methodology: Discussion; Presentation (Slides: 2.4, 2.5, 2.6)

Slide 2.4: Abortion Scenario

- Abortions account for 8% of Maternal Mortality Ratio (MMR) though varies across states
- MMR: 178/1,00,000 live births (SRS 2010 – 12)
- Unsafe abortions lead to complications such as sepsis/bleeding and may lead to death. Many of those who survive suffer from chronic, debilitating diseases
- Every two hours, one woman dies of complications due to unsafe abortion

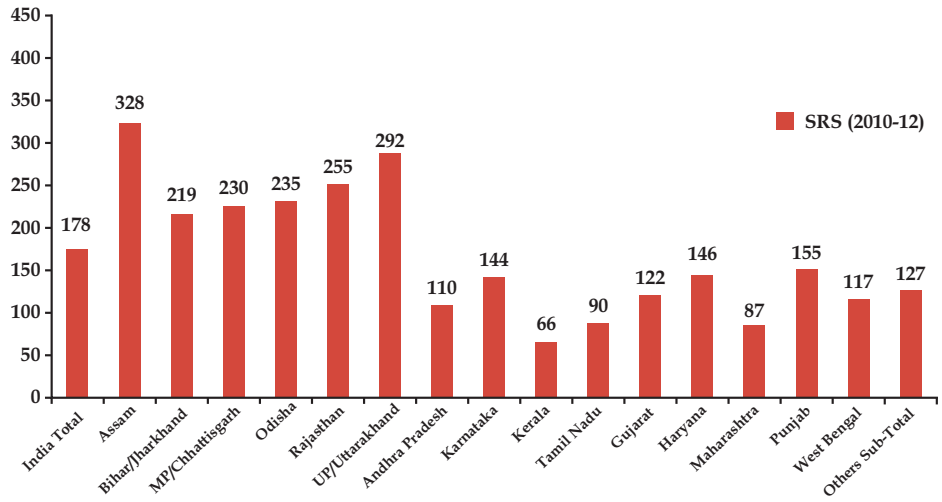
Slide 2.5: Major Causes of Maternal Death



Source: RGI-SRS, 2001-03

Share the MMR of different states with the participants. Also share with them that exact data on abortions is not available for most of the states therefore this data is based on projected figures.

Slide 2.6: MMR Across States



Sources of Abortion Data:

Sample Registration Survey, Registrar General of India; Annual Health Survey for High Focus States; Health Management Information System – HMIS; State Programme Implementation Plans - PIPs; Monitoring through quarterly CAC format; Evaluation done by different agencies; Estimates by WHO.

4. Policies for Safe Abortion Care

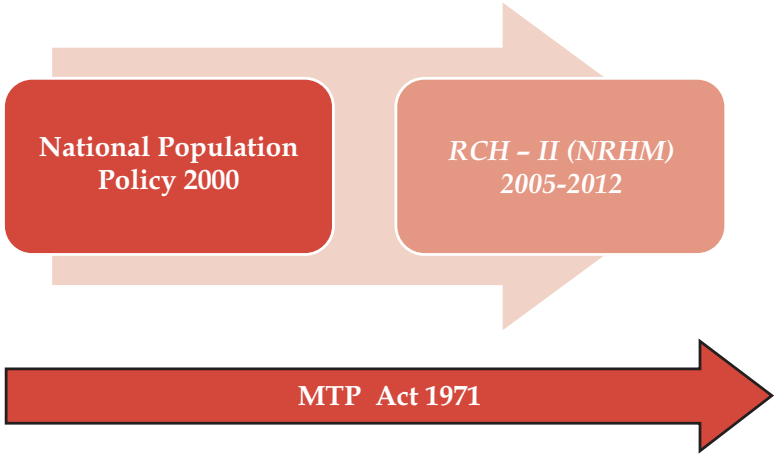
Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 2.7, 2.8, 2.9, 2.10 [a, b], 2.11, 2.12, 2.13)

Policy Framework for Increasing CAC Access

Share with the participants that as unsafe and illegal abortions have significant contribution to MMR, the Government of India policies and strategies (NPP/RCH II) have focussed on interventions to enhance the access and availability of services for comprehensive abortion care in both public and private sectors, within the framework of the MTP Act.

Slide 2.7: Policy Framework for CAC Access



A. National Population Policy 2000

The National Population Policy (NPP) 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.

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

Slide 2.8: CAC Elements under the National Population Policy 2000

1. Community-level education
2. Make safe and legal abortion more attractive

3. Adopt updated and simple technologies
4. Promote collaborative arrangements with the private sector
5. Eliminate the cumbersome site registration process
6. Additional training centers for training of providers
7. Competent post-abortion care, including family planning
8. Ensure services at PHC and CHC

1) **Community-level education** campaigns should target women, household decision-makers and adolescents about the **availability** of safe abortion services and the 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 training of providers in safe abortions

7) **Provide competent post-abortion care,** including family planning counselling and services and the identification of other health needs

8) **Ensure services** for the 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. An integrated strategic approach under RMNCH+A

Slide 2.9: CAC Initiatives under RCH II/NRHM

i. Establishing CAC service delivery

ii. Generating awareness (IEC/BCC)

iii. An integrated strategic approach under RMNCH+A

i. Establishing CAC service delivery

Slide 2.10(a): Establishing CAC Services

a. Dissemination of CAC Guidelines (2010) to states

b. Provision of CAC services at 24X7 PHCs/FRUs (DHs/SDHs/CHCs)

c. Funds to states/UTs for operationalization of MTP services

d. Capacity building of medical officers in safe MTP techniques

e. Train ANMs, ASHAs etc. to provide confidential counselling for MTP and contraception

Slide 2.10(b): Establishing CAC Services Contd...

a. Inclusion of MMA drugs in EDL

b. Directive to supply of MMA drugs by state

c. Certification of private and NGO sector facilities through DLCs

d. A quarterly tool (format) for monitoring of CAC services

e. 'Nischay', pregnancy detection kits to sub-centres

ii. Generating Awareness (IEC/BCC):

Slide 2.11: Generating Awareness (IEC/BCC)

a. Sensitization workshops on CAC for state and district officials

b. Standard IEC/BCC material on safe abortion developed at the Center and disseminated to the states for printing

c. Funds to states/UTs for planning of IEC activities

d. Orientation/training of ASHAs on skills to create awareness in the community and facilitate women in accessing services

iii. An integrated strategic approach under RMNCH+A

Slide 2.12: Integrated Strategic Approach under RMNCH+A

- Primary prevention through improving the access and availability of contraception
- A strategic approach to integrate early detection of pregnancy, safe abortion care services and contraception counselling/services to address repeat unintended pregnancies and abortions

Slide 2.13: Initiatives under RMNCH+A

1. Strengthening Delivery Points

2. Strengthening Quality of Training

3. Maternal Death Review

1. **Strengthening delivery points on priority for provision of services:** Delivery points are facilities which are conducting deliveries above a minimum benchmark
2. **Strengthening the quality of training:** Improving quality of teaching and training by providing adequate teaching aids, teaching material and mannequins
3. **Maternal Death Review (MDR):** MDR is a strategy to improve the quality of obstetric care and reduce maternal mortality and morbidity by focusing on the 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

5. CAC: Woman Centered Approach

Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 2.14, 2.15, 2.16, 2.17, 2.18)

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

The approach for making CAC a woman centered care is detailed below.

Explain to the participants, the concept of woman centered approach in abortion care:

Slide 2.14: CAC: Woman Centered Approach

Woman Centered Comprehensive Abortion Care means 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

Present the framework for woman centered comprehensive abortion care to the participants, introducing them to the key elements that would help transition abortion care to woman centered comprehensive abortion care.

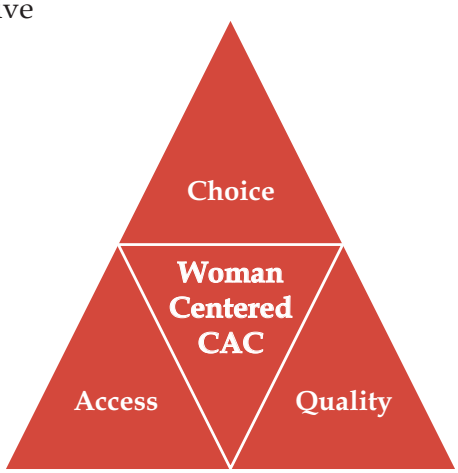
Slide 2.15: Elements of Woman Centered CAC

The three key elements of Woman Centered Comprehensive Abortion Care are:

i. Choice

ii. Access

iii. Quality



Framework for Woman Centered Comprehensive Abortion Care

i. Choice

Slide 2.16: Choice

- Right and opportunity to select between options without interference from others
- For a woman to have informed choice she should have complete and accurate information; opportunity to ask questions and freedom to express concerns to knowledgeable health care personnel

Choice means a woman's right to determine:

- When to become pregnant
- Whether to continue with or terminate a pregnancy
- Freedom to select among available abortion procedures, contraceptives, providers, facilities etc.

ii. Access

Slide 2.17: Access

- Availability of services to a woman as and when she needs them
- Services to a woman irrespective of her economic or marital status, age, educational or social background
- Services without delay because of administrative and logistic hurdles
- Services available close to woman's home

Emphasize that for enhancing access, health systems should undertake training of providers both in public and private sectors to provide services. It is the medical and ethical responsibility of trained providers to provide abortion care for legal indications.

iii. Quality

Slide 2.18: Quality

- Devote adequate time for counselling;
- Maintain privacy and confidentiality
- Use safe technologies, such as MVA, EVA and MMA

- Follow standard protocols for infection prevention, pain management and management of complications
- Offer post-abortion contraceptive services
- Provide reproductive and other health services (RTI/STI, counselling on sexual violence etc.)
- Services tailored to a woman's medical and personal needs

6. Personal Commitment

Time: 5 minutes 

Methodology: Discussion (Slide: 2.19)

Tell the participants that this is an opportunity to make a personal commitment for ensuring comprehensive abortion care services at their facilities when they go back from this training. Your 'Power Statement' will fill you with pride.

Give a few minutes to participants to write a statement in their manuals.

Slide 2.19: My Power Statement

As a trained CAC service provider, I will_____

_____

_____

_____

_____

_____

_____

_____

Sample/example: "I will make use of the skills which I have acquired during this training to provide CAC services to women who need them and I will not refuse services on inconsequential grounds."

Take a few volunteers to present their statements in the group. Encourage the group to acknowledge them by giving a round of applause. Alternately, encourage one participant to read a statement each day for the duration of the training. Tell the participants to remember the statement carefully as it would be taken up in the final session of this training.

7. Summary

Time: 5 minutes

Methodology: Presentation (Slide: 2.20)

Slide 2.20: 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 physical, economic, social and policy factors limit the availability and utilization of services for women
- Government of India policies under NPP and RCH II give a substantial focus on CAC interventions
- Availability of trained providers and quality services at facilities 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: Access, Choice and Quality

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

Reference Materials

For more information on national programs and strategies, refer to the following documents:

1. CAC Training and Service Delivery Guidelines
2. Handbook for RMNCH+A Counsellors
3. Maternal and Newborn Health Toolkit

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Second Trimester Pregnancy Termination

Chapter 3

REPRODUCTIVE RIGHTS

3. Reproductive Rights

Time: 30 minutes

Advance Preparation

Flip chart, markers, VIPP cards

Session Plan

S. No.	Sub-session	Methodology	Time (30 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Presentation	5 minutes
2.	Reproductive Rights a. Reproductive and Sexual Health b. Concept of Rights-Based Approach c. Sexual and Reproductive Rights	Brainstorming Discussion Presentation	10 minutes
3.	Barriers in Promoting Sexual and Reproductive Health & Rights (SRHR)	Discussion Presentation	10 minutes
4.	Summary	Presentation	5 minutes

3. Reproductive Rights
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

Key to Self Assessment Tool:

1) False 2) True 3) a, b, c

1a. Self Assessment Tool
1b. Introduction to the Session

Time: 5 minutes

Methodology: Presentation (Slide: 3.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss correct responses with them. Share the objectives of the session.

Slide 3.1: Session Objectives

- Define reproductive and sexual health
- Understand the concept of rights-based approach for reproductive health
- Know the various sexual and reproductive rights
- Identify the potential barriers in promoting sexual and reproductive health and rights

2. Reproductive Rights
2a. Reproductive and Sexual Health

Time: 10 minutes

Methodology: Brainstorming; Discussion; Presentation (Slides: 3.2, 3.3, 3.4, 3.5)

Slide 3.2: Definition of Reproductive Health 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.

2b. Concept of the Rights-based Approach

Slide 3.3: 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 imply that people are able to have a satisfying and safe sex life and 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.

Rights-based Approach in Sexual and 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.

The violation of sexual and reproductive rights are directly linked to adverse public health outcomes such as un-intended pregnancies, maternal and neonatal mortality, anaemia, unsafe abortions, violence, sexually transmitted diseases and HIV/AIDS etc.

Ask the participants why reproductive health care should have a rights-based approach and how adoption of this approach by providers will benefit women coming for abortion care. Share the following information with the participants:

Slide 3.4: Rights-based Approach in Reproductive Health

- 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

2c. Sexual and Reproductive Rights

Discuss with the participants some of the internationally recognized sexual and reproductive rights. Elaborate on a few of the rights that are mentioned below:

Slide 3.5: Sexual and Reproductive Rights

1. Right to life and survival
2. Right to liberty and security of a person
3. Right to privacy
4. Right to receive information

5. Right to marry and have a family
6. Right to decide the number and spacing of one's children
7. Right to the highest attainable standard of health
8. Right to benefits of scientific progress
9. Right to non-discrimination and respect for difference
10. Right to be free from sexual and gender-based violence

Discuss with the participants about how respecting each of the above reproductive rights can lead to an improvement in the reproductive health of individuals.

Sr. No.	Sexual and Reproductive Rights	Improving Reproductive Health
1.	Right to life and survival	• Prevents maternal deaths due to unsafe abortion
2.	Right to liberty and security of a person	• Obtains informed consent for all procedures, including sterilization, abortion and HIV testing
3.	Right to privacy	• Ensures privacy for all services • Keeps information confidential
4.	Right to receive information	• Offers sufficient information to help men/women to make good reproductive health decisions
5.	Right to marry and have a family	• Prevents early or coerced marriages • Provides access to infertility services for women and men
6.	Right to decide the number and spacing of one's children	• Provides access to a range of contraceptive methods • Helps people choose and use a family planning method
7.	Right to highest attainable standard of health	• Provides access to affordable, acceptable, and comprehensive reproductive health services so that the woman does not suffer from complications • Provides access to safe, legal and high quality abortion services
8.	Right to benefits of scientific progress	• Ensures safer and less painful technologies

Sr. No.	Sexual and Reproductive Rights	Improving Reproductive Health
9.	Right to non-discrimination and respect for difference	• Offers distinctive reproductive health services to all groups, including adolescents and unmarried women • Offers services that meet women's and men's distinctive reproductive health needs
10.	Right to be free from sexual and gender-based violence	• 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

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

3. Barriers in Promoting Sexual and Reproductive Health and Rights (SRHR)

Time: 10 minutes 

Methodology: Discussion; Presentation (Slides: 3.6, 3.7)

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.

Ask the participants to think of the barriers women face in exercising their sexual and reproductive rights. List these on the Flip chart. Add from the points in the slide below, if some of them were not mentioned in the discussion:

Slide 3.6: Barriers to Sexual and Reproductive Rights (Women's Perspective)

a. Lack of understanding and awareness of the rights

b. Limited decision-making power in matters of pregnancy, abortion and child birth

c. Issues around consent by self/spouse/parents

d. Limited participation of men in family planning and reproductive health

Slide 3.7: Barriers to Sexual and Reproductive Rights (Provider's Perspective)

1. Lack of understanding and awareness of the rights

2. Issues around consent by spouse/parents

3. Incorrect interpretation of law making false assumptions/judgement about sexuality and morality
4. Poor quality services lead to its under-utilization
5. Shortage of trained manpower pushes women to seek help from unauthorized provider
6. Use of outdated and unsafe technology
7. Only highly qualified professionals approved for services

4. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 3.8)

Slide 3.8: Summary

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

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

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Second Trimester Pregnancy Termination

Chapter 4

LAW AND ABORTIONS

4. Law and Abortions

Time: 60 minutes

Advance Preparation

Flip chart, markers, MTP Act booklets

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Presentation	5 minutes
2.	Salient Features of the MTP Act	Quiz Discussion Presentation	15 minutes
3.	Salient Features of the MTP Rules	Quiz Discussion Presentation	15 minutes
4.	Salient Features of the MTP Regulations	Discussion Presentation	10 minutes
5.	Penalty for Violation of the MTP Act	Discussion Presentation	5 minutes
6.	PCPNDT Act	Discussion Presentation	5 minutes
7.	Summary	Presentation	5 minutes

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

4. Law and Abortions

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 only

   b. Seven years of imprisonment only

   c. Two to seven years of imprisonment

   d. None of the above

Key to Self Assessment Tool:

1) False	2) False	3) c, d	4) 3, 5
5) f	6) c		

1a. Self Assessment Tool
1b. Introduction to the Session

Time: 5 minutes

Methodology: Presentation (Slide: 4.1, 4.2)

Greet the participants and facilitate the completion of the self assessment tool. Discuss the correct responses with them. Share the objectives of the session.

Slide 4.1: Session Objectives

- Salient Features of the MTP Act:
  - Under what conditions can pregnancy be terminated?
  - Who can terminate a pregnancy?
  - Places where pregnancy can be terminated?
- Salient Features of MTP Rules:
  - District Level Committee: composition and site approval process
  - Equipment requirement at the sites
  - Experience and training required by an RMP
- Salient features of MTP Regulations:
  - Documentation and reporting
- Penalty for violations of the MTP Act
- Comparative objectives of PCPNDT Act and 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 MTP Act.

Share the development process of the MTP Act, Rules and Regulations with the participants.

Slide 4.2: Development Processes

- **MTP Act:** is passed by both houses of parliament and receives assent by the President
- **MTP Rules:** are made by the Central Government and passed by the parliament; notified in the official gazette
- **MTP Regulations:** are made by the state government and passed by the state legislature

- 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 the 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 an MTP provider: five out of 25 cases to be assisted to an RMP under the MTP Act, should be performed independently. Provider after this training 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 at an unapproved site

2. Salient Features of the MTP Act

Time: 15 minutes 

Methodology: Quiz; Discussion; Presentation (Slides: 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10)

To initiate the discussion on different topics in the session, ask the participants the question on preceding slide, take few responses and then share the correct answers with the participants on the subsequent slides.

The MTP Act defines:

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

Slide 4.3: Question 1

Is abortion available on demand
and
a woman's legal right in India?

Slide 4.4: Answer: No
Indications When Pregnancy can be Terminated

- 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

- 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?

Ask the participants about who can legally terminate a pregnancy. Take a few responses and present the complete information.

Slide 4.5: Who can Terminate a Pregnancy?

Only a Registered Medical Practitioner (RMP) under the 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

Slide 4.6: Question 2

An unmarried woman, aged 21 years, comes with an eight weeks pregnancy for MTP

(a) Whose consent should be taken before the procedure?

(b) Who can give an opinion on terminating the pregnancy?

Present the following facts about consent for the procedure and opinion of an RMP during pregnancy termination to the participants:

Slide 4.7: Consent for Procedure

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

Spousal consent is not mandatory

Slide 4.8: Opinion of RMP

- For termination of pregnancy up to 12 weeks, the opinion of one RMP is required
- For termination of pregnancy between 13-20 weeks, opinion of two RMPs is required

C. Places Where Pregnancy can be Terminated

Slide 4.9: Question 3

Which sites are legally approved to provide MTP services?

Slide 4.10: Sites for Pregnancy Termination

1) Hospital established or maintained by the Government

2) Private site approved by the Government or a District Level Committee constituted by the Government for the purpose

3. Salient Features of MTP Rules

Time: 15 minutes

Methodology: Quiz; Discussion; Presentation (Slides: 4.11, 4.12, 4.13, 4.14, 4.15, 4.16, 4.17, 4.18, 4.19, 4.20, 4.21, 4.22)

MTP Rules defines:

A. District Level Committee: Composition and site approval process

B. Infrastructure requirement for the approval of sites

C. Experience and training required by an RMP

A. District Level Committee: Composition and Site Approval Process

Slide 4.11: Question 4

- Is it necessary for a site to get approved before providing abortion care services?
- Is approval of private sites granted at the state level or district level?

Slide 4.12: MTP Site Approval

- All private sites need approval before starting abortion services
- Public sector sites do not need separate approval, provided they have the required infrastructure
- Approval of private sites is granted at the district level by the District Level Committee (DLC)

The District Level Committee 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. The composition of DLC is as below:

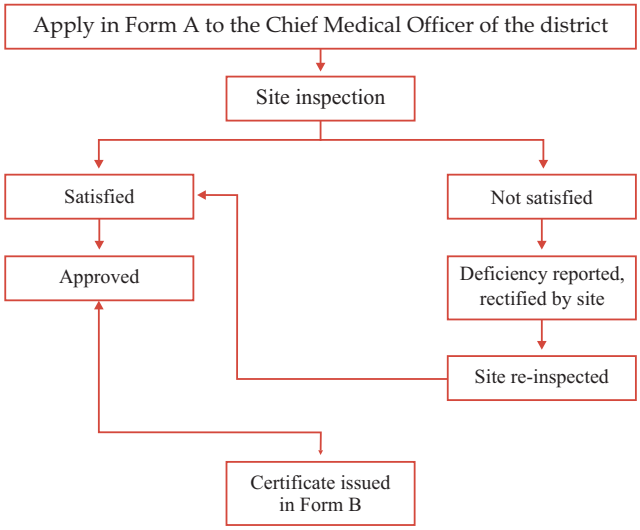
Slide 4.13: District Level Committee: Composition

Three to five members including the Chairperson.

- 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 and Panchayati Raj Institution of the district
- At least one member of the committee should be a woman
- The tenure of the committee will be for two calendar years and the tenure of the NGO member will not be for more than two terms (four years)

Present to the participants the process of site approval for a private site through a DLC.

Slide 4.14: Private MTP Site Approval Process



Slide 4.15: Form-A: Site Approval Application

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 stertilization equipment.

Place :.....

Date : ..... Signature of the owner of the place.

Slide 4.16: Form-B: Site Approval Certificate

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 Govermment 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 a 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 life long and periodic renewal is not required unless the CMO has a reason to cancel/suspend the approval.

B. Infrastructure Requirement for Approval of Sites

Tell the participants the essential infrastructural requirements for approval of a site for performing MTPs

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.

Slide 4.17: Infrastructure Requirement: First Trimester 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

Slide 4.18: Infrastructure Requirement: Second Trimester Site

- An operation table
- Instruments for performing abdominal or gynecological surgery
- Anesthetic equipment
- Resuscitation and sterilization equipment
- Drugs and parenteral fluids for emergency use
- Back-up facilities for treatment of shock
- Facilities for transportation

The details of the drugs, equipments and supplies required for CAC services at different levels of health facilities are enumerated in Annexure 1 (ref: CAC Training and Service Delivery Guidelines, GoI 2010) at the end of the chapter.

C. Experience and Training Required by RMP.

Slide 4.19: Question 5

What is the training/experience required by an RMP for performing termination of pregnancy?

Slide 4.20: Experience and Training Requirement

1. A practitioner who holds a post-graduate degree or diploma in Obstetrics and Gynaecology
2. A practitioner who has completed six months as House Surgeon in Obstetrics and Gynaecology
3. A practitioner who has at least one year experience in the practice of Obstetrics and Gynaecology at any hospital that has all facilities
4. A practitioner who has assisted a Registered Medical Practitioner (RMP) in 25 cases of medical termination of pregnancy 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)

Slide 4.21: Question 6

- Can medical methods of abortion be provided by an MBBS doctor who is not MTP certified?
- Can MMA be provided from an unapproved site?

Slide 4.22: Medical Methods of Abortion (MMA)

- Provider's eligibility: Only an RMP, as under the MTP Act, can prescribe MMA drugs
- Site eligibility: Medical Methods of Abortion 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

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

4. Salient Features of MTP Regulations

Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 4.23, 4.24, 4.25, 4.26, 4.27, 4.28, 4.29)

Ask the participants if they can enlist the formats to be filled in for documenting an abortion procedure. Share the documentation required for the process of pregnancy termination, as under the MTP Regulations.

Slide 4.23: Mandatory Documentation under the MTP Act

a) Form 'C': Consent Form

b) Form I (Opinion Form): RMP shall certify this form within three hours from the termination of pregnancy

c) 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

d) Form III (Admission Register): An approved site shall maintain case records in Form III. This register is kept for a period of five years from the date of last entry

Slide 4.24: Form C: Consent Form

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

Slide 4.25 Form I: RMP, Opinion Form

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

Slide 4.26: Form II: Monthly Reporting Form

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

Slide 4.27: Form III: Admission Register

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

- Custody of forms: Duly filled Form C and Form I shall be placed in an envelope and sealed by an RMP and kept in safe custody until it is sent to the head of the hospital or the owner of the approved place
- Admission Register: should be kept in safe custody and shall not be open for inspection by any person except under the authority of law.

Ask the participants to enlist the essential protocols to be followed while providing an abortion procedure so that it is safe and legal.

Slide 4.28: Essential Protocols of Safe and Legal Abortion

- 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.

Women can also present with other types of abortions at the facilities:

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

Slide 4.29: Documentation for Other Types of Abortion

Types: Spontaneous, Inevitable, Incomplete and Missed: None of these come under the purview of the MTP Act.

Documentation:

- Form I not required
- Consent as taken for any other procedure and not on Form C
- Procedure not recorded in Admission Register (Form III) but in Labour (OT) Procedure Register

The definition of the above types of abortions is given in Annexure 2.

5. Penalty for Violation of the MTP Act

Time: 5 minutes

Methodology: Discussion; Presentation (Slides: 4.30, 4.31)

Ask the participants if they can recall any violations of the provisions of the MTP Act and Rules. List these on the flip chart. Tell the participants that the consequences of violating the provisions of the MTP Act are severe. Share the following points with them:

Slide 4.30: Violation of the MTP Act

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

- Any person terminating a pregnancy who is not a registered medical practitioner 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 next working day of the termination of the pregnancy.***

6. PCPNDT Act

Time: 5 minutes

Methodology: Discussion; Presentation (Slide: 4.31)

Share with the participants that the practice of sex determination, sex selection and female foeticide are a major cause for the countrywide decline in female child sex ratio. Share with them the following data:

Child Sex Ratio (No. of Girl Child per 1000 Boy Child, in 0-6 years Age Group)	
Year	**Total**
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 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.

Slide 4.31: PCPNDT and MTP Act		
	MTP Act	**PCPNDT Act**
Objective	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
Underlying reason	Wish to terminate an unintended or unwanted pregnancy	Son/gender preference in the community, low valuation of girls, increasing dowry demands
Expected outcome	Reduce unsafe abortions	Improve sex ratio

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.)

7. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 4.32)

Slide 4.32: Summary

- In India, it is legal to terminate pregnancy up to 20 weeks, under special circumstances.
- Only the consent of woman (more than 18 years) is required for MTP
- For private sites: MTP site approval is done by 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 to check sex determination that leads to female feticide and a decline in the sex ratio

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

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
1.	**Examination room**			
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
2.	**Procedure room**			
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
3.	**Instruments**			
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
4.	**Resuscitation equipment**			
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
5.	**Sterilization equipment**			
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
6.	**Drugs & parenteral fluid**			
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
7.	**Supplies**			
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
	First trimester cases (expected)	6-8		
	First trimester cases (expected)	6-8 (30%MMA- 2 cases)	10-15 (30% MMA -3 cases)	35 (30% MMA - 10 cases)
	Second trimester cases (expected)		1	5

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

Annexure 2

Definition of different types of abortions:

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 continuation of pregnancy in this situation

5. Missed abortion is a condition when the products of conception are retained in uterus after fetal demise

Climate setting
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 5

COUNSELLING SKILLS

5. Counselling Skills

Time: 120 minutes

Advance Preparation

Flip chart, markers, VIPP cards, case scenarios for role play, IEC material

Session Plan

S. No.	Sub-session	Methodology	Time (120 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Discussion Presentation	10 minutes
2.	Counselling: Definition and Essential Elements a. Definition of Counselling b. Qualities of a Trained Counsellor c. Essential Elements of Counselling	Brainstorming Discussion Presentation	20 minutes
3.	Prerequisites for Counselling and Role of Site Staff	Brainstorming Discussion Presentation	25 minutes
4.	Practicuum: Counselling Skills	Role play Presentation	60 minutes
5.	Summary	Presentation	5 minutes

5. Counselling Skills

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

Key to Self Assessment Tool:

1) False	2) True	3) True	4) True
5) b	6) False	7) a	

1a. Self Assessment Tool
1b. Introduction to the Session

Time: 10 minutes

Methodology: Discussion; Presentation (Slide: 5.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss correct responses with them. Share the objectives of the session emphasizing that counselling is a critical component in providing quality abortion care services.

Slide 5.1: Session Objectives

- Define counselling and the qualities of a good counsellor
- Understand the essential elements of counselling and effective communication in woman centered comprehensive abortion care
- Provide contraceptive counselling for different methods
- Understand counselling roles for different staff at the health facility
- Define IEC/BCC activities including IPC

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.

2. Counselling: Definition and Essential Elements
2a. Definition of Counselling

Time: 20 minutes

Methodology: Brainstorming; Discussion; Presentation (Slides: 5.2, 5.3, 5.4, 5.5, 5.6, 5.7)

Ask the participants the key words which define counselling according to them. Write them on the flip chart. Present the definition of counselling. Then explain why words given by them define/do not define counselling.

Slide 5.2: What is Counselling?

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 problems or concerns

2b. Qualities of a Trained Counsellor

Tell the participants that we will now generate a list of essential qualities in an abortion care counsellor. To generate quick responses, ask the participants, "What would you look for in a counsellor"? Ask each participant to speak on only one quality. Write them on the flip chart. Add if any points from the list below are not covered.

Slide 5.3: Qualities of a Trained Abortion Care Counsellor

- 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 non-technical language
- Always maintains confidentiality and privacy

2c. Essential Elements of Counselling

Tell the participants that we will now discuss essential elements of counselling which are helpful in making the communication between the health care provider and the woman effective.

Slide 5.4: Essential Elements of Counselling

- Active listening
- Verbal communication
- 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.

Ask the participants if they can enlist a few examples of active listening. Take a few examples from them. Tell the participants that the ideal behavior for a counsellor/service provider when listening to a woman can be summarized through the acronym SOLER:

Slide 5.5: Active Listening

S – Sit **squarely** in relation to 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

Tell the participants that all the steps followed in the process of verbal communication could be easily remembered using the acronym 'GATHER'.

GATHER Approach

Slide 5.6: Verbal Communication - GATHER

GATHER	VERBAL COMMUNICATION
G – Greet	• Use of open-ended questions
A – Ask	• Avoid closed-ended questions
T – Tell	• Closing a counselling session
H – Help	
E – Explain	
R – Refer/Return	

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

Provide referrals

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'
- Avoid asking questions beginning with 'why' as they seem judgmental

Ask the participants if now they can think of a few examples of close ended questions.

Close-ended questions:

- Usually have a response in 'Yes' or 'No'
- Are asked when the counsellor needs specific information to help analyze or take a decision

While closing a counselling session:

- 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

Tell the participants that often people communicate many thoughts and feelings through body language, gestures and postures, without speaking a single word. Take examples from the group.

Slide 5.7: Non-Verbal Communication

Positives

- Actions
- Gestures
- Facial expressions
- Maintaining eye contact
- Nodding

Negatives

- 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. Confirm verbally the interpretation of any clues, to avoid miscommunication.

3. Prerequisite for Counselling and Role of Site Staff

Time: 25 minutes

Methodology: Brainstorming; Discussion; Presentation (Slides: 5.8, 5.9, 5.10, 5.11, 5.12)

A. Appropriate Place for Counselling

Ask the participants about their views on the appropriate place for counselling. Discuss the responses keeping in mind the following points:

Slide 5.8: Appropriate Place for Counselling

- Where privacy is 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

B. Appropriate Time for Counselling

Ask the participants what would be an appropriate time for counselling during the whole process of abortion care. Discuss the responses keeping in mind the following points:

Slide 5.9: Appropriate Time for Counselling

i. Pre-procedure

ii. During procedure

iii. Post-procedure, and

iv. During follow-up visit

- If required, in a scheduled formal session at any point in time during the process
- Contraceptive counselling should be done at all the available opportunities, enlisted above

i. Pre-procedure counselling

It focuses on providing general information to the woman and help her:

- Clear doubts and thoughts about terminating this pregnancy by asking her the reason for termination of pregnancy
- 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 a risk to her health
- Select the method for termination
- Give informed consent
- Take a decision on accepting a contraceptive method. Inform her 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.

ii. During procedure counselling

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

iii. Post-procedure counselling

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

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

  If the woman has any of following symptoms, she needs to go 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

- **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 and address and contact details of the facility referred to.

iv. Counselling during the follow-up visit

- Ask the woman:
  a. If she has any questions or anything to discuss about her health or condition
  b. If there has been 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

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
- is aware that she could change or switch to another method if not satisfied

Share the following points with the participants (mentioned below in the slide) that should be kept in mind for effective contraceptive counselling to help the woman choose an appropriate method:

Slide 5.10: Effective Contraceptive Counselling

- Assess individual situation
- Availability of contraceptive methods
- Use of the methods; effectiveness; side effects
- Support the selected method

1. Assess the woman's individual situation: The counsellor should consider both, the woman's clinical condition and her personal situation and discuss any potential barriers to the successful use of contraception in a sensitive manner
2. It is important to determine which contraceptive methods are available and accessible to a woman, both at the facility and within her community
3. The counsellor should explain the characteristics, use (how it works), side effects and effectiveness of the available methods

4. 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

Tell the participants what could be the negative impact of coercion/insistence for post-abortion contraception.

- 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 health care system and hence not receive the much needed services for contraception and safe abortions

Voluntary Informed Consent

Inform the participants that voluntary informed consent is a very crucial part of counselling in abortion care. Share the following information with the group:

Slide 5.11: Voluntary Informed Consent

Voluntary informed consent is a process by which a woman gives her consent after she is given full information about her options for:

- Continuing or terminating the pregnancy
- Abortion procedure(s) available to her including benefits, risks and alternatives
- Pain medication alternatives
- Contraceptive methods

Ensure the woman has a free choice, without any pressure or coercion.

Role of Site Staff

Service providers at the facility, who come in contact with the woman coming for abortion care, play different roles in her health care. Ask the participants to enumerate the role of different site staff in relation to abortion care. Share ideas from the following practice matrix of 'Who' and 'Could do what' for counselling in an abortion care setting.

Each staff member at the facility has a role in making the environment enabling and non-threatening for a woman coming for abortion. Possible ways of sharing counselling role among different staff members at the health facility:

Slide 5.12: Counselling by Different Facility Staff	
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

4. Practicuum: Counselling Skills

Time: 60 minutes

Methodology: Role play; Presentation (Slides: 5.13, 5.14, 5.15, 5.16, 5.17, 5.18, 5.19)

Counselling Role-Plays

Tell the participants that they will now practice the ideas discussed during this session through role play. Divide them in two to three groups. Distribute case scenarios among them; explain that they need to focus on verbal and non-verbal communication between a counsellor and a woman for the given scenario. Give 20 minutes for preparation, 10 minutes for enacting the scenario and 10 minutes for discussion on role play.

One group should prepare and present an example of a bad counselling scenario and the other group should prepare and present an ideal counselling scenario.

The feedback on counselling skills of performing group should be given as per the checklist (Annexure 1).

Slide 5.13: Case Scenario 1

Anita, a 35 year old woman with two children, has missed her periods for two months. She remembers her husband using condoms most of the times. She does not want another child. Anita is feeling tired and concerned about this pregnancy and has come to the clinic to find a way out.

Points to discuss:

- How will the provider deal with Anita to counsel her on abortion and contraceptive options available to her?

Slide 5.14: Case Scenario 2

Amna, a 25 year old woman, has discovered that her periods are two weeks late. She has three children under the age of six years and she cannot afford to have another child. She wants to have an abortion done and then start using a contraceptive method.

Amna confided her situation to the ANM at the sub-center to get her suggestion on what to do now.

Points to discuss:

- What information should the ANM share with Amna to help her choose from the available options for abortion and contraception?

Slide 5.15: Case Scenario 3

Rita is a 17 year old unmarried girl. She has come to the clinic with Usha, a 25 year old married woman, who is Rita's neighbour. Usha tells the doctor that Rita has not had her periods and is l2 days overdue. Usha also mentions that Rita had sexual contact a few times with a friend. Rita suspects that she may be pregnant and so has come to the clinic for help.

Points to discuss:

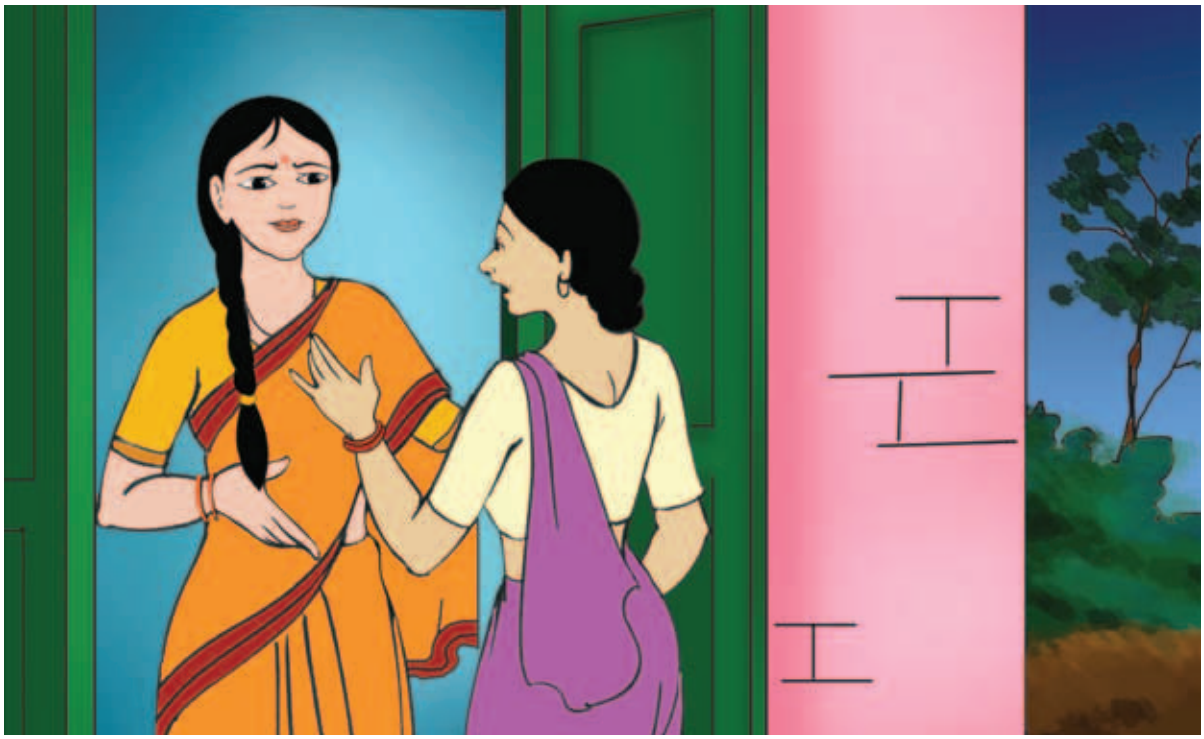
- How should the provider deal with Rita?
- What are the important points which the provider needs to explain to Rita and Usha?

Before summarizing the chapter, the participants should be told about the different types of communication activities (Annexure 2) and IEC material

Share the copies of the approved IEC material with the participants:

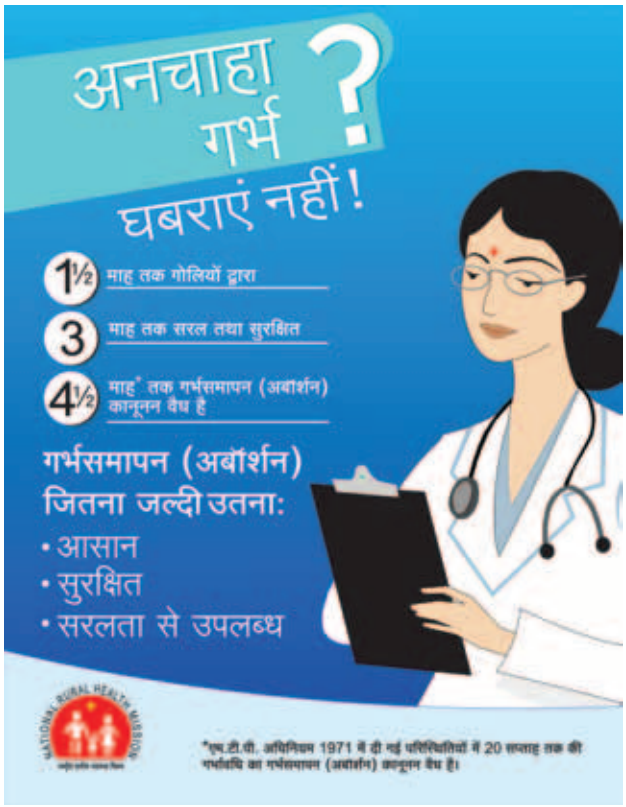
Slide 5.16: IEC Materials 1 – ANM/ASHA Booklet

Slide 5.17: IEC Materials 2 – Flipbook



Slide 5.18: IEC Materials 3 – Leaflet

Slide 5.19: IEC Materials 4 – Poster



5. Summary

Time: 5 minutes

Methodology: Presentation (Slide: 5.20)

Slide 5.20: 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

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

Counselling Observation Checklist

Instructions for observation: Silently observe the counselling session. Share your evaluation and comments with the counsellor at the end of the session.

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

Types of Communication Activities

- **Information Education and Communication (IEC)**
- **Behavior Change Communication (BCC)**
- **Interpersonal Communication (IPC)**

IEC focuses on providing correct information through various communication channels to promote awareness on any particular issue.

BCC is a systematic process to use comprehensive communication strategies to promote positive behaviors that are appropriate to people's settings and provide a supportive environment that will enable them to initiate and sustain positive behaviors.

Difference between BCC and IEC:

IEC is only providing information, whereas BCC includes the following:

- Providing information
- Providing a supportive environment
- Support to transform knowledge into behaviour
- Support in adapting and sustaining positive behaviors
- Work at all level (individual, family, community)

IPC means direct communication with the target audience. This term usually applies to verbal and non-verbal interactions in one-on-one or small-group settings. It is face-to-face communication by which people exchange information, feelings and clarify doubts. It is not just about what is actually said - the language used - but **how** it is said and the non-verbal messages sent through tone of voice, facial expressions, gestures and body language.

IPC is an important component of BCC, which helps people to understand the information, internalize it, clarify doubts and transform knowledge into behaviour.

Climate setting
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

CLINICAL ASSESSMENT

6. Clinical Assessment

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards, pelvic model, Cusco's vaginal speculum, case studies

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Discussion Presentation	5 minutes
2.	Components of Clinical Assessment	Brainstorming Group Work Discussion Presentation	20 minutes
3.	Abortion Care in Pre-existing Medical Conditions	Discussion Presentation	10 minutes
4.	Case Studies/Practice Pelvic Examination	Case Study Discussion Presentation	5 minutes
5.	Different Uterine Evacuation Methods	Discussion Group Work Presentation	15 minutes
6.	Summary	Presentation	5 minutes

6. Clinical Assessment

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 a higher center
   c. Managing certain pre-existing conditions requires 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 preventing complications - True or False

3) The physical examination for an 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

Key to Self Assessment Tool:

1) d	2) True	3) True	4) d
5) b	6) a, b, d		

1a. Self Assessment Tool

1b. Introduction to the session

Time: 5 minutes

Methodology: Discussion; Presentation (Slides: 6.1, 6.2)

Greet the participants and facilitate the completion of the self assessment tool. Discuss correct responses with them. Share the objectives of the session.

Slide 6.1: Session Objectives

- Identify components of clinical assessment
- Understand abortion care in pre-existing medical/surgical conditions
- Understand the different methods available for uterine evacuation

Ask the participants if they think it is essential to assess a woman's clinical status before performing an abortion procedure and why? Note their responses. Complete the list from the points mentioned below in Slide 6.2:

Slide 6.2: Significance of Clinical Assessment

- To properly evaluate the woman's health status
- To identify pre-existing medical/surgical conditions
- To take necessary steps to manage pre-existing medical/surgical conditions
- To help the woman in deciding from the available options of abortion technologies and contraception

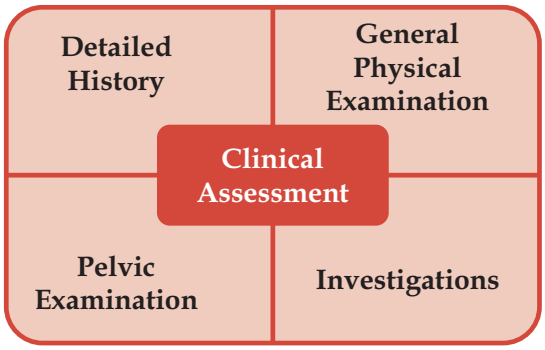
2. Components of Clinical Assessment

Time: 20 minutes

Methodology: Brainstorming; Group Work; Discussion; Presentation (Slides: 6.3, 6.4 (a, b, c), 6.5, 6.6, 6.7 [a, b], 6.8, 6.9, 6.10, 6.11)

Clinical assessment has four components:

Slide 6.3: Four Components of Clinical Assessment



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

Inform the participants on different aspects of clinical assessment through a gallery walk. Paste four pages of the flip chart around the room each labeled with one of the four above-mentioned components of clinical assessment. Divide the participants in four groups and ask each group to list the information that they should get under each component of clinical assessment on the respective charts.

Ensure that all the points listed below under each component are covered:

a) Detailed History

It is important that providers take a woman's clinical history early during their interaction. This will help determine the length of the pregnancy and identify pre-existing medical conditions which require attention.

Slide 6.4(a): History

- 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

Slide 6.4(b): History

- 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

Slide 6.4 (c): History

- History of pre-existing medical/surgical conditions:
  - Hypertension
  - Heart disease
  - Diabetes mellitus
  - Epilepsy
  - Asthma
  - Renal disease
  - Drug allergies
  - Bleeding disorders
  - Current medication
  - Previous uterine/abdominal surgery

Explain to the participants that if history of any of the above conditions is found, it may be necessary to refer the woman to an appropriate facility or be prepared to act according to the woman's special needs.

b) General Physical Examination

Tell the participants that the physical examination should begin with a general health assessment which includes the following:

Slide 6.5: General Physical Examination

- 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

Accurately determining the length of the pregnancy is a critical factor in both selecting an abortion technology and preventing complications. In induced abortion care, the miscalculation of the length of pregnancy is a significant cause of complications.

Calculation of Gestation Age

Tell the participants how to calculate the length of pregnancy/gestation age for the procedure.

Slide 6.6: Calculating Gestation Age

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

  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.

Explain to the participants that we will demonstrate the pelvic examination first on the pelvic model and then on a woman and they will practice in a similar manner.

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.

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 to reassure her.

Slide 6.7(a): Pelvic Examination (Preparation)

1. Ask the woman to pass urine
2. Position the woman by helping her to move onto the edge of the table with legs folded at the knees
3. Attend to any special anatomical or physical needs, including disability, arthritis or injuries

Slide 6.7(b): 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 (Annexure 1) followed by the procedure. A 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 her 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.

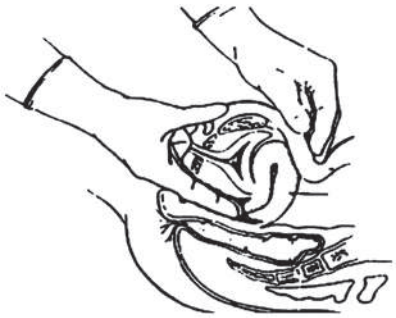
- Insert index and middle finger of one hand gently into the vagina, and with the other hand palpating the abdomen, assess the size of the uterus
- Pregnancy as early as six weeks from LMP can be diagnosed during the bimanual examination

Let the participants practice the assessment of the uterine size on the pelvic model and woman till they are proficient.

Explain the following positions of the uterus to the participants. This would help them in avoiding perforation or failure of the procedure in different positions of the uterus:

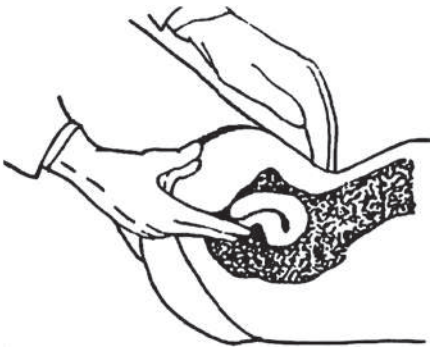
A. Anteverted Uterus

Slide 6.8: Anteverted Uterus (Tilted Forward)



B. Retroverted Uterus

Slide 6.9: Retroverted Uterus (Tilted Backwards)



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

Discuss the possible conditions where the gestation age calculated as per LMP does not correspond to the uterine size assessed by bimanual examination.

Slide 6.10: Uterine Size Larger/Smaller than Period of Amenorrhea

Uterine size larger than period of amenorrhea	Uterine size smaller than period of amenorrhea
• Full bladder • Inaccurate menstrual dating • Multiple pregnancies • Associated uterine abnormalities such as fibroids • Gestational trophoblastic disease (molar pregnancy) • Conceived in lactational amenorrhea	• Inaccurate menstrual dating • Secondary amenorrhea/irregular periods • Lactational amenorrhea • Ectopic pregnancy • Spontaneous abortion • No pregnancy

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

Slide 6.11: 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

1. Ectopic Pregnancy

Ectopic pregnancies can be diagnosed with a careful history, examination and USG. Since it is an obstetric USG, it must be done in accordance with the PCPNDT Act.

Signs/symptoms during ectopic pregnancy might include:

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

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

2. Molar pregnancy

It is an abnormal pregnancy characterized by the overgrowth of villi. In molar pregnancies, hydropic villi fill the uterus and there is no fetus present. Molar pregnancy can be diagnosed with careful history, examination and USG. It requires special follow-up with serial beta HCG tests even after the entire pregnancy tissue has been evacuated.

3. Fibroids

These are benign pelvic tumors whose growth may be stimulated during pregnancy. Fibroids may obstruct or distort the uterine cavity, making it difficult to perform an abortion procedure. Treatment plan should include an USG followed by abortion procedure or USG guided procedure at an appropriate level of facility.

3. Abortion Care in Pre-existing Medical Conditions

Time: 10 minutes 

Methodology: Discussion; Presentation (Slide: 6.12)

Discuss the following pre-existing medical conditions in a woman coming for termination of pregnancy and how the management will be different for the associated medical conditions:

Slide 6.12: Pre-existing Medical Conditions

- Hypertension
- Anaemia
- Diabetes
- Heart disease
- Asthma
- Epilepsy
- Blood clotting disorder

Table 6.1: Abortion in Pre-existing Medical Conditions

Hypertension	• In controlled hypertension, the woman should take her usual dose of anti-hypertensive medication on the day of the abortion procedure • In uncontrolled hypertension or BP > than 160/100 mm, the woman should be referred to an appropriate level of health facility • Methergin should be avoided • MMA is contraindicated in hypertension

Anaemia	• If haemoglobin is between 8–11 gm%, perform the procedure with caution and then treat for anaemia • If haemoglobin is < 8 gm%, bring the levels to 8 gm% and then perform the procedure • MMA is contraindicated if Hb is < 8 gm%
Diabetes	• In controlled diabetes, take the morning dose of medication before the procedure • 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 • MMA is contraindicated in this condition
Heart disease	• If asymptomatic, proceed with procedure • 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 • MMA is contraindicated in this condition
Asthma	• The woman should not be having an acute asthmatic attack prior to procedure • Some prostaglandins (PGF2 alpha) should not be used in asthmatics in case of post-abortal atony; PGE1 (misoprostol) can still be given
Epilepsy	• The woman should take her usual dose of anti-epileptic medication on the day of the abortion procedure • MMA is contraindicated in uncontrolled epilepsy
Blood-clotting disorders	• 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 • MMA is contraindicated in this condition

4. Case Studies/Practice Pelvic Examination

Time: 5 minutes 

Methodology: Case Study; Discussion; Presentation (Slides: 6.13, 6.14, 6.15, 6.16)

The trainer should decide between giving a practice session on clinical assessment to the participants or doing case studies in this time duration.

Conducting Case Studies

Tell the participants that the next activity will require practical application of the information that has been discussed so far in the session. Ask the participants to read the case study by turns and give their responses to the question asked. Take additional responses from the group and then summarize the responses with the help of the slide on the key to each study.

Slide 6.13: Case Study 1

Mina, a 32–year-old woman, had her LMP about two and a half months ago. She has taken some medicines which her friend had given to her to terminate the pregnancy at home. After taking the drug, Mina has been experiencing nausea and vomiting, but no bleeding. She has come to you and wants an abortion completed now. How will you clinically assess Mina for further treatment?

Slide 6.14: Key to Case Study 1

1. Detailed history: especially history of drug intake – name, dose, frequency; bleeding – volume, duration; pain abdomen; dizziness, fainting
2. Examination: General physical and pelvic examination
3. Investigations

Slide 6.15: Case Study 2

Meera, an extremely nervous 19 year old girl, has come to the clinic with her mother. Meera has a bruise on her left arm from a possible incidence of sexual assault. Upon examination, you detect a foul-smelling purulent discharge coming from the cervix. Meera did not have her periods which were due two weeks ago. How will you clinically assess Meera for further treatment?

Slide 6.16: Key to Case Study 2

1. Detailed history
2. Examination: General and pelvic examination (look for type and severity of infection)
3. Investigations: USG, cervical and vaginal swab, if possible

5. Different Uterine Evacuation Methods

Time: 15 minutes

Methodology: Discussion; Group work; Presentation (Slides: 6.17, 6.18)

A detailed and careful clinical assessment can guide the service provider to judge the 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.

Ask the participants to enlist the different methods which can be used for the evacuation of uterine contents and complete the list from the following:

Slide 6.17: Uterine Evacuation Methods

A. Vacuum Aspiration

- Manual Vacuum Aspiration (MVA)
- Electric Vacuum Aspiration (EVA)

B. Medical Methods of Abortion (MMA)

C. Dilatation & Curettage (this technology is not recommended)

Overview and Comparison of Uterine Evacuation Methods

Enlist different aspects of the uterine evacuation methods on a flip chart. Divide the participants into three groups. Assign one uterine evacuation method to each group. Give them 10 minutes to write responses to each aspect written on the chart for their assigned method. Groups then present the responses to the larger group.

The three groups will be:

a. Manual Vacuum Aspiration (MVA)

b. Electric Vacuum Aspiration (EVA)

c. Medical Methods of Abortion (MMA)

Slide 6.18: Aspects of UE Methods for Comparison

1. Define the method
2. Gestation limit
3. Effectiveness
4. Time taken for the procedure
5. POC check
6. Number of visits required for the procedure
7. Risk of cervical and uterine injury
8. Risk of foetal malformation on continuation of pregnancy

Start the discussion on various methods.

The details on various aspects of uterine evacuation by different methods is as below:

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

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

6. Summary

Time: 5 minutes

Methodology: Presentation (Slide: 6.19)

Slide 6.19: Summary

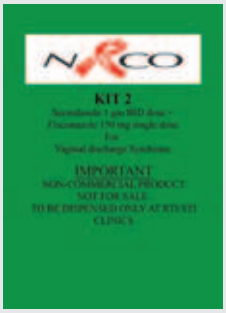
- Ensuring privacy and confidentiality during history taking and examination helps the woman to confide in the provider
- Four components of clinical assessment are: detailed history; physical examination; pelvic examination; investigations
- Detailed history and thorough physical examination help to 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

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

Annexure 1

Guidelines for Treatment of Pelvic Infection

STI/RTI Syndromic Case Management

1. Vaginal Discharge		
Symptoms: • Excessive vaginal discharge • Burning while passing urine, increasing frequency • Genital complaints by sexual partners • Low backache Note the nature and type of discharge (quantity, colour and odor) Treat partners, if symptomatic	Tab Secnidazole 2 gm OD stat + Cap Fluconazole 150 mg OD Stat	Kit-2/Green 
2. Cervical Discharge		
Symptoms: • Burning while passing urine, increasing frequency • Genital complaints by sexual partners • Low backache Note the nature and type of discharge (quantity, colour and odor) Treat partners, if symptomatic	Tab Azithromycin 1 gm OD stat + Tab Cefixime 400 mg OD Stat	Kit-1/Gray 
3. Lower Abdominal Pain		
Symptoms: • Lower abdominal pain • Fever • Vaginal discharge • Menstrual irregularities such as heavy/irregular vaginal bleeding • Dysmenorrhoea, dyspareunia, dysuria, tenesmus • Lower backache • Cervical motion tenderness Treat male partners	Tab Cefixime 400 mg OD stat + Tab Metronidazole 400 mg BD x 14 days + Doxycycline 100 mg BD x 14 days	Kit-6/Yellow 

Climate setting
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 7

MEDICAL METHODS OF ABORTION (MMA)

7. Medical Methods of Abortion (MMA)

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self-Assessment Tool b. Introduction to the Session	Discussion Presentation	5 minutes
2.	Medical Methods of Abortion: a. Advantages and Limitations of MMA b. Eligibility Aspects of MMA c. Documentation/Reporting for MMA	Brainstorming Discussion Presentation	15 minutes
3.	MMA Protocol a. Drugs used in MMA b. MMA: Schedule c. MMA: Effectiveness	Brainstorming Discussion Presentation	15 minutes
4.	Management of Side Effects and Complications with MMA	Brainstorming Discussion Presentation	20 minutes
5.	Summary	Presentation	5 minutes

7. Medical Methods of Abortion (MMA)

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 medical methods of abortion - True or False

4) Counselling prior to medical methods of abortion includes a discussion of all EXCEPT:

   a. The importance of completing the process once it has begun

   b. Basic information about medical methods of abortion

   c. The necessity of obtaining spousal consent

   d. Side effects and complications

5) Which of the following is NOT a potential side effect of medical methods of abortion?

   a. Diarrhoea

   b. Tingly sensation

   c. Vomiting

   d. Fever and/or chills

Key to Self Assessment Tool:

1) False 2) True 3) False 4) c

5) b

1a. Self Assessment Tool

1b. Introduction to the Session

Time: 5 minutes

Methodology: Discussion; Presentation (Slide: 7.1)

Greet the participants and facilitate the completion of the self-assessment tool. Discuss the correct responses with them. Share the objectives of the session.

Slide 7.1: Session Objectives

- List the advantages, limitations, indications and contraindications for MMA
- Understand the protocol of MMA drugs
- Know the documentation and reporting procedures for MMA
- Recognize side effects and complications during MMA and its management

Medical Methods of Abortion (MMA) is a non-surgical, non-invasive method for the 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.

2. Medical Methods of Abortion (MMA)

Time: 15 minutes

Methodology: Brainstorming; Discussion; Presentation (Slide: 7.2)

Medical Methods of Abortion (MMA) is commonly known as Medical Abortion.

2a. Advantages and Limitations of MMA

Ask the participants if they know of the advantages and limitations of MMA over other available methods for termination of pregnancy.

Slide 7.2: Advantages and Limitations of MMA

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 a quick abortion procedure since MMA takes longer, the mean duration of bleeding being 9.5 days
Anesthesia 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

2b. Eligibility Aspects of MMA

Ask the participants if they know of the various eligibility aspects related to MMA including : (a) indications and contraindications (b) provider and site eligibility for providing MMA. Enlist them on the chart and complete from the information given below:

Indications and Contraindications for MMA

Slide 7.3: Indications and Contraindications for MMA

Indications:

- Women seeking termination of pregnancy up to seven weeks (49 days from LMP with regular cycles) of gestation*

Contraindications:

- Anaemia (Haemoglobin <8 gm%)
- Confirmed or suspected ectopic pregnancy
- Undiagnosed adenexal mass
- Uncontrolled hypertension; BP ≥ 160/100 mm Hg

Slide 7.4: Contraindications for MMA (contd...)

- Heart problems such as angina, valvular disease and arrhythmia which can lead to sudden cardiovascular collapse
- 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

**Mifepristone + misoprostol (1 tab mifepristone 200 mg + 4 tablets misoprostol 200 mcg 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.*

Share with the participants the conditions where the MMA drugs have to be prescribed with caution.

Slide 7.5: Conditions for Special Precautions in MMA

- Pregnancy with IUCD in situ: Remove IUCD before giving drugs
- Pregnancy with uterine scar: Although safe, exercise caution with history of LSCS, hysterotomy or myomectomy
- Bronchial asthma: Misoprostol, a bronchodilator can be used, but not other prostaglandins
- Pregnancy with fibroid*
- Women on anti-tubercular drugs**

**Large fibroid encroaching on endometrial cavity can cause heavy bleeding and can interfere with uterine contractility.*
***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

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

Slide 7.6: Provider and Site Eligibility for MMA

Provider:

- MMA drugs can be prescribed ONLY by Registered Medical Practitioners (RMPs), as per the MTP Act

Site:

- Primary, secondary and tertiary level of 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 and certificate by owner of approved site displayed at clinic

2c. 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:

Slide 7.7: Documentation/Reporting Requirement for 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

3. MMA Protocol

Time: 15 minutes

Methodology: Brainstorming; Discussion; Presentation (Slides: 7.8, 7.9)

A brief description of the MMA drugs, their method of administration, schedule and effectiveness is given below:

3a. Drugs Used in MMA

Drugs Used

Commonly used drugs for MMA are mifepristone and misoprostol.

Ask the participants the mechanism of action and features of the two drugs used in medical methods of abortion: mifepristone and misoprostol.

Slide 7.8: About Mifepristone

- An antiprogestin which blocks the progesterone receptors in the endometrium causing the necrosis of uterine lining and detachment of implanted embryo
- Causes cervical softening and increased production of prostaglandins, leading uterine contractions
- Sensitizes the uterus to the effect of prostaglandins
- Available as 200 mg tablet
- A small percentage of women (3%) may expel products with mifepristone alone

Slide 7.9: About Misoprostol

- A synthetic prostaglandin E1 analogue
- Binds to myometrial cells causing strong uterine contractions, cervical softening and dilatation. This leads to expulsion of conceptus from the uterus

- Available as 25, 100 and 200 mcg tablets.

Advantage of misoprostol over other prostaglandins:

- Economical and stable at room temperature in comparison to PGF2alpha derivatives
- Well absorbed from different routes of administration

Details on different routes of administration for misoprostol are given in Annexure 3.

3b. MMA: Schedule

Describe the steps that a provider needs to take on each of the visits made by the woman during MMA protocol.

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.

Guidelines for Providers

Slide 7.10: First Visit /Day 1 /Day of Mifepristone Administration

1. Detailed history
2. Counselling including general and method specific counselling
3. Physical and pelvic examination
4. Contraceptive options
5. Investigations (Injection Anti D 50 mcg if Rh negative)
6. Informed consent
7. Mifepristone 200 mg orally
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

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

First Visit/Day 1/Day of Mifepristone Administration

1. **Complete history:** Refer to the section on history taking in Chapter 6 on `Clinical Assessment'

2. **Counselling-General:** Refer to Chapter 5 on `Counselling Skills' for details

   Method-specific counselling

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

   - It is a non-invasive and non-surgical method
   - The process is similar to a spontaneous abortion
   - She needs to make a minimum of three visits to the facility (Days 1, 3, 15)
   - She has to follow a definite drug protocol
   - She may have vaginal bleeding for 8-13 days
   - She has to be ready for a VA procedure in case of failure of the method or excessive bleeding. (Soaking two or more pads per hour for two consecutive hours)
   - She has to stay within the accessible limits of the appropriate health care facility
   - She may experience side effects of the drugs, that is nausea, vomiting, diarrhoea, etc.
   - There could be teratogenic (harmful) effect on the foetus, if pregnancy continues
   - A small percentage of women (3%) may expel products with mifepristone alone, but total drug schedule with misoprostol must be completed
   - During abortion process, it is ideal to avoid intercourse to prevent infection or use barrier methods

3. **Physical and pelvic examination to rule out contraindications:**

   - Check for pallor: If pallor exists, heavy bleeding during the procedure may worsen the condition and increase the risk of shock and ill health
   - Check blood pressure
   - Check cardiovascular and respiratory system for any pre-existing disease
   - Carry out pelvic examination (P/S and P/V) to:
     - Assess the size of uterus and confirm the period of gestation
     - If the size of uterus is less then period of amenorrhea, rule out ectopic pregnancy and if size is more, rule out uterine/pelvic conditions such as fibroid
     - Look for any infection

4. **Contraceptive options**

   - Oral pills can be started on 3rd or 15th day of the protocol
   - IUCD can be inserted on Day 15, provided the presence of infection is ruled out
   - Condoms can be used as soon as she resumes sexual activity

- Tubal ligation can be done after first menstrual cycle. However if desirous of concurrent tubal ligation, surgical method of abortion is preferred
- Injectables can be given on the 3rd or 15th day
- Vasectomy, if chosen, can be done independent of the MMA procedure

5. **Investigations (Recommended)**
   - Haemoglobin
   - Routine urine examination
   - Blood Group: ABO Rh especially in primigravida

   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 6 on 'Clinical Assessment')

6. **Obtain informed consent:** Get the consent of the woman/guardian in Form C. The provider should also sign the RMP opinion form (Form I) before going ahead with the procedure

7. **Give tablet mifepristone,** 200 mg orally to the woman
   - Antibiotics: Routine use of prophylactic antibiotics is not indicated except in cases of:
     - Nulliparous women
     - Women with vaginal infections

8. **Give contact address and phone number** of the facility where woman can go in case of any 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

Slide 7.11: Follow-up Card

Second Visit/Day 3/Day of Misoprostol Administration

Slide 7.12: Second Visit/Day 3/Day of Misoprostol Administration

1. Note any history of bleeding/pain or any other side effects after mifepristone
2. Misoprostol 400 mcg (two tablets of 200 mcg) oral /vaginal
3. Observe for four to six hours in the clinic/hospital
4. Prescribe drug for pain relief
5. Perform bimanual examination just before discharging her from the facility, to rule out expulsion of POC
6. Inform the woman about warning signs
7. She must keep filling the card

1. **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

2. **Administer tablet 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

3. **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 to 13 days. Heaviest bleeding lasts one to four hours which coincides with the expulsion of POCs

4. **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

5. **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 POC is complete, whichever is earlier as per the doctor's discretion

6. Inform the woman about warning signs (report to the center/provider in case of excessive bleeding/acute abdominal pain). Also inform her:
   a. To use clean sanitary napkins
   b. To avoid tampons and douche
   c. To report if there is no bleeding even 24 hours after taking misoprostol
   d. That she can have side effects such as nausea, vomiting, diarrhoea (usually mild), headache, fever, dizziness
   e. To return for follow-up on the fifteenth day
7. Keep filling the card

Third Visit/Day 15/Follow-up Visit

Slide 7.13: Third Visit/Day 15/Day of Follow-up

1. Note relevant history
2. Carry out 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 if bleeding continues
5. Ask the woman to report back if there are no periods within six weeks

Drug Protocol

Summarize the drug protocol for the participants.

Slide 7.14: Protocol for MMA for upto Seven Weeks

Mifepristone on Day 1	**Misoprostol on Day 3**		**Day 15**
200 mg (1 tablet) orally (available as 200 mg tablet)	**Dose**	**Route**	• Confirm and ensure completion of the process • Contraception
	400 mcg	Oral/vaginal/ sublingual/buccal *(WHO, 2012)*	

3c. MMA: Effectiveness

Ask the participants if they are aware of MMA effectiveness. Take their responses and then share the information below:

Slide 7.15: 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%

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

4. Management of Side Effects and Complications with MMA

Time: 20 minutes

Methodology: Brainstorming; Discussion; Presentation (Slide: 7.16, 7.17)

Side Effects

Ask the participants to enlist the side effects associated with MMA drugs. Complete from the list below:

Slide 7.16: Side Effects with MMA Drugs

a. Bleeding per vaginum
b. Abdominal pain
c. Fever, warmth and chills
d. Gastrointestinal side effects
e. Headache and dizziness

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

Post-abortion infection is rare after medical methods of abortion. Persistent fever (> 38°C for two reading four hours 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. Anti-emetic and anti-diarrhoeal medicines maybe 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. Advise the woman to take plenty of fluids, rest and exercise caution while changing positions.

Complications and Their Management

Ask the participants to enlist the possible complications associated with MMA. Complete from the list below:

Slide 7.17: Potential Complications with MMA

i. Severe vaginal bleeding
ii. Incomplete abortion
iii. Continuation of pregnancy
iv. Infection

i. Severe Vaginal Bleeding

Soaking two or more pads per hour for two consecutive hours need 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 assess 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 11 on 'Complications of Abortions' 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 are 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
- If the gestation sac is visible but it 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 medical methods of abortion.

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
- 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
- If USG shows a viable gestation sac, the 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 teratogenic effect of the drugs.

iv. Infection

Infection of the uterus is rare in the process of medical methods of abortion.

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

6. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 7.18[a,b])

Slide 7.18(a): 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 and III)

Slide 7.18(b): Summary

- The drug protocol should be strictly followed for the 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 a slight risk of teratogenic effect of the drugs

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

Annexure 1

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															
	Routine 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
Pre-procedure tasks		
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 medical methods of abortion (pregnancy upto seven weeks)		
Explores her views on abortion options and which abortion method is the best for her		
If the woman chooses medical methods of abortion provides 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: • Common side effects and symptoms • Importance of attending required clinic visits • Warning signs indicating the need to return to the clinic		
Explains how the mifepristone and misoprostol will be administered and what to expect after taking them		
Explains that if the medical methods of abortion should fail, vacuum aspiration will be necessary to terminate the pregnancy		

Day 1: Skills required during first visit to clinic (mifepristone administration)	Yes	No
Asks the woman whether she has additional questions		
Obtains written informed consent		
Provides first dose for MMA		
Provides mifepristone 1 tablet 200 mg orally		
Post-procedure tasks		
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		
Ask her to return to the clinic for the second dose after two days		

Day 3: Skills required during second visit to clinic (misoprostoI administration)	Yes	No
Pre-procedure tasks		
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		
Provides second dose for MMA		
Administers misoprostol in clinic (per protocol) two tablets vaginal/oral/sublingual/buccal		
Post-procedure tasks		
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 (misoprostoI 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
Greets the woman in a friendly, respectful manner; ensures privacy		
Inquires about her experience of the abortion process, asks her if she saw the expulsion of POC and feels that the abortion is complete. Asks whether she is still having symptoms of pregnancy		
Explains what to expect during this follow-up visit		
Assessment to ensure abortion is complete		
Assesses the completeness of the abortion by: • Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping, any visible parts of POC expelled) • Conducting a physical examination (pelvic examination to assess the size and consistency of the uterus and opening of the cervical os) • Advising/performing an ultrasound for the presence of gestation sac, if it is still unclear whether the abortion is complete		
If the abortion is not complete, discusses treatment options: expectant management, additional misoprostol administration or vacuum aspiration		
If the pregnancy is continuing: • Discusses need for vacuum aspiration to terminate it • Arranges to complete the procedure by VA		

Day 15: Skills required during third visit to clinic (Follow-up visit)	Yes	No
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		

Routes of Administration for Misoprostol

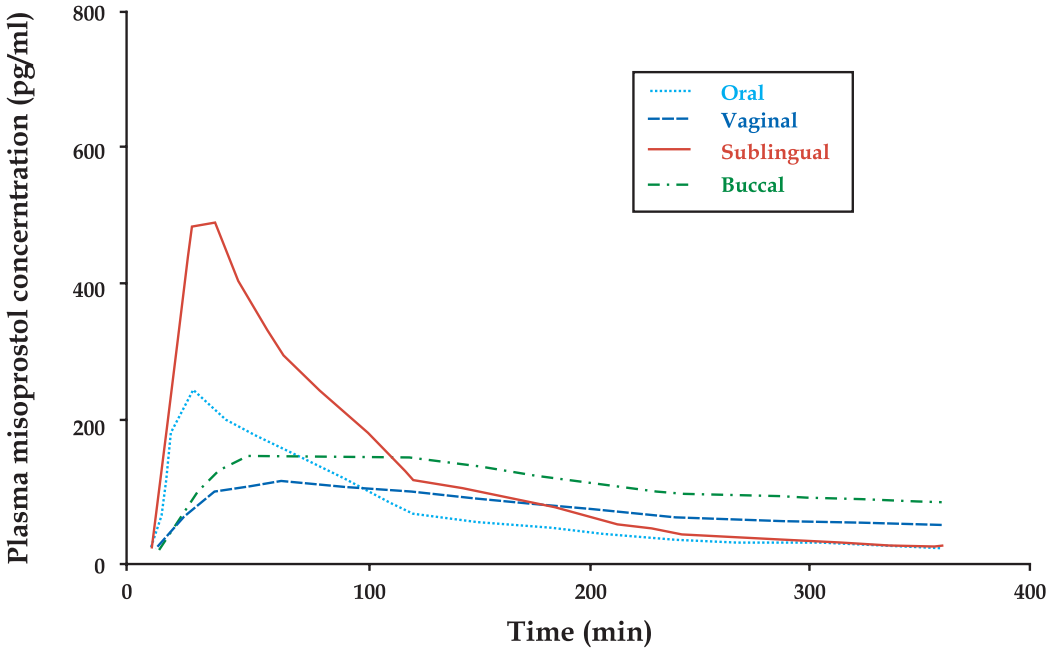
Uptake of misoprostol through different routes of administration:

Oral: Rapid onset (8 minutes); peak at 30 minutes; and short total duration of action (120 minutes). There are no regular uterine contractions following cessation of uterine tonus with this route (unlike all other routes) unless repeated doses are given.

Vaginal: Gradual onset (20 minutes); peak at 75 minute; long duration (4 hours) and sustained (upto 6 hours) 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 (11 minutes); peaks at 30 minutes; and long duration of action, like vaginal route (4 hours). Serum levels achieved are highest with this route.

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



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

Climate setting
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 8

INFECTION PREVENTION

8. Infection Prevention

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards, utility gloves, surgical gloves, set of personal protective barriers (cap, mask, gown), syringe with needle and cap, bleaching powder (for chlorine solution), plastic containers (bucket, mug, plastic teaspoon), MVA kit (aspirator and cannula); charts on: instrument processing, waste management, hand washing

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Presentation	10 minutes
2.	Cycle of Disease Transmission	Brainstorming Discussion Presentation	10 minutes
3.	Universal Precautions	Brainstorming Discussion Demonstration Presentation	20 minutes
4.	Steps for Instrument Processing	Discussion Demonstration Presentation	15 minutes
5.	Summary	Presentation	5 minutes

8. Infection Prevention
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 by 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

Key to Self Assessment Tool:

1) b	2) c	3) e	4) c
5) a	6) d	7) c	

1a. Self Assessment tool

1b. Introduction to the Session

Time: 10 minutes

Methodology: Presentation (Slide: 8.1)

Greet the participants and facilitate the completion of the self-assessment tool. Discuss the correct responses with them. Share the objectives of the session.

Slide 8.1: Session Objectives

- Understand the cycle of disease transmission in an abortion care setting
- Know the components of universal precautions
- Know the protocols for waste management
- Understand the steps for instrument processing

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
- Prevent spread of antibiotic-resistant micro-organisms
- Reduce the overall cost of health care services.

Hence all health care workers should adopt appropriate infection prevention practices in their facilities.

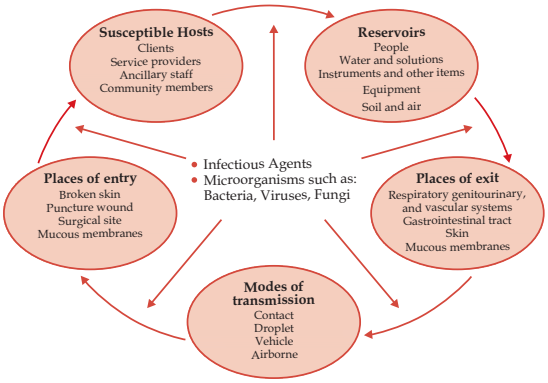
2. Cycle of Disease Transmission

Time: 10 minutes

Methodology: Brainstorming; Discussion; Presentation (Slide: 8.2)

Share with the participants the cycle of disease transmission.

Slide 8.2: Cycle of Disease Transmission



3. Universal Precautions

Time: 20 minutes

Methodology: Brainstorming; Discussion; Demonstration; Presentation (Slides: 8.3, 8.4 [a, b, c, d], 8.5, 8.6, 8.7, 8.8, 8.9)

Universal Precautions

Universal Precautions are so called because they should be practiced by all health care workers against body fluids, wet surfaces and during contact with clients at all times.

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.

Ask the participants if they can enlist components of universal precautions. Complete from the list in Slide 8.3.

Slide 8.3: 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 an important (though often neglected) practice to prevent infection.

Slide 8.4(a): Hand Washing

When should we wash our hands?

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

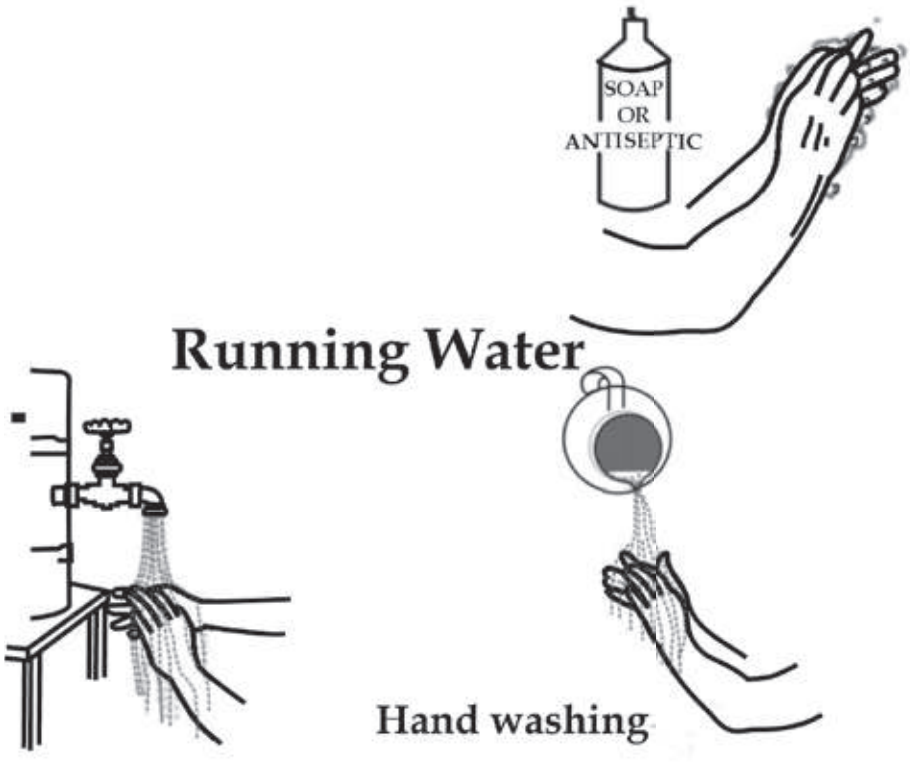
Slide 8.4(b): Hand Washing

How should we wash our hands?

- Use soap and clean, running water
- 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.*

Slide 8.4(c): Hand Washing



Slide 8.4(d): Hand Washing (Routine and Surgical)

- The steps for both routine and surgical hand washing are same but duration is different
- For routine hand wash, the total duration is 40 to 50 seconds
- For surgical hand wash, time spent on each step is three times more. Total duration is 3 to 5 minutes

B. Personal Protective Barriers

Ask the participants to make a list of all the protective barriers they know of and are used in their settings. Complete from the list below.

Slide 8.5: Personal Protective Barriers

- Gloves (surgical; utility; examination)
- Face mask
- Eye-cover
- Gown
- Cap
- Footwear/cover

Three types of gloves are used in the clinical practice:

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

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 and disposed of immediately after a procedure followed by hand washing

The gloves should not be a substitute for hand washing.

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

C. Aseptic Techniques

Please refer to step 3 on pages 138-139 in Chapter 9 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.

Ask the participants to name some sharp items used during service provision.

Answers may include blades, hypodermic needles, tenaculae, suture needles and scissors.

Slide 8.6: Safety with Sharp Items

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

Read the case scenario in slide 8.7 and ask the participants if it presents a good solution for proper disposal of sharp items, in the given situation.

Slide 8.7: Site Scenario

A clinic decided that, to reduce costs, they would put one large container at the centrally located nurses' station. Workers would bring their sharps there from all over the clinic. Is this a good solution for the disposal of sharps?

Answer: No. Containers should be located at every place where needles are used because carrying needles can cause accidental injuries.

In spite of the 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

Ask the participants about the cleanliness schedule that they follow at their facilities. Share with them the protocol to be followed.

Slide 8.8: Cleanliness Protocol

- 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, chairs, 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 table, examination couches, chairs, trolley tops or Mayo stands, lamps and other potentially contaminated surfaces 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 water after cleaning Clean the floors with a mop soaked in a disinfectant cleaning solution
Each week	Clean ceilings with a mop dampened with a disinfectant cleaning solution

Preparation of 0.5% chlorine solution

Calcium Hypochlorite or Chlorinated lime:

If using bleaching powder: Use the formula – (0.5/% active chlorine in powder) x 1000 = gms of powder/litre of water. So for the bleaching powder with 35% available chlorine, the formula will be:

(0.5/35) x 1000 = 14.3/15 gms/litre of water

Dissolve 3 teaspoons of bleaching powder (15 gm of calcium hypochlorite) in one liter of water. Increase the quantity of Chlorine in the same proportion to prepare a larger quantity of solution.

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, following rules apply:

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

Each health care facility should have its own guidelines. Most experts recommend the following (given below), though some differ in duration of contact and concentration.

For small volume spills:

- 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
- Wipe with gauze or cloth with gloved hands
- Discard the gauze or cloth as biomedical waste

For large volume spills:

- Close the area using a wet floor or biohazard sign board
- Mop with absorbent cotton/gauze with gloved hands and discard it in infectious waste-bin
- 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) over it
- For highly infectious spills use 10% bleach solution
- Leave it for at least 10 minutes contact period
- Wipe thoroughly with gloved hands using cotton or gauze and dispose accordingly
- Reapply disinfectant and wipe

E. Waste Management Plan

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

All the 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 material, 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.

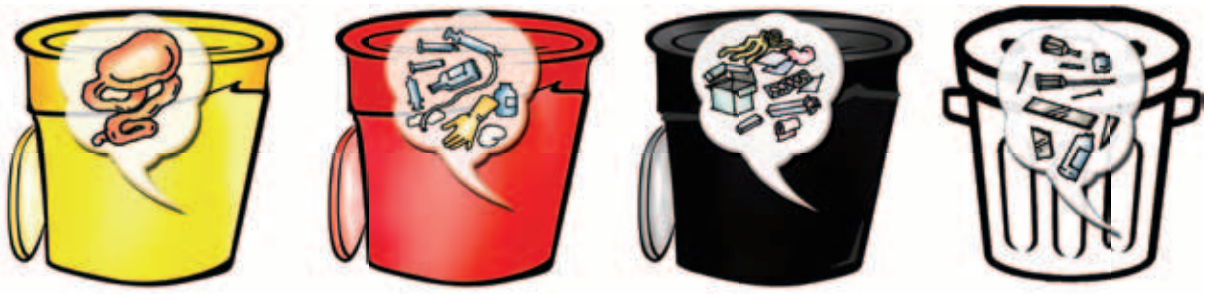
There are four steps in waste management plan:

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

1. Segregation

Most of the health facilities use color coded bags or containers to collect different types of waste. The illustration below shows the types of waste and the containers for collection.

Slide 8.9: 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 and 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 infections
- Never transport waste through crowded areas

4. Disposal of Waste

Ask the participants how they currently dispose of infectious waste at their sites and share the information given below with them.

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

If an 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 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. Second trimester POC, since the placenta and other foetal parts are already formed, 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

4. Steps for Instrument Processing

Time: 15 minutes

Methodology: Discussion; Demonstration; Presentation (Slides: 8.10, 8.11, 8.12, 8.13)

Show the Instrument Processing Chart (Annexure 4) to the participants and allow them a minute to have a look at it. Discuss the steps of processing instruments, as given in Slide 8.10.

Slide 8.10: Steps for Processing of Instruments

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.

Slide 8.11: Steps in Decontamination

- Use gloves
- Draw solution into cannula and aspirator and flush each of the used cannulae
- 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

Ask the participants if they know the difference between sterilization and high level disinfection. Refer to Slide 8.12.

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

Slide 8.12: Sterilization /HLD of MVA Equipment

Sterilization options:

- Autoclave at 121°C/250°F for 30 minutes with a pressure of 106 kPa/15 lbs/in^2
- 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

Slide 8.13: Precautions During Sterilization/HLD

For autoclave:

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

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

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

Please remember:

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

5. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 8.14)

Slide 8.14: 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: segregation; collection and storage; transportation; disposal
- Steps of instrument processing: decontamination soak; cleaning; sterilization/HLD; storage

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

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 1st glove by cuff

Slip hand into glove by holding cuff 4

5 Pick 2nd glove by slipping fingers under cuff

Put 2nd 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 1st glove partly 2

3 Holding near cuff, pull 2nd 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/ thermocol, 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
- X Don't mix infectious waste with non-infectious waste
- X 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 
Sterilization		
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^2)	✓	✓
2. Fully immerse aspirator/cannula in 2% glutaraldehyde solution for 10 Hrs.	✓	✓
High-level Disinfection (HLD)		
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.	✓	✓

Storage

- Immediately use aspirator/cannula after processing
- Store HLD processed aspirator/cannula in dry and covered HLD tray for not more than 24 hours
- Store sterilized aspirator/cannula in sterilized drum for not for more than 7 days

Climate setting
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 9

VACUUM ASPIRATION (VA)

9. Vacuum Aspiration (VA)

Time: 120 minutes

Advance Preparation

Flip chart, markers, pelvic model, perineal sheet, gloves, MVA Kit (aspirator and cannula), MTP instruments (sponge holder, Sim's speculum, Anterior vaginal wall retractor, vulsellum, dilator set), strainer, bowl for POC, 10 ml syringe with needle, MVA procedure chart

Session Plan

S. No.	Sub-session	Methodology	Time (120 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Presentation	10 minutes
2.	Indications and Contraindications for Vacuum Aspiration (VA)	Presentation	10 minutes
3.	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	Demonstration Hands on Presentation	30 minutes
4.	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	Discussion Presentation	10 minutes
5.	Post-procedure Care	Discussion Presentation	10 minutes
6.	Summary	Presentation	5 minutes
7.	Practice on Pelvic Model	Demonstration	25 minutes
8.	MVA Video CD		20 minutes

9. Vacuum Aspiration (VA)
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 the 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 had 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

Key to Self Assessment Tool:

1) d	2) d	3) c	4) d
5) b	6) d	7) d	

1a. Self Assessment Tool

1b. Introduction to the Session

Time: 10 minutes

Methodology: Presentation (Slide: 9.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss the correct responses with them. Share the objectives of the session.

Slide 9.1: Session Objectives

- Enlist indications and contraindications for VA (MVA and EVA)
- Explain MVA/EVA equipment and steps of the procedure
- Know the protocol for post-procedure and follow-up care after VA
- Demonstrate steps of the MVA procedure on the pelvic model

Vacuum Aspiration (VA) 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.

VA is a safe abortion care technology which has been endorsed nationally and internationally:

- **National Population Policy 2000*:** 'In strengthening policies for safe abortion, adopt updated technologies that are safe and easy e.g. Manual Vacuum Aspiration, not necessarily dependent on anesthesia.'
- **FIGO/WHO Endorsement:** 'Properly equipped hospitals should abandon curettage and adopt the aspiration methods, selecting Manual and/or Electric Vacuum Aspiration.'

2. Indications and Contraindications for VA

Time: 10 minutes

Methodology: Presentation (Slides: 9.2, 9.3)

Ask the participants to enlist the indications and contraindications for VA and add from the list in the slide below, if all the indications are not covered.

**Ref: NPP, 2000*

Slide 9.2: Indications for VA

- Termination of pregnancy upto 12 weeks uterine size according to examination or LMP
- Treatment of incomplete abortion upto 12 weeks LMP
- Missed abortion upto 12 weeks LMP
- Molar pregnancy (Hydatidiform Mole)

Slide 9.3: Contraindications for VA

- Termination of pregnancy of uterine size/gestation age more than I2 weeks
- Incomplete abortion of uterine size more than 12 weeks
- Acute cervicitis/PID
- Multiple fibroids
- H/o bleeding disorder
- Suspected uterine perforation

Caution to be used in pre-existing medical conditions

3. MVA Equipment & Procedure

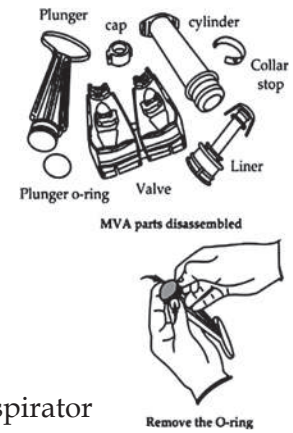
Time: 30 minutes

Methodology: Demonstration; Hands on; Presentation (Slides: 9.4, 9.5, 9.6, 9.7, 9.8, 9.9, 9.10, 9.11, 9.12, 9.13, 9.14, 9.15, 9.16, 9.17)

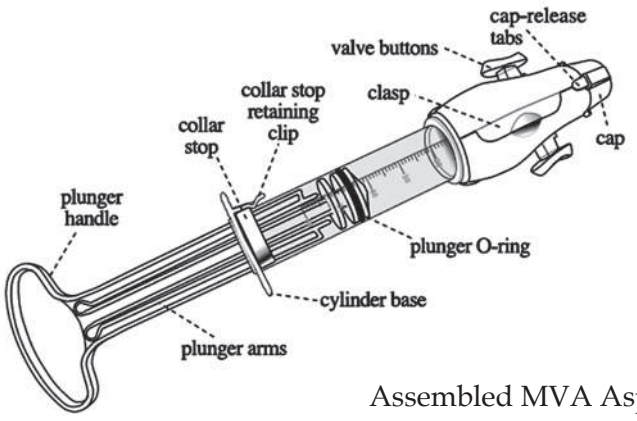
3a. Parts and Features of MVA Kit (Aspirator and Cannula)

Show different parts of the aspirator to the participants and describe all of them, including their functions.

Slide 9.4: Manual Vacuum Aspirator



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 a 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 the double valve aspirator is that it can be used for pregnancy termination upto 12 weeks

Demonstrate the steps for disassembling the MVA aspirator

Slide 9.5: Disassembling the MVA Aspirator

1. Pull apart the cylinder and plunger from the valve assembly
2. Press cap-release tabs to remove cap in the valve assembly unit
3. Open hinged valve by pulling open the clasp
4. Remove valve liner
5. Disengage collar stop by sliding under retaining-clip. Pull plunger completely out of cylinder
6. Displace O-ring by pressing its sides and rolling it down into the groove below*

**Sharp objects should never be used to remove the O-ring, as it can damage the ring.*

Ask the participants to disassemble the MVA aspirator while you guide them.

Now reassemble the instrument while demonstrating each step to the participants.

Slide 9.6: Reassembling the MVA Aspirator

a. Place valve liner in the valve by aligning ridges

b. Close valve; ensure it snaps into place

c. Put the cap onto end of valve assembly unit

d. Push cylinder straight upto the base of valve

e. Place O-ring into groove near tip of plunger

f. Spread one drop of lubricant around O-ring with finger

g. Press plunger arms, push them straight into cylinder

h. Insert collar stop tabs into holes in cylinder

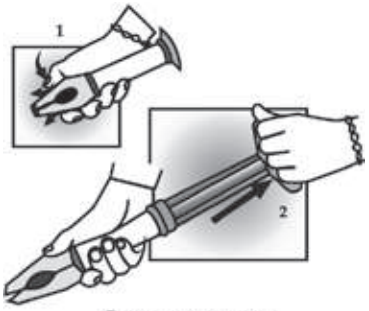
i. Move plunger in and out to lubricate

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 like K-Y Jelly and Glycerol can be used as lubricant.

Explain to the participants about' charging' (creating a vacuum) the aspirator.

Slide 9.7: Charging the Aspirator

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



Create a vacuum

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 that a 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 be recreated.

Distribute MVA aspirators among the participants. Allow them a few minutes to inspect and handle the aspirator. Ask the participants to disassemble and reassemble the aspirator, create and check the vacuum. Find out if anyone is having any difficulty. Go around helping and guiding them.

Discuss with the participants about what are the possible reasons for vacuum failure in the MVA aspirator.

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

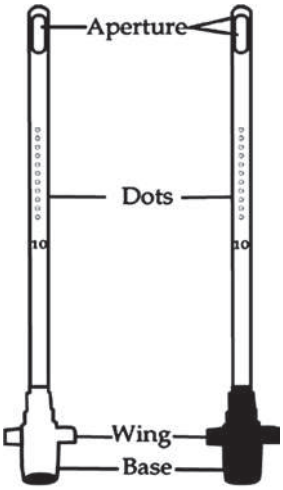
1. Aspirator is not properly assembled
2. O-ring is not properly positioned
3. Cylinder is not firmly seated on valve assembly

Slide 9.8: Replace MVA Aspirator if:

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

Cannula

Slide 9.9: Cannula



Easy Grip Cannulae

Describe the following features of accompanying cannula in MVA kit to the participants:

- 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 POC. The suggested number of the cannula as per the uterine size is as below:

Slide 9.10: 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.

Slide 9.11: Replace Cannula if:

- It is cracked, twisted or bent, especially near the tip
- Tissue cannot be removed from its body while cleaning

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

3b. 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 and 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.

Ask the participants to enumerate sources of pain during the pregnancy termination procedure. Summarize with the help of slide below:

Slide 9.12: Sources of Pain During VA

- Psychological pain: anxiety, fear and apprehension heighten the sensitivity to pain
- Cervical dilatation
- Movement of the cannula against the uterine walls and the uterine contractions

Pain management during the VA procedure has two components:

1. Non-pharmacological
2. Pharmacological (use of medication)

Non-pharmacological Management

Ask the participants how the procedure can be made less painful with non-pharmacological support, without using medication and note their responses on the chart. Add from the list given in the slide below.

Slide 9.13: Pain Management: 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

Pharmacological Management

Ask the participants to list various medications to alleviate the pain. Ask them to prepare a list of locally available drugs and pain relief practices that are being followed in their health facilities.

Slide 9.14: Pain Management: Pharmacological

Anxiety

- Anxiolytics
- General anaesthesia

Cervical dilatation

- Local anaesthesia
- Analgesics

Uterine cramping

- Analgesics

Source of Pain and its Management	Dose and Timing	Duration of Effect	Side Effects
Anxiety 1. Anxiolytics i.e. Diazepam 2. General anaesthesia	Diazepam 10 mg orally 1 hour prior to procedure or 2-5 mg IV 20 minutes prior to procedure	4-6 hours	• Disorientation • Dizziness

Source of Pain and its Management	Dose and Timing	Duration of Effect	Side Effects
Cervical dilatation			
1. Lignocaine/Local Anesthesia	10 ml of 1% lignocaine	60-90 minutes	• Dizziness • Seizures
2. Analgesics (NSAID) Ibuprofen	400-800 mg 1 hour prior to the procedure	4-6 hours	• Gastritis
Uterine cramping			
1. Analgesics lbuprofen	400-800 mg 1 hour prior to the procedure	4-6 hours	• Gastritis

Local Anesthesia: Paracervical Block

Advantages of local anesthesia:

- Very effective
- Woman is responsive
- Early recovery
- 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.

3c. Steps for Performing MVA Procedure

Share with the participants the chart on 10 steps of performing Manual Vacuum Aspiration procedure. Discuss each step in detail while demonstrating it on the pelvic model.

Slide 9.15: Ten Steps of MVA

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 in section 3a
- Check the availability of all appropriate sized cannulae, 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

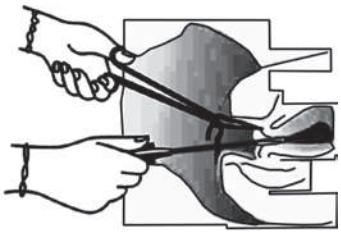
- Use Lignocaine one per cent (10 ml). Give the paracervical block using a 22-24 gauge needle. There is increasing evidence to show that pre-testing before the administration of local anaesthesia need not be mandatory
- Apply slight traction with the vulsellum/allis forceps to identify the area between the smooth cervical epithelium and the vaginal tissue. Insert the needle just under the epithelium to a depth of 2-3 mm at 4 and 8 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 anaesthesia to be effective

Step 5: Dilate cervix

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

Step 6: Insert cannula

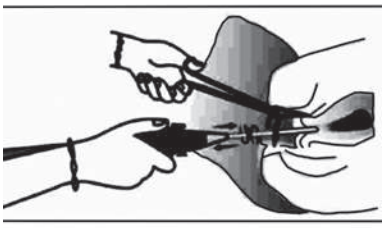
- Rotate the cannula while gently applying forward pressure
- Insert cannula slowly beyond the internal os



Insert canula into uterus

Step 7: Suction of uterine contents

- Attach charged aspirator to cannula
- Release valve buttons to start suction and observe the POCs flowing into the cylinder
- Gently rotate cannula 180 degrees in each direction
- Use a gentle "in and out" motion



Suction of uterine contents

- Do not withdraw cannula opening beyond external os before aspiration is complete

Slide 9.16: Signs of Procedure Completion

- Gritty sensation over the surface of uterus
- Cervix gripping over the cannula
- Red or pink foam without tissue passing through the 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 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 the evacuation of POC
4. Wrong dates

If the procedure is apparently complete:

- Wipe the cervix with a swab to assess bleeding
- Perform bimanual examination to check uterine size and firmness, if required

Step 9: Concurrent procedures

The following procedures can be done along with the MVA procedure if the woman requests for it:

- Tubal ligation
- IUCD insertion

However, accepting a concurrent contraceptive method should not be a prerequisite to providing MVA services.

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

Step 10: Instrument processing

- Immerse the aspirator in chlorine/bleaching solution after rinsing and disassembling
- Refer to Chapter 8 on 'Infection Prevention' for further details

3d. Solving Instrument Related Problems

Brief the participants on instrument related problems that can occur during the MVA procedure and how to resolve them.

Slide 9.17: MVA Instrument Related Problems

Situations where the vacuum can decrease unexpectedly during the procedure:

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

Resolving the above problems mentioned in the Slide 9.17:

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

4. Electric Vacuum Aspiration

Time: 10 minutes

Methodology: Discussion, Presentation (Slide: 9.18)

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.

4a. Parts and Features of EVA Equipment


EVA machine

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. The cannulae are either available with or without an adapter for connecting to the suction tube. The cannula without the adapter can be directly fitted into the tube.

4b. Pain Management Plan

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

4c. Steps for Performing EVA Procedure

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

Steps 2–6 are the 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. This provides a constant level of vacuum after it has reached the desired level for sucking out the uterine contents.

4d. Solving Instrument Related Problems

Slide 9.18: Instrument Related Problems (EVA)

- Vacuum pressure not built upto the optimum level
- Cannula accidentally withdrawn out of the cervical opening
- Cannula aperture gets clogged

1. Vacuum pressure not built upto the optimum levels, can be due to:
   - The connection between the cannula and suction tube is loose
   - Suction jar filled with POC
   - The jar lid is not snuggly fit
2. If the cannula is accidentally withdrawn out of the cervical opening:
   - Switch off the suction machine
   - Reinsert the cannula into the uterine cavity
   - Switch on the machine, build the suction levels and continue evacuation
3. If the cannula aperture gets clogged:
   - Switch off the suction machine
   - Pull out the cannula from the uterine cavity
   - Remove the tissue clogging the cannula using tissue/artery forceps
   - Re-insert cannula, switch on the machine and continue evacuation

5. Post-procedure Care

Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 9.19, 9.20, 9.21)

Ask the participants to enlist the elements of post-procedure care in a woman who has undergone on abortion procedure.

Slide 8.19: Elements of Post-procedure Care

1. Physical monitoring
2. Emotional support
3. Contraceptive counselling
4. Addressing other health issues
5. Providing discharge instructions

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

Elements of Post-procedure Care

1. Physical monitoring:
   - Take her vital signs
   - Evaluate abdominal pain
   - Evaluate bleeding per vaginum which should decrease over time
2. Providing emotional support
3. Contraceptive counselling: women may be re-counselled on using a regular contraceptive method 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

Discuss with the participants that it is important to explain to the woman about what she can expect and what she should do during the recovery period.

- Antibiotics: Give broad spectrum antibiotics for five days. Providing antibiotics to women undergoing VA reduces the 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 the symptoms, as enlisted in Slide 9.20

Now discuss the situations during post-procedure as well as recovery period when immediate attention is needed.

Slide 9.20: Conditions Requiring Immediate Attention Post-procedure

- 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

It is essential to know the symptoms and signs of complications which require immediate attention during recovery period.

Slide 9.21: Conditions Requiring Immediate Attention in Recovery Period

- Fever, chills, fainting, vomiting
- Distended, tender abdomen
- Foul-smelling discharge per vaginum
- Cramping, bleeding more than during 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 the 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 the 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

6. Summary

Time: 5 minutes 

Methodology: Presentation (Slide 9.22)

Slide 9.22: 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 a 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

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

7. Practice on a Pelvic Model

Time: 25 minutes 

Methodology: Demonstration

Divide the participants into groups. Each group should perform simulated practice of the uterine evacuation procedure by MVA on a pelvic model. Within the group, ask one participant to be the provider and perform the procedure while another participant plays the observer, reading the checklist (Annexure 1) step by step to complete the procedure. The trainer should supervise these practice sessions.

8. MVA Video CD

Time: 20 minutes

Methodology: Watching the CD on the MVA procedure

Annexure 1

Uterine Evacuation Procedure with MVA Aspirator

Skills Checklist

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

Climate setting
Abortion scenario
Reproductive Rights
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Infection Prevention
Vacuum Aspiration
Complications of Abortions
Post Abortion Contraceptive Choices
Second Trimester Pregnancy Termination

Chapter 10

COMPLICATIONS OF ABORTIONS

10. Complications of Abortions

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards, case study handouts

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Discussion Presentation	10 minutes
2.	Abortion Complications: a. Complications During Abortion Procedure b. Management of Abortion Complications c. Management Options at Different Levels of Health Facilities d. After Care of Complications	Brainstorming Case Study Discussion Presentation	45 minutes
3.	Summary	Presentation	5 minutes

10. Complications of Abortions

Self Assessment Tool

Please encircle the correct response:

1) Retained products of conception (POC)/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 onsite

   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. Can still lead to infection and/or retained POC

c. Quite often leads to infertility

d. a and b

Key to Self Assessment Tool:

1) d	2) a	3) c	4) c
5) d	6) d		

1a. Self Assessment Tool
1b. Introduction to the Session

Time: 10 minutes

Methodology: Discussion; Presentation (Slide: 10.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss the correct responses with them. Share the objectives of the session.

Slide 10.1: Session Objectives

- Describe complications associated with abortions
- Recognize signs and symptoms of different abortion complications
- Know the protocols for management of abortion complications

Providers encounter two types of abortion complications during service provision:

i. Complications that occur while the provider is him/herself performing the procedure

ii. Complications due to procedure done outside

2. Abortion Complications

Time: 45 minutes

Methodology: Brainstorming; Case Study; Discussion; Presentation (Slides: 10.2 [a, b], 10.3, 10.4, 10.5, 10.6, 10.7, 10.8, 10.9, 10.10, 10.11)

2a. Complications During Abortion Procedure

When performed by a trained provider, the abortion procedure rarely results in immediate or delayed complications. In many cases, complications can be avoided by accurately estimating the duration of pregnancy; ensuring that the woman has passed urine before examination as well as before procedure; and 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.

Ask the participants to enlist the common complications of abortions they have seen or heard during service provision at their facilities. Summarize the discussions as in slide 10.2[a, b].

Slide 10.2(a): Complications During the Abortion Procedure

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

Slide 10.2(b): Possible Complications after Abortion Procedure

These complications can present following the procedure done by the provider him/her self or by another provider:

a. Shock
b. Secondary Haemorrhage
c. Infection/sepsis
d. Continuation of pregnancy

Sequelae:

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

2b. Management of Abortion Complications

Ask the participants to plan the management of different complications of abortions, based on the presenting signs and symptoms of the woman. Facilitate the discussion among participants and encourage the sharing of their personal experiences.

The description of common complications with their symptoms and management is given below.

A. Haemorrhage/Excessive Vaginal Bleeding

Ask one of the participants to read the case study (No. 1) given below. Involve all the participants and facilitate a discussion on the identification and management of the complication in the case study. At the end of the discussion, share the chart on the complication with them to summarize all the key points of its management.

Slide 10.3: Case Study 1

A young woman with heavy vaginal bleeding and abdominal pain comes back to the clinic in distress the day after a vacuum aspiration procedure was done.

Q. 1 What is the provisional diagnosis?

Q.2 (a) How will you manage her, if her clinical condition is stable?

Q. 2 (b) How will you manage her, if her clinical condition is not stable?

Key to Case Study 1

Q.1: Provisional diagnosis is `Incomplete abortion'.

Q.2 (a): Manage the woman as per protocols given under Chart 1 (Excessive Vaginal Bleeding, Clinically Stable Woman)

Q 2 (b): Manage the woman as per protocols given under Chart 2 (Excessive Vaginal Bleeding, Clinically Unstable Woman)

The main causes of excessive vaginal bleeding are:

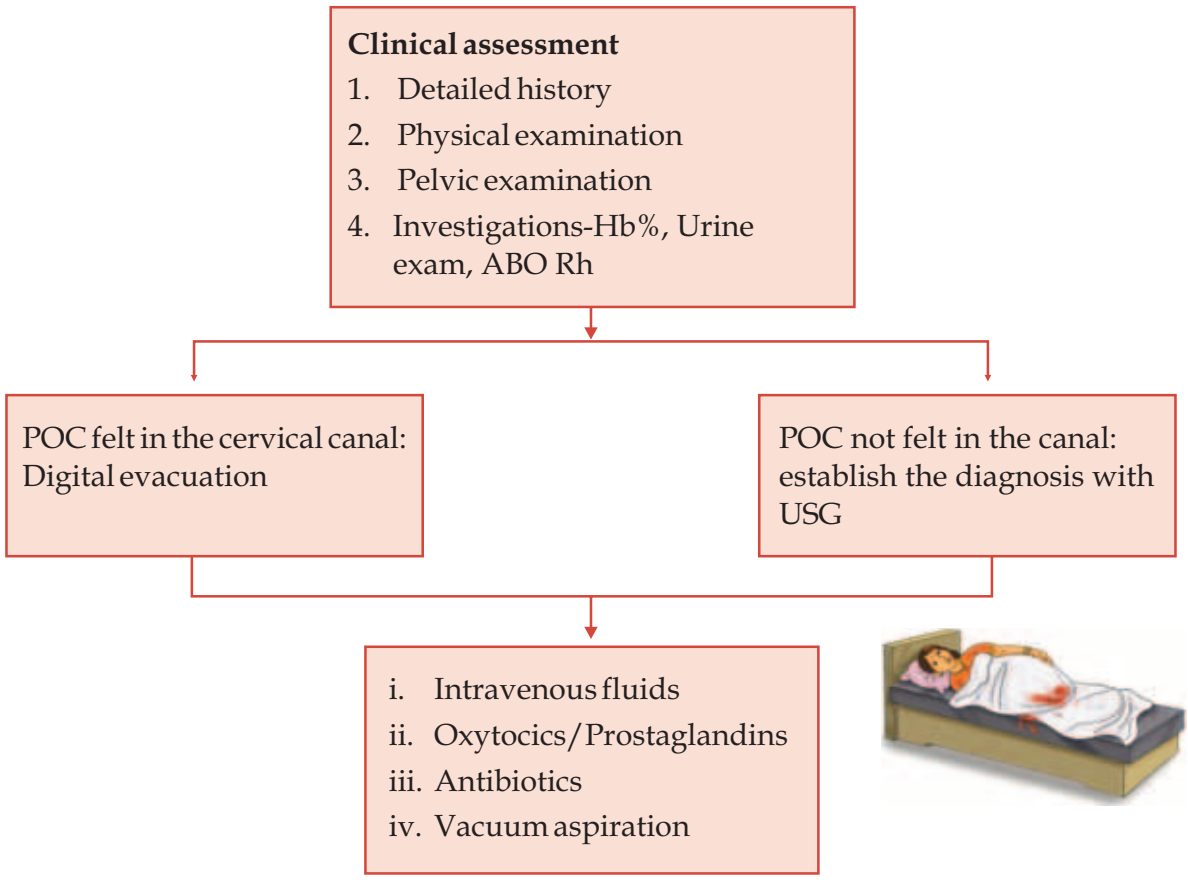
- Retained products of conception
- Trauma/lacerations of cervix
- Trauma to uterus, including perforation
- Uterine atony

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

A. (i) Excessive vaginal bleeding with clinically stable woman:

For management of a clinically stable woman with excessive vaginal bleeding, refer to Chart 1 below: given as Slide 10.4:

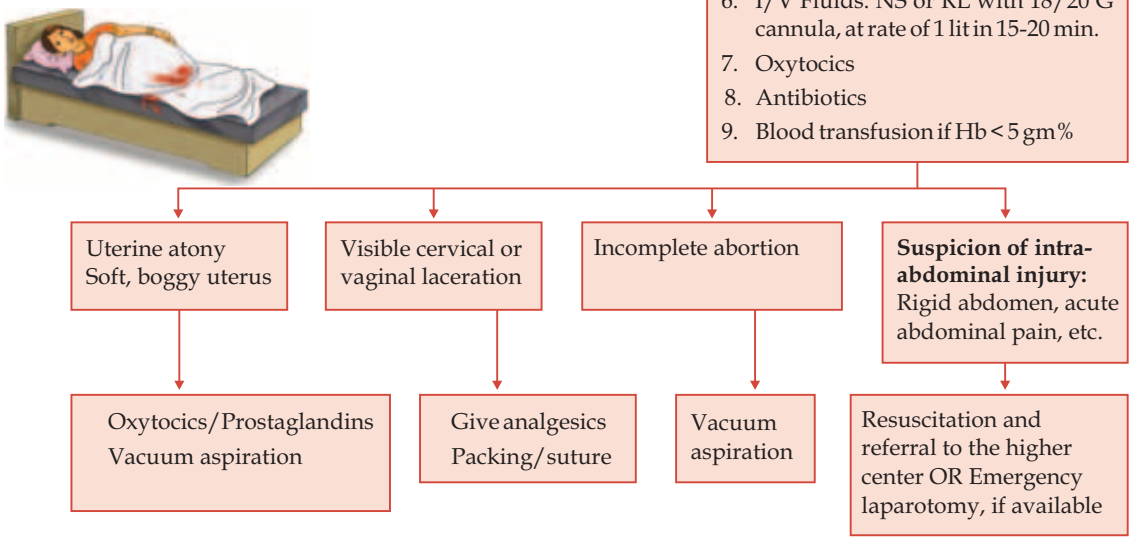
Slide 10.4: Chart 1 - Excessive Vaginal Bleeding, Clinically Stable Woman



A. (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 given as Slide 10.5.

Slide 10.5: Chart 2 - Excessive Vaginal Bleeding, Clinically Unstable Woman



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

B. Uterine Perforation

Slide 10.6: Case Study 2

A woman with a retroverted uterus has an EVA procedure, during which you note that the instruments pass a little further than expected. However, you presume this is due to the shape of her uterus. As she is recovering, her heart rate becomes rapid and her blood pressure begins to fall. You also notice that the bleeding per vaginum is more than expected.

Q.1 What is your provisional diagnosis?

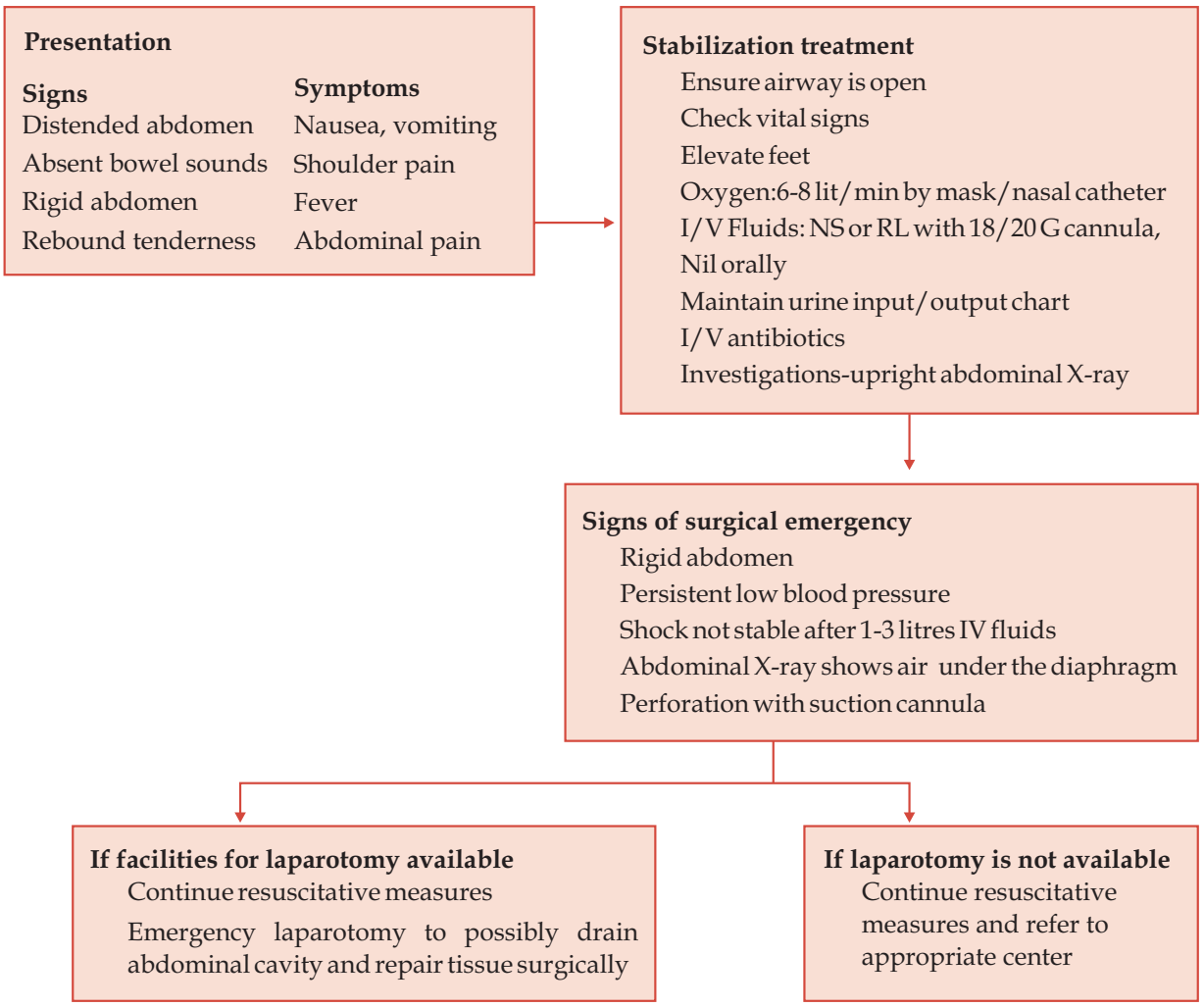
Q.2 How will you manage her?

Key to Case Study 3

Q.1: Provisional diagnosis is 'suspected uterine perforation'

Q.2: Manage the woman as per protocols given under Chart 3 (Uterine Perforation), given as Slide 10.7

Slide 10.7: 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.

Slide 10.8: Case Study 3

A woman comes to the clinic with fever, persistent abdominal pain and foul-smelling discharge. She gives history of getting an abortion procedure a week ago.

Q.1 What is your provisional diagnosis?

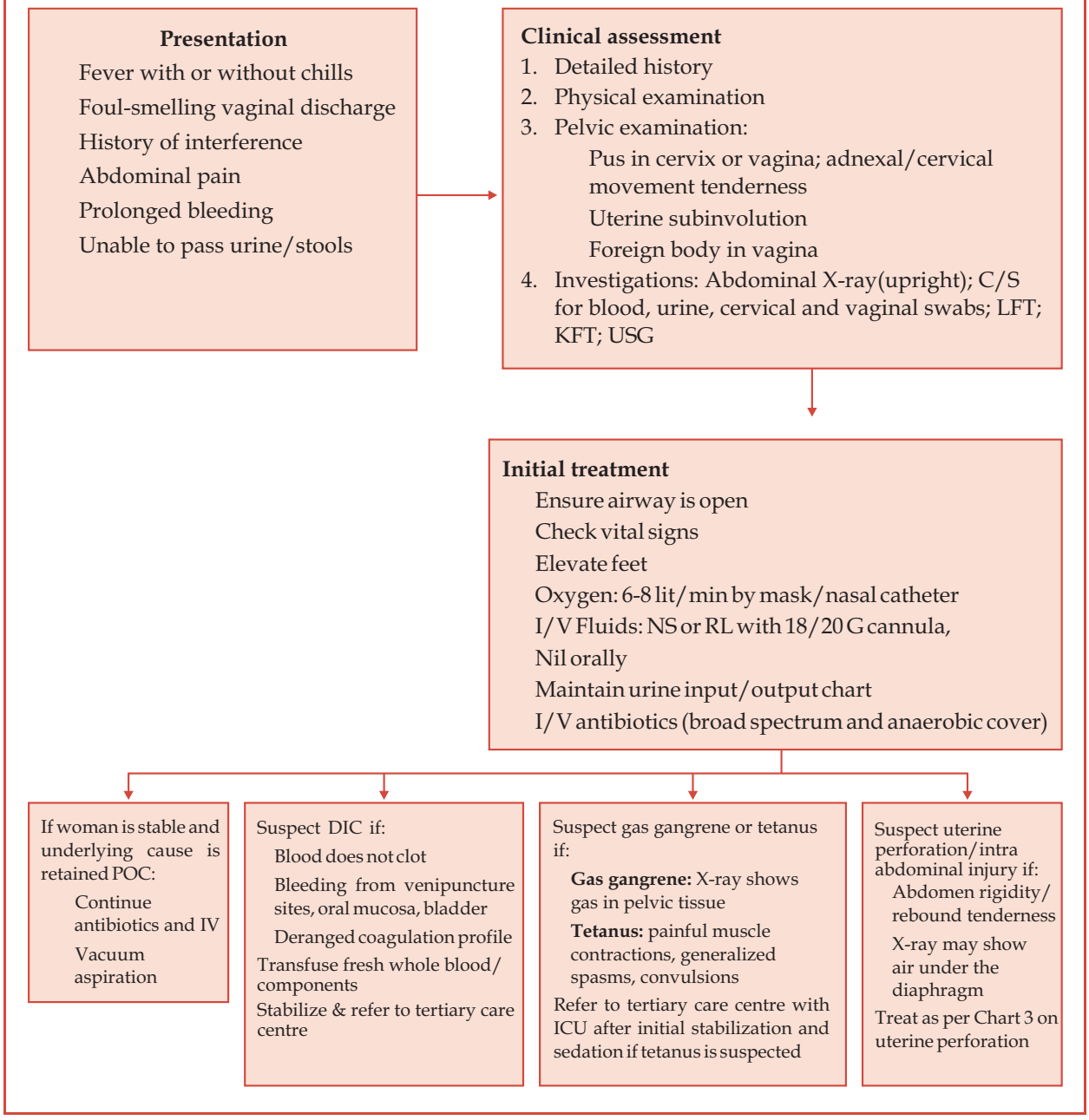
Q.2 How will you manage her?

Key to Case Study 3

Q.1: Provisional diagnosis is `Post-abortion Sepsis'.

Q.2: Manage the woman as per protocols given under Chart 4 (Sepsis) in Slide 10.9.

Slide 10.9: 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 an early and mild stage to a late and severe condition, hence treatment should be promptly provided. The woman should be quickly stabilized followed by establishing the diagnosis and managing accordingly.

Slide 10.10: Case Study 4

A woman with a history of abortion procedure, done five days ago at a private clinic, comes to you in an unconscious state, after bleeding heavily on the previous night.

Q.1 What is your provisional diagnosis?

Q.2 How will you manage her?

Key to Case Study 4

Q.1: Provisional diagnosis is `Shock (Haemorrhagic)'

Q.2: Manage the woman as per protocols given under Chart 5 (Shock)

Slide 10.11: Chart 5 - Shock

Presenting signs and symptoms

Fast Pulse (> 110)
Low blood pressure (90 syst) or less
Pallor
Cold and clammy extremities
Fast breathing (>30/min)
Low conscious levels/unconscious
Low urine output (<30 cc/hr)

Clinical assessment

1. Detailed history
2. Physical examination
3. Pelvic examination
4. Investigations (after stabilization)-Hb, urine exam, ABO Rh, TLC, DLC, electrolytes, urea, creatinine, X ray chest

Stabilization treatment (follow principle of ABC, taking care of: Airway, Breathing, Circulation)

Ensure airway is open
Check vital signs
Elevate feet; Keep warm
Oxygen: 6-8 lit/min by mask/nasal catheter
I/V Fluids: NS or RL with 18/20 G cannula,
Nil orally
Maintain urine input/output chart
I/V antibiotics

Assess response to fluids after 20-30 minutes

Signs of stabilization:

Increased blood pressure syst ≥ 100
Improving mental status
Increasing urine output ≥ 100 ml per 4 hours

If stable:

Adjust IV and oxygen
Establish the cause:

1. Haemorrhagic - refer to Chart 1 and 2
2. Septic-refer to Chart 4

If not stable:

Continue IV and oxygen
Rule out other causes
Stabilize and refer to the appropriate level of facility

Sequelae

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 an increased risk of ectopic pregnancy

2c. 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.

Share with the participants the management of different complications at different levels of health facilities:

Slide 10.12: Management Options at Different Levels of Facilities

At Primary Level (PHC and CHC Level)	At Secondary/Tertiary Level Hospital (District Hospital and Medical College)
• Initial clinical assessment of woman coming with abortion complications • Initiation of resuscitation/stabilization treatments including antibiotic therapy, intravenous fluid replacement and oxytocics • Diagnosis of the type of abortion complication • Investigations- haemoglobin, blood grouping and cross matching • Preparation for definitive treatment or referral to an appropriate facility for further management and care • Uterine evacuation	• All services provided at the primary level • Blood cross-matching and transfusion, USG, X ray abdomen and other relevant investigations • Laparotomy and indicated surgery • Treatment of severe complications (bowel injury, tetanus, renal failure, gas gangrene etc.) • Treatment of Disseminated Intravascular Coagulopathy (DIC)

2d. After-care of Complications

Ask the participants about the after-care of the woman who has experienced complications. Answers should reflect the following:

After-care of a woman who has experienced abortion complications:

- Give physical and emotional support to the woman
- Advise her about medications to be taken, contraception and follow-up visit
- Counsel her about her condition and any resulting life changes required
- Give her written instructions for care after discharge, according to her individual needs and clinical status

4. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 10.13)

Slide 10.13: 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

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have doubts.

Climate setting
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

POST ABORTION CONTRACEPTIVE CHOICES

11. Post-abortion Contraceptive Choices

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards, contraceptive tray

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Presentation	10 minutes
2.	Contraceptive Counselling: a. Importance of Contraceptive Counselling b. Barriers to Contraception	Discussion Presentation	10 minutes
3.	Eligibility for Contraceptive Methods	Discussion Presentation	10 minutes
4.	Misconceptions about Contraceptive Methods	Discussion Presentation	15 minutes
5.	Emergency Contraception	Discussion Presentation	10 minutes
6.	Summary	Presentation	5 minutes

11. Post-abortion Contraceptive Choices

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 an 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

Key to Self Assessment Tool:

1) True	2) True	3) True	4) True
5) a, c	6) c	7) c	

1a. Self Assessment Tool
1b. Introduction to the Session

Time: 10 minutes

Methodology: Presentation (Slide: 11.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss the correct responses with them. Share the objectives of the session, laying emphasis on the fact that contraceptive counselling and provision of a suitable contraceptive method is an important component of CAC services.

Slide 11.1: Session Objectives

- Recognize the importance of contraceptive counselling and barriers to contraception
- Determine a woman's eligibility for various contraceptive methods following abortion care
- Clarify common misconceptions about different contraceptive methods
- Understand mechanism of action, eligibility and administration of emergency contraception

2. Contraceptive Counselling

Time: 10 minutes

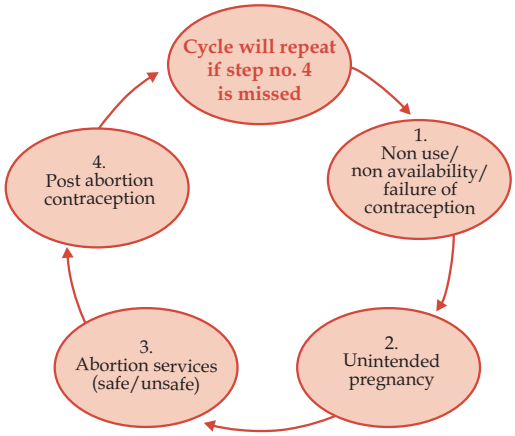
Methodology: Discussion; Presentation (Slides: 11.2, 11.3)

2a. Importance of Contraceptive Counselling

Share with the participants the importance of contraceptive counselling.

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

Slide 11.2: Break Cycle of Unintended Pregnancy



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 its consequences.

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 choice offered to her.

For more details on contraceptive counselling, refer to Chapter 5 on 'Counselling Skills'.

2b. Barriers to Contraception

Tell the participants that there are several factors that act as a barrier to post-abortion contraceptive service provision and should be kept in mind while giving contraceptive counselling. These include:

Slide 11.3: Barriers to Contraception

i. Health System

- Lack of opportunities to make contraception a part of routine abortion care
- Abortion care is a multi-visit process

ii. Woman

- Little societal support after abortion
- Unaware that fertility can return immediately after the abortion
- Lack of awareness of complications due to repeated abortions

3. Eligibility for Contraceptive Methods

Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 11.4, 11.5)

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

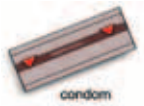
- There are no severe complications requiring further treatment
- The woman receives adequate counselling and gives informed consent
- The provider screens the woman's eligibility for a particular contraceptive method

Ask the participants if they know of the different contraceptive methods available. Complete from the list below:

Slide 11.4: Contraceptive Methods

Temporary methods:

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



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

Permanent methods:

- Male sterilization
- Female sterilization

Tell the participants that we will now talk about the details of the available contraceptive methods.

Details of all contraceptive methods:

Method	Timing after first Trimester Abortion	Advantages	Remarks
Condoms (Male)	As soon as the woman resumes her sexual activity	• Prevent STIs, including HIV/HBV • Safe. No hormonal side effects • Can be used without seeing health care provider • Usually easy to obtain and sold at many places • Enables a man to take responsibility for preventing pregnancy • Effective immediately • Can be easily discontinued	• Latex condoms may cause irritation to some people • May make sex less enjoyable for either partner • Small possibility of condom slipping off or breaking during sex, if not properly used or stored • Failure rate is 2/100 women*
Female Condoms	As soon as the woman resumes her sexual activity	• Prevent STIs, including HIV/HBV • Safe. No hormonal side effects • Effective immediately • It empowers woman to make her choice	• May make sex less enjoyable for either partner • Difficult to insert and remove • More expensive than male condoms

Method	Timing after first Trimester Abortion	Advantages	Remarks
		• 40% stronger than latex used in male condoms	• Failure rate is 5/100 women users*
Oral Contraceptive Pills	May be given immediately after abortion (using vacuum aspiration or on Day 3 of medical methods of abortion)	• Highly effective • Can be started immediately • Can be provided by health workers other than doctors • Does not interfere with intercourse	• Requires continued motivation and daily use • Re-supply must be available • Effectiveness may be lowered if woman using Rifampin, Dilantin, and Griseofulvin • No protection against STIs/HIV/HBV • Failure rate is 0.3/100 women users*
Progestin-only Injectable DMPA, NET-EN	• May be given immediately after abortion (using vacuum aspiration or on Day 3 of medical methods of abortion) • May be appropriate for use if the woman wants to delay choice of a long-term method	• Highly effective • Can be started immediately, even if infection is present • Does not interfere with intercourse • Not user-dependent, except for remembering to come for injections every two or three months, depending on the type of injection • No supplies needed by user	• May cause irregular bleeding, spotting, amenorrhea. • Excessive bleeding may occur in rare instances • Delayed and un-predictable return to fertility after stopping use • Must return for injections every two or three months or as advised • No protection against STIs/HIV/HBV • Failure rate is 0.3/100 women users*
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)	• Highly effective • Effective immediately • 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) • Immediate return to fertility following removal • Does not interfere with intercourse • No regular supplies needed by the user	• May increase menstrual bleeding and cramping during the first few months • No protection against STIs/HIV/HBV • Trained provider needed for insertion and removal • Failure rate is 0.6/100 women users*
Female Sterilization	Female sterilization procedures are usually performed immediately after a surgical abortion.	• Permanent method, highly effective • Does not interfere with intercourse	• Adequate counselling and fully informed consent are required before female sterilization procedure

Method	Timing after first Trimester Abortion	Advantages	Remarks
	If there is infection or severe blood loss is experienced, female sterilization should not be performed	• No long-term side effects • Immediately effective	• Slight possibility of surgical complication • Requires trained staff and appropriate equipment • No protection against STIs/HIV/HBV • Failure rate is 0.5/100 women users*
Male sterilization (No-scalpel Vasectomy)	This procedure can be done independent of the abortion procedure	• Very effective • Permanent • No interference with sex • No repeated clinic visits required • No apparent long-term health risks • Enables a man to take responsibility for preventing pregnancy • Supplies required till azoospermia is confirmed	• 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 • Semen analysis should be done after 3 months to confirm azoospermia • No protection against sexually transmitted diseases (STDs) including HIV/HBV • Failure rate is 0.1/100 women*
Natural Family Planning Methods: Fertility awareness based/ Standard Days Method	Effective only after menstrual cycles are regular	• No supplies required • Under control of couple	• Effective after cycles regularize • Effective only in women with regular cycles between 26-32 days • Have high failure rates (3 to 5/100 women users) so should not be the method of choice

**Failure rates are first year pregnancy rates.*

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

Share with the participants the different contraceptive options for women with special conditions:

Slide 11.5: Contraceptive Options for Special Conditions

- RTI/pelvic infections
- Trauma to genital tract; uterine perforation; vaginal or cervical trauma
- Haemorrhage and severe anaemia
- Second trimester abortion
- HIV positive cases
- Adolescents

Woman's Clinical Situation	Potential Contraceptive Method for Use	Contraceptive Method to be Avoided
Reproductive tract/ pelvic infection (confirmed or presumptive diagnosis)	• Provide a short-term method (condoms or hormonal) and follow-up later for long-term method	• Delay female sterilization or IUCD insertion until infection is either ruled out or fully resolved.
Trauma to genital tract; uterine perforation; vaginal or cervical trauma; chemical burns	• Provide a short-term method (condoms or hormonal) and follow-up later for long-term method	• Delay female sterilization until trauma is healed • Delay IUCD insertion until uterine perforation or other trauma has healed • Injuries that affect the vagina or cervix may limit the use of female barrier methods and spermicides
Haemorrhage and severe anaemia	• Provide a short-term method (condoms or hormonal) and follow-up later for long-term method	• Delay female sterilization and IUCD insertion until the condition is resolved because of the risk of further blood loss
Second trimester abortion	• Oral Contraceptive Pill • Barrier methods (condoms) • Female (only minilap) sterilization • IUCD	
HIV positive cases	• Condoms (male or female) with or without spermicide should be used during each act of intercourse • Other methods along with condoms can also be used	
Adolescents	• Condoms • Hormonal contraceptive methods • Dual contraception recommended	

4. Misconceptions about Contraceptive Methods

Time: 15 minutes

Methodology: Discussion; Presentation (Slides: 11.6, 11.7, 11.8, 11.9, 11.10, 11.11)

Slide 11.6:

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.

Ask the participants what health service providers could do to counter the negative effects of rumours and misconceptions about the different contraceptive methods. Discuss following ideas and strategies:

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 the various methods.

Ask the participants to give some examples of the misconceptions about the different contraceptive methods that they have heard of or know of. Discuss all the misconceptions associated with each method with them

Misconceptions and Facts about Condoms

Slide 11.7: Misconceptions about Condoms

1. If a condom slips off during sexual intercourse, it might get lost inside the woman's body.
2. There is a big danger of condom breaking or tearing during intercourse

1.	Misconception	• If a condom slips off during sexual intercourse, it might get lost inside woman's body
	Fact	• 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

2.	Misconception Fact	• There is a big danger of condom breaking or tearing during intercourse • 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)

Misconceptions and Facts about OCP

Slide 11.8(a): Misconceptions about OCP

1. I need to take the pill only when I sleep with my husband
2. I am still protected from pregnancy when I stop taking the pill if I have been using it long enough
3. The pill is dangerous and causes cancer

Slide 11.8(b): Misconceptions about OCP

4. Women who take the pill for several years need to stop the pill to give the body a 'rest period'
5. The pill can't be used following an abortion
6. The pill causes infertility or makes it difficult for a woman to become pregnant once she stops using it

1.	Misconception Fact	• I need to take the pill only when I sleep with my husband • A woman must take the pill every day in order not to become pregnant
2.	Misconception Fact	• I am still protected from pregnancy when I stop taking the pill if I have been using it long enough • Pills protect against pregnancy only if they are taken every day
3.	Misconceptions Facts	• The pill is dangerous and causes cancer • Numerous studies have disproved this misconception. The pill has been safely used by millions of women for over 30 years. Infact, studies show that the pill can protect women from some forms of cancer, such as those of the ovary, endometrium
4.	Misconception Fact	• Women who take the pill for several years need to stop the pill to give the body a 'rest period' • 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

5.	Misconception Fact	• The pill can't be used following an abortion • 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 reasonably be sure that the woman is not pregnant
6.	Misconception Fact	• The pill causes infertility or makes it difficult for a woman to become pregnant once she stops using it • Studies have clearly shown that the pill does not cause infertility or decrease a woman's chances of becoming pregnant once she stops taking it

Misconceptions and Facts about IUCD

Slide 11.9: Misconceptions about IUCD

1. The thread of the IUCD can trap the penis during intercourse
2. A woman who has an IUCD cannot do heavy work
3. The IUCD might travel inside a woman's body to her heart or her brain
4. The IUCD causes ectopic pregnancy
5. An IUCD cannot be inserted after an abortion

1.	Misconception Fact	• The thread of the IUCD can trap the penis during intercourse • 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)
2.	Misconception Fact	• A woman who has an IUCD cannot do heavy work • 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
3.	Misconception Fact	• The IUCD might travel inside a woman's body to her heart or her brain • There is no passage from the uterus to the other organs of the body
4.	Misconception Fact	• The IUCD causes ectopic pregnancy • There is no evidence that the use of an IUCD increases the risk of an ectopic pregnancy

5.	Misconception Fact	• An IUCD cannot be inserted after an abortion • 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)

Misconceptions and Facts about Female Sterilization (Tubectomy)

Slide 11.10: Misconceptions about Tubectomy

1. A woman who has been ligated loses all desire for sex (becomes frigid)
2. A woman who has been ligated becomes sick and is unable to do any work
3. A woman who undergoes ligation has to be hospitalized
4. Ligation shortens the lifespan of a woman and may cause early menopause

1.	Misconception Fact	• A woman who has been ligated, loses all desire for sex (becomes frigid) • 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
2.	Misconception Fact	• A woman who has been ligated becomes sick and is unable to do any work • 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'
3.	Misconception Fact	• A woman who undergoes ligation has to be hospitalized • Usually there is no need for hospitalization of the woman undergoing tubal ligation. She 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
4.	Misconception Fact	• Ligation may cause early menopause • 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

Misconceptions and Facts about Male Sterilization (Vasectomy)

Slide 11.11: Misconceptions about Vasectomy

1. Vasectomy is the same as castration
2. A man who submits to vasectomy has his manhood taken away. Worst of all, he will no longer enjoy sex
3. 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

1.	Misconception Fact	• Vasectomy is the same as castration • 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
2.	Misconception Fact	• A man who submits to vasectomy has his manhood taken away. Worst of all, he will no longer enjoy sex • Vasectomy does not interfere with any other physiological functions; or causes any other type of changes. 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
3.	Misconception Fact	• 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 bod • 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

5. Emergency Contraception

Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 11.12, 11.13, 11.14, 11.15, 11.16, 11.17)

Introduce the topic of emergency contraception (EC) to the participants by presenting the following information:

What is 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 emergency and not be used as an ongoing contraceptive method. This avoids giving the mistaken impression that use of the method is limited to the morning following every unprotected sexual act (morning after pill).

When can Emergency Contraception be Used?

Ask the participants to enlist the indications for use of EC and complete the information from the slide below.

Slide 11.12: Indications for EC

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

Failure of contraception or its 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

Slide 11.13: Methods used for EC

- Emergency contraceptive pills (ECPs) are hormonal contraceptives which can be used upto 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 upto 120 hours (five days) after an unprotected sexual intercourse

How do Emergency Contraceptive Pills Work?

Explain to the participants the possible mechanism of action of the EC pills.

Slide 11.14: Mechanism of Action of EC

- 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

The mechanism active in a particular case depends on the time of the menstrual cycle, when emergency contraceptive pills are used.

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.

Discuss the advantages, contraindications and limitations of the ECPs.

Advantages of Emergency Contraceptive Pills

Slide 11.15: Advantages of ECPs

a. Are safe, effective, easy to use and easily available

b. Can be taken at any time during a menstrual cycle after an unprotected intercourse

c. Do not require a physical examination

d. Can be obtained over-the-counter from a chemist's shop without prescription

e. 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 ECPs while pregnant, the emergency pills will neither harm the foetus nor would it be effective to terminate the pregnancy.

Contraindications of Emergency Contraceptive Pills

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

Dose and Regimen of the Emergency Contraceptive Pills

Discuss the dose and regimen of ECPs.

Slide 11.16: Dosage of ECPs

Type of pills	Dosage
Progestin-only pill	1 tablet of 1.5 mg levonorgestrel single dose
Low dose pills	4 stat + 4 (after 12 hours of the first dose)

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

Slide 11.17: Misconceptions about EC

1. ECPs can cause abortion
2. ECP is contraindicated in many medical conditions
3. ECP when taken once during the cycle, will give protection for full cycle

1. ECPs can cause abortion : No. ECPs will not disturb an established pregnancy.
2. ECP is contraindicated in many medical conditions: No medical conditions rule out use of ECPs. Even medical conditions that rule out continuing use of oral contraceptives do not apply to ECPs.
3. ECP 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.

Explain to the participants what to advise a woman in case of ECP failure.

How to Manage Failure of EC

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) and 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.

6. Summary

Time: 5 minutes

Methodology: Presentation (Slide: 11.18)

Slide 11.18: 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 available and let the woman know where she can obtain them

- Commonly held misconceptions about contraceptive methods are a barrier in their acceptance in the community
- Emergency contraceptive pills help women avoid unwanted pregnancies in cases where regular contraceptive methods have failed or are incorrectly used or under special situations such as rape or forced sex

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have any doubts.

Climate setting
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 12

SECOND TRIMESTER PREGNANCY TERMINATION

12. Second Trimester Pregnancy Termination

Time: 60 minutes

Advance Preparation

Flip chart, markers, VIPP cards

Session Plan

S. No.	Sub-session	Methodology	Time (60 minutes)
1.	a. Self Assessment Tool b. Introduction to the Session	Discussion Presentation	10 minutes
2.	Legal Requirements for Second Trimester Abortion: a. Site/Provider Eligibility b. Documentation/Reporting	Discussion Presentation	10 minutes
3.	Methods for Second Trimester Pregnancy Termination	Brainstorming Discussion Presentation	20 minutes
4.	Post-procedure Care a. Immediate Care b. Contraception c. Follow-up Care	Brainstorming Discussion Presentation	15 minutes
5.	Summary	Presentation	5 minutes

12. Second Trimester Pregnancy Termination

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

Key to Self Assessment Tool:

1) 20 2) False 3) False 4) 15

5) d 6) d

1a. Self Assessment Tool

1b. Introduction to the Session

Time: 10 minutes

Methodology: Discussion; Presentation (Slide: 12.1)

Greet the participants and facilitate the completion of the self assessment tool. Discuss the correct responses with them. Share the objectives of the session.

Slide 12.1: Session Objectives

- Understand the legal requirements under MTP Act, Rules and Regulations for performing second trimester abortions
- Know steps for different methods of second trimester pregnancy termination
- Give information about contraception and follow-up care to the woman coming for second trimester termination

Second trimester pregnancy termination is associated with a 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 the 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.

2. Legal Requirements for Second Trimester Abortion

Time: 10 minutes

Methodology: Discussion; Presentation (Slides: 12.2, 12.3)

The sites and providers eligible to offer first trimester abortions may not be eligible for providing second trimester abortions under the law because of a higher risk of complications.

2a. Site/Provider Eligibility

Ask the participants if they remember provider and site eligibility criteria for providing second trimester pregnancy termination, as discussed in Chapter 4 on `Laws and Abortion'. Write them on the flip chart and complete the information, as given below:

Slide 12.2: Second Trimester Terminations: Eligibility Criteria

Eligibility Criteria: Provider

- Experience and training requirement as under the MTP Rules
- Opinion recorded by two RMPs as under the 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 termination

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 the Chapter 4 on `Law and Abortions'.

2b. Documentation/Reporting

Ask the participants about the necessary documentation under the MTP Regulations for a second trimester termination. Inform them that it is mandatory to fill and record information in the following forms for each second trimester termination case performed. Explain all the forms listed below:

Slide 12.3: Documentation/Reporting under 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

3. Methods for Second Trimester Pregnancy Termination

Time: 20 minutes

Methodology: Brainstorming; Discussion; Presentation (Slides: 12.4, 12.5, 12.6, 12.7, 12.8)

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

Discuss the components of clinical assessment of the woman for second trimester termination (same for all the methods) with the participants.

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 6 on `Clinical Assessment' for more details.

Ask the participants various second trimester termination methods they know of and list them on the flip chart. Group the methods under broad categories Medical and Surgical.

Slide 12.4: Second Trimester Termination Methods

A. Medical Methods
   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 Methods
   1. Dilatation and Evacuation (D&E)
   2. Hysterotomy

Discuss the various second trimester medical methods for pregnancy termination with the participants.

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 methods.

It is preferable to get a pre-anesthetic checkup 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 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.

Anti-spasmodic such as Drotaverine is also an option for pain relief.

Share the Mifepristone – Misoprostol regime with the participants as below:

Slide 12.5: 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 three hours

Total: up to five doses (including the first dose of misoprostol)

WHO, 2012

Refer to Chapter 7 on Medical Methods of Abortion (MMA) for details on different routes of administation 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 vital signs should be checked every two hours.

2. Misoprostol alone regime

Cervical priming and inducing uterine contractions

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

Slide 12.6: 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 tents: These are made of hygroscopic material, which swells up by absorbing cervical and vaginal secretions. They gradually dilate and soften the cervix and also stimulate uterine contractions. In clinical practice, it has been observed that the maximum dilatation with laminaria tents is achieved in six to eight hours of insertion.

Disadvantage of using laminaria tents is that they can lead to infection, particularly if they are 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

Ask the participants what can be the potential problems during second trimester termination done by medical methods. List them on a flip chart and explain each one of them.

Slide 12.7: Potential Problems During Termination by Medical Methods

- Membranes rupture during the process before cervix is sufficiently dilated
- Placenta not expelled within half an hour of the fetal expulsion
- If fetal expulsion does not occur within 24 hours from the initial dose

a. If the membranes rupture during the course of abortion process before the cervix is adequately dilated, the vaginal route for misoprostol may be less desirable and sublingual or buccal routes may be used instead.

   After the fetus is expelled, the maternal side of the cord should be clamped and the fetus wrapped in a cloth or paper sheet.

   After expulsion of the placenta, examine the fetus and placenta to confirm that expulsion is complete.

b. The placenta should be expelled within half an hour of fetal expulsion. If it does not happen, 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

Slide 12.8: Surgical Methods

- Dilatation & Evacuation
  - Dilatation/cervical priming
  - Uterine evacuation
- Hysterotomy

1. Dilatation and Evacuation (D&E)

With the advent of medical methods of abortion, Dilatation and Evacuation 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 (especially in cases of previous caesarean section)

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 an ultrasound to confirm complete evacuation.

2. Hysterotomy

Hysterotomy is a mini caesarean section 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 fetus and placenta

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

If the fetus 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 of the foetus till signs of life exist.

4. Post-procedure Care

Time: 15 minutes

Methodology: Brainstorming; Discussion; Presentation (Slides: 12.9, 12.10, 12.11, 12.13)

4a. Immediate Care

Ask the participants to enlist the components of immediate post-procedure care after second trimester termination.

Slide 12.9: Second Trimester Termination: Immediate Post-procedure 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 the health care team can ensure that she is well enough to return home.

Before discharge every woman should be informed that:

Slide 12.10: Discharge Instructions

1. Bleeding per vaginum for a few days
2. If bleeding increases, contact the health facility/provider
3. Abdominal cramping is normal. If cramping increases rather than decreasing, contact health facility/provider
4. Follow-up visit within two weeks of the procedure
5. Avoid intercourse till complications resolved and chosen contraceptive method becomes effective
6. Information on warning signs and symptoms

1. She will experience some bleeding per vaginum for a few days to weeks which 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 the 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.

4b. Contraception

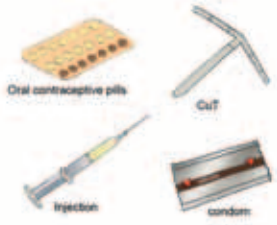
Ask the participants to explain the importance of providing contraception to all women coming for pregnancy termination. Also ask them to enumerate the various methods which can be used after second trimester termination.

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.

Slide 12.11: Second Trimester Termination: Contraceptive Options

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

Laparoscopic ligation should not be done*



Tubectomy

**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 the possibility exists of the rings slipping from the tubes, leading to the failure of the tubal ligation.*

For more details, refer to Chapter 11 on 'Post-abortion Contraceptive Services'.

4c. Follow-up Care

Ask the participants to list the key points for follow-up visit after second trimester termination.

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.

Slide 12.12: 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 that is cervical cancer screening, anaemia, RTI/STI etc.
- Record follow-up visit in the register

5. Summary

Time: 5 minutes 

Methodology: Presentation (Slide: 12.13)

Slide 12.13: 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.
- A follow-up visit within two weeks of the procedure is most appropriate.
- Sex selection is not an indication for second trimester pregnancy termination under the law.

Ask the participants if they now know the answer for each of the questions in the self assessment tool. Clarify if they still have doubts.

Climate setting
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 12

SECOND TRIMESTER PREGNANCY TERMINATION