Bangladesh National Menstrual Regulation Services Guidelines

Directorate General of Family Planning

Kingdom of the Netherlands

World Health Organization
Country Office for Bangladesh

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Preface

Menstrual Regulation (MR) Services have been started in this country since 1974 and included in the National Family Planning Program in 1979. In the early days of the Family Planning Program, MR acted as a backup support to contraceptive failure but it is now an important component of Reproductive Health services to reduce the maternal mortality and morbidity.

The MR services are provided in all the service delivery centres under the Directorate General of Family Planning. Besides District Hospitals and Medical College Hospital also have provision to delivery such services. At present many NGOs and private hospitals and clinics are also providing the MR services. The National MR program gives the good evidence of GO-NGO collaboration and also provides coordinated service delivery modalities between the DGFP and DGHS.

Through the MR program had been initiated in Bangladesh a long time ago, no comprehensive service delivery guideline had been developed. The Directorate General of Family Planning has long realized the need to develop a comprehensive guideline for MR services which will contain norms, policy statements and regulations and serve as performance descriptions and directives for provides offering technical support to providers in the practice of evidence-based clinical decision making and medical management.

I am very happy to know that finally we are able to formulate a complete National Menstrual Regulation Service Guideline which will guide our service providers to ensure quality of care. This grate job has been accomplished through the combined efforts of the MCH-Services Unit of DGEP with the technical and financial assistance of the World Health Organization.

I would like to thank the World Health Organization and MCH-Services unit of DGFP for taking this challenge of developing the National Guideline for MR Services, which is essential to the improvement of knowledge and skills of our service providers and also to ensure the quality of care.

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Director General
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Acknowledgement

The National Menstrual Regulation Service Guideline has been developed after a series of meetings with different stakeholders. Since the inception of MR program under Directorate General of Family Planning; policy makers, program planners, service providers felt the need for a comprehensive service delivery guideline. We express our gratitude to the World Health Organization (WHO) for technical assistance and the Embassy of the Kingdom of the Netherlands for the financial support to formulate this guideline.

Some references from International Journals; Ipas and guideline of some countries are incorporated as references in this guideline. We are indebted to them. We would like to express our appreciation to RHSTEP, BAPSA and Marie Stopes Clinic Society (MSCS) for their support and contribution which has been crucial in developing the guideline.

We are also thankful to Dr. Ferdousi Begum, the national consultant for painstaking effort in developing this guideline. We are grateful to Dr. Jyoti Reddi, for her technical assistance at different stages of development of the guidelines.

For making valuable recommendations and suggestions in different meetings and workshop, we are especially grateful to all concerned service providers and managers of the Directorate General of Family Planning, consultants of Obstetrical and Gynecological Society of Bangladesh.

Special thanks to the Officials of MCH-Services unit of Directorate General of Family Planning for taking the lead in initiation and subsequent effort for long time to complete the development of National Menstrual Regulation Service Guideline.

Finally, we are highly indebted to Mr. M M Neazuddin, immediate post Director General of Directorate General of Family Planning for giving valuable support and suggestions without which the National MR Guideline would not have become a reality.

Dr Mohammed Sharif
Director (MCH-Services) &
Line Director (MC-RAH)

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BMMS	Bangladesh Maternal Mortality Survey
BRAC	Bangladesh Rural Advancement Committee
BSMMU	Bangabandhu Shaikh Mujib Medical University
BWHC	Bangladesh Women's Health Coalition
CCMRA, B	Coordination Committee on Menstrual Regulation Agencies in Bangladesh
CuT380A	Copper T 380A
D & C	Dilatation (of uterine cervix) and Curettage (of endometrium)
DGFP	Directorate General of Family Planning
DH	District Hospital
DGHS	Directorate General of Health Services
DMPA	Depo medroxy progesterone acetate
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
FPCST-QAT	Family Planning Clinical Supervision Team - Quality Assurance Team
FS	Facilitative Supervision
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
ICMH	Institute of Child and Mother Health
IM	Intra muscular
IP	Infection prevention
IV	Intra venous
LMP	Last menstrual period
MA	Medical Assistant

MCH	Maternal and Child Health
MCHTI	Maternal and Child Health Training Institute
MCWC	Mother and Child Welfare Centre
MFSTC	Mohammadpur Fertility Services and Training Centre
MoHFW	Ministry of Health and Family Welfare
MMR	Maternal Mortality Ratio
MR	Menstrual Regulation
MSCS	Marie Stopes Clinic Society
MRTSP	Menstrual Regulation Training and Services Program
MVA	Manual Vacuum Aspiration
NGO	Non Government Organisation
NSAID	Non Steroid Anti Inflammatory Drug
NTC	National Technical Committee
PID	Pelvic Inflammatory Disease
Rh blood type	Rhesus blood type
RHSTEP	Reproductive Health Services, Training & Education Programme
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Community Medical Officer
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
TACMR, B	Technical Advisory Committee on Menstrual Regulation in Bangladesh
THC	Thana Health Complex
THC/ UHC	Upazila Health Complex
USG	Ultrasonography
VA	Vacuum Aspiration
VAW	Violence Against Women
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organization

Chapter 1

Introduction and Background

Menstrual Regulation (MR) programme is an important component of reproductive health services in Bangladesh. MR started in a few urban government family planning clinics in 1974. In 1979, MR services were incorporated into the National family planning progamme and were implemented in all government hospitals, health and family welfare clinics.

The National MR programme has contributed significantly in the reduction of maternal mortality and morbidity. Today, MR services are available in Bangladesh as part of its Family Planning programme at all levels of the healthcare system and through public, non-governmental organisations (NGOs) and private facilities. MR is performed by a procedure called Manual Vacuum Aspiration (MVA) by government trained doctors and paramedics; namely, Family Welfare Visitor (FWVs) and female Sub-Assistant Community Medical Officer (SACMOs). However, unknown large numbers of unsafe MRs are performed annually by untrained persons in unhygienic and illegal places which pose a great threat to maternal health.

Several MR guidelines developed by various agencies working in this area exist in the country. Though the MR programme has been implemented for a long time, comprehensive National MR Guidelines are essential for service improvement and quality of care. This document has been developed by Directorate-General of Family Planning (DGFP) with technical assistance from the World Health Organization (WHO) under the current MR Initiative funded by the Embassy of the Kingdom of the Netherlands (EKN) for 'Strengthening the National Menstrual Regulation programme to reduce the Maternal Mortality and Morbidity in Bangladesh'.

The National Menstrual Regulation Services Guidelines contains norms, policy statements and regulations; performance descriptions and directives for providers, and offers technical support to providers in the practice of evidence-based clinical decision-making, and medical management of clients for MR procedures. This document will guide and facilitate the policy makers, programme managers, service providers and trainers to provide quality and safe MR services, which contribute significantly in reducing maternal mortality and morbidity.

1.1 Background

Maternal death due to unsafe abortion is less than 1% according to the Bangladesh Maternal Mortality Survey, 2011. In the past, a significant proportion of maternal deaths was due to unsafe MR. Menstrual regulation is performed by MVA by the MR trained doctors and paramedics since its inception by Directorate General of Family Planning (DGFP).

National MR Programme under the DGFP was largely sustained with international donor funds, provided by the United States Agency for International Development (USAID) through MRTSP (Menstrual Regulation Training and Services Programme), and subsequently by the Ford Foundation, Pathfinder International and the Population Crisis Committee (now Population Action International). Later the Swedish International Development Cooperation Agency (SIDA) and Royal Netherlands Embassy have supported the MR NGOs. Recently WHO is undertaking a large MR project involving Government and NGOs. This National MR Service establishes an excellent example of public private partnership.

- Mohammadpur Fertility Services and Training Center (MFSTC) provide MR services and give training to the service providers.
- The Reproductive Health Services Training and Education Programme (RHSTEP), founded initially in 1979 as the Menstrual Regulation Training and Services Project (MRTSP), is the primary organization for MR training in the country. This organization provides training and services from 18 medical college hospitals and district hospitals throughout the country.
- The Bangladesh Association for the Prevention of Septic Abortion (BAPSA), founded in 1982, coordinates between public and private MR trainees and training institutions, and publishing the *'MR Newsletter'* (now named as 'Healths and Rights'). They also provide MR services in their service centres and refresher training at four clinics.
- Bangladesh Women's Health Coalition (BWHC), founded in 1980, provides MR services at 24 clinics and MR training to FWV at three clinics.
- Marie Stopes Clinic Society (MSCS) is another leading MR Service provider in urban areas through its multiple clinics.
- Family Planning Association of Bangladesh (FPAB) is also providing MR services through their service outlets.

1.2 Regulatory bodies for MR programme:

Since 1987, three committees have been established to advise and supervise the National MR Programme:

a) National Technical Committee (NTC) recommends the technical aspects of clinical services of the programme.

b) The Technical Advisory Committee (TAC) for MR services was established in 1990 with the Director-General of the DGFP as chairman and Director (MCH-Services) as the member secretary to advice on technical, programmatic and policy issues with respect to MR programme and other aspects of sexual and reproductive health and rights.

c) The Coordination Committee of MR Agencies in Bangladesh (CCMRA, B) was established in 1987 including four MR organizations namely MFSTC, MRTSP (now RHSTEP), BAPSA, and BWHC as members with the task of promoting and improving the quality of MR services in Bangladesh. Other MR NGOs also have now become the members of this committee.

DGFP procures the MR Kits (syringe and cannulae) and distributes them to all the public service centres and selected NGO clinics. MR services are routinely reported through MIS, and regularly supervised and monitored by the higher authorities to ensure and maintain the quality of care.

Chapter 2

Purpose of the Guidelines

This document presents recommended norms, policy statements and regulations and serves as performance descriptions and directives for clinical management of menstrual regulation services.

The intended audiences for these guidelines are policy makers, health professionals, programme managers and service providers involved in the provision of MR services.

2.1 Broad objectives

- Define the national policies and regulations for MR services;
- Define and set the 'minimum standards' for MR service, and
- Define and set the 'minimum standards' of infrastructure for MR services.

2.2 Specific Objectives

The specific objectives of the guidelines are:

- To ensure that the MR services provided to women are safe, affordable and readily accessible;
- To reduce maternal morbidity and mortality due to unsafe abortion through appropriate MR services;
- To reduce unwanted pregnancies through post MR contraception and FP Services;
- To facilitate the provision of MR care to women to make free and informed decisions regarding MR, and to further inform women about available reproductive health services and follow-up care and
- To improve women's broader sexual and reproductive health by facilitating the access to or integration of MR services.

Chapter 3

Legal Aspects of Menstrual Regulation and the Guiding Principles

In 1979, a memorandum from the Population Control and Family Planning Division, Government of People's Republic of Bangladesh stated that "MR is one of the methods of the official family planning programme". A memorandum in 1980 stated that registered medical practitioners and FWVs or other paramedics with MR training can provide MR services. Over the past decade, the focus of the programme has shifted to the women's reproductive health and rights issues.

3.1 Definition

Menstrual regulation is the procedure of regulating the menstrual cycle when menstruation is absent for a short duration.

3.2 Written Informed Consent

The goal of informed consent is to obtain legal consent for performing the procedure, and to ensure that the woman's decision is voluntary and that she is informed of the procedure, choices and consequences of MR.

Obtaining informed consent of the woman who is the client is an essential part of MR services after the woman has decided to opt for MR procedure.

- This consent of the client should be in writing and in a language that she understands.
- The informed consent must be obtained after screening and selecting the client for MR before performing the MR procedure. Client selection requires history taking, physical examination, investigation (only if necessary for the client) and counselling .
- In special cases (mentally handicapped, younger age), the signature of the guardian/relative/ husband is also to be obtained. The informed consent form (Annexure 3.2) may be a part of the client screening form.

Service providers should keep in mind that:

- Accurate information must be provided regarding the risks and benefits of MR. This information may be provided either on an individual basis or in group sessions respecting the need for confidentiality and privacy.
- There must be documentation that the client affirms that she understands the procedure and its alternatives; the potential risks, benefits, and complications; that her decision is not coerced (forced); and that she is prepared to accept MR.
- A woman must undergo MR as early as possible in accordance with good medical practice.
- Information on and supply of contraceptives to clients must be available at the facility, or there should be provision for referral for contraceptives.
- All reasonable precautions must be taken to ensure the client's confidentiality.

3.3 Where MR Services can be provided

Government service centres and the Government-approved NGOs and private institutes/hospitals/ clinics having trained and skilled service providers on MR with appropriate and adequate logistic and equipment can provide MR services. These include:

- Government medical institutes such as BSMMU, MFSTC, MCHTI and ICMH
- Medical college hospitals (Government and Government-approved Private)
- District hospitals
- Mother and child welfare centres
- MCH-FP clinic at upazilla health complexes
- Union health and family welfare centres
- Government-approved NGO institutes/hospitals/clinics
- Government approved private institutes/hospitals/clinics

3.4 Who can perform MR and when

Any registered medical practitioner, who has specific training on MR procedures in any government recognized MR clinic in the country, or working experience in the obstetric department of a recognized medical hospital where MR procedure is a part of routine work can perform MR. Menstrual Regulation (MR) can be carried out by these qualified and trained medical doctors and specialists till the tenth week following the last menstrual period. Any Family Welfare Visitors (FWVs) or other category of paramedical personnel (e.g. Female SACMO, NGO paramedics) who have undergone a formal paramedical training course of at least 18 months' duration in any recognized institution, and thereafter obtained a specific training in MR procedure in a government recognized MR clinic, can provide such services to a client for eight weeks following the last menstrual period (LMP).

GUIDING PRINCIPLES FOR MENSTRUAL REGULATION

The service providers, there must have a standard approach towards a client seeking MR care, to ensure confidentiality, dignity privacy and designed to enhance her ability to make autonomous, informed decisions.

1. Respecting a woman's right to confidentiality

Respect for a woman's right to privacy means that discretion and confidentiality are guaranteed. A woman seeking MR care should be reassured that the decision regarding MR will not be revealed to any other person, including her parents, husband, relatives, community, religious members, or law-enforcement agents without her prior consent.

Providers should know the few exceptions to confidentiality under the law and inform women of these exceptions, such as in cases of violence, and uphold such laws. Under all circumstances, women's safety and rights should be protected.

2. Promoting a woman's right to dignity and autonomy

All staff have a duty to respect a woman's dignity. Seeking MR may be a particularly vulnerable time in a woman's life, it can be a difficult decision for many, and fear of disapproval or poor treatment enhances the feeling of vulnerability. Providers and staff should therefore:

- Maintain a positive and empathetic attitude towards the woman.
- Create a respectful relationship with her, using both verbal and non-verbal communication, and
- Approach her warmly, non-judgmentally and supportively.

3. Conscientious Objection

A provider cannot refuse to provide MR if the service is needed immediately to protect the life or health of the woman seeking service. If a provider refuses MR care because of her/his personal opinion /convictions or deficiency of skills, he or she must refer the client to another provider well in time who will have to provide the service.

4. Referral

There may be need for referral of MR clients with pre-existing medical or surgical conditions (such as heart disease, uncontrolled hypertension, diabetes mellitus, congenital epilepsy, and liver disease resulting in jaundice) or difficult gynecological conditions (such as congenital anomaly of uterus, suspected molar or ectopic pregnancy and uterine scars) to higher/specialized centres. All concerned should extend their maximum cooperation in these cases.

Chapter 4

Counselling

Counselling is a structured interaction in which a person voluntarily receives emotional support and guidance from a trained person, in an environment that is conducive and open to sharing of thoughts, feelings and perceptions. During counselling of a client; a counsellor gets opportunities for discussion about her personal and family life, social and cultural background, reproductive health etc. and thereby helps the client to take an informed decision on her own.

A counselling process in general comprises technique several steps denoted by the acronym GATHER:

G	Greetings to the client and establishment of rapport
A	Ask the client and assess the client's needs and demands
T	Tell the client about MR, options and other relevant services
H	Help the client in decision-making
E	Explain the contraceptive services
R	Return for follow up

It is important to note that:

- Every client who seeks MR services must be counselled. Counselling is an integral part of safe MR services and is as important for performing the procedure correctly.
- Counselling should be private and confidential. The client must first be asked while she is alone if she wants any other person to join her, as she may prefer to be counselled in private. Another person, such as the client's spouse, may be asked to join the client for counselling.
- Counselling should preferably be done in a separate room, otherwise choose a place where privacy and confidentiality can be maintained.
- Active listening should be practiced.. The client should be allowed to express her feelings, concerns and emotions without interruption.
- The device provider should be non-judgmental while interacting with the client and sensitive towards her needs.

- Relevant circumstances including physical, social, economical aspects; family and future plans with the client/couple/family should be discussed.
- Counselling is also important to help the client decide about using a method of contraception if she wishes to prevent or delay another pregnancy.

Counselling may be detailed as:

a. Pre MR procedure counselling

b. During the MR procedure and

c. Post procedure counselling

4.1 Pre-procedure Counselling

Pre-MR counselling is important for the following reasons:

- To provide clear, simple information that helps the client to decide whether she desires MR;
- To ensure that the consent for the procedure is given after receiving complete information about her options, the procedure and its implications;
- To help the MR service provider to assess if the client is fit for MR; and
- To help the client to decide the appropriate contraceptive method of choice after the MR procedure.

4.1.1 Critical Steps in Pre - procedure counselling

Step 1. Greeting and establishing rapport with the Client

- When the client comes, greet the client cordially and request her in a respectful manner to sit. Focus your total concentration on the client and express your sincerity during conversation. Reassure the client about confidentiality.
- Establish rapport with the client and gain her confidence. MR is a very sensitive issue and the client may be reluctant to discuss the relevant issues. Building rapport will give the client the opportunity to give her full history. This is also important for predicting likely problems that may affect management.

Step 2. Interacting and assessing client's needs and demands

- Make the client feel comfortable mentally as well as physically. The former is extremely important as the client may have some conflicted feelings about MR.
- Help the client to discuss frankly about her problems. It is important to keep in mind that when a woman comes for MR, she is afraid, apprehensive and hesitates to discuss her problems frankly, which may adversely affect proper decision-making.

- Keep counselling appropriate to the client's level of education and understanding. Use simple language and allow the client to clarify doubts. Use local language or colloquial terms while discussing about any symptoms/diseases.
- Give her enough time to understand, answer and ask questions.
- Identify the client's needs and demands for MR by asking relevant questions related to personal, familial, social and medical history and past use of contraceptive methods. Ensure that her decision to have MR is hers alone and she is not being forced by a partner or family member.

Step 3. Informing the client about MR and other relevant services

If the client wishes MR procedure, assess the client and if found eligible for MR, explain the process clearly and in detail in a simple language. Explanation should include details of

- Physical examination
- Informed written consent and confidentiality
- Pain control during and after the procedure
- MR procedure itself
- Likely risks associated with the procedure
- Follow up visits and care after the procedure
- Immediate risk of pregnancy (as early as 9-10 days) if no contraceptive method is used
- Contraceptive methods and follow up.

Explore whether she has any misconception or apprehensions about MR and provide her proper information accordingly.

Step 4. Helping the client in decision making

- After providing the details about MR and addressing the client's questions; help the client to take a decision on her own about availing MR services. The client may further consider her financial conditions, future plans, husband's/guardian's preferences/reservations etc. for decision-making. Information/ clarifications should be provided to the client if needed during this decision-making process.
- Allow the client to give voluntary, informed consent. Explain the consent form to her and verify whether she has properly understood it. Then, help the client to sign the informed consent form.
- Involve the husband/accompanying person if the client agrees and is comfortable. Ask the client first if she wants another person involved in the consent process.

Step 5. Explaining the Family Planning/Contraceptive services

- Discuss various post-MR contraceptive methods including their mechanism of action, advantages, disadvantages and possible side-effects (Table 4.1:Post-MR Contraceptive Methods).
- Help the client to select a contraceptive method of her choice and assess whether the method chosen is appropriate (based on history and examination). If the chosen contraceptive method is not appropriate, explain the reason and help her choose another method.
- If the chosen contraceptive method is appropriate, provide the method-specific information. In case the method is not available at the centre, provide information and assistance for getting the appropriate service elsewhere. In this case, provide her with another interim method of contraception until the chosen method is available to her.
- If she chooses implant, Intra Uterine Device (IUD) or tubal ligation as a family planning method for contraception, obtain separate consent for that procedure in the specific consent form.
- If the client is not willing to accept a contraceptive method:
  - Do not refuse MR;
  - Assure the client that she will not be refused MR
  - Wait for an opportunity to counsel her after the procedure. Explain to her about the chances of getting pregnant and the consequences of repeat MRs.
  - If she is still not willing to accept a contraceptive method, call for follow-up in a week's time and counsel again. If she agrees, encourage her to bring her spouse or another support person.

Step 6. Ensuring follow up visit by client

Explain the client about importance of the follow up visit. Request the client to come for her follow up visit as per schedule.

4.2. Counselling during procedure

- Maintain verbal contact, hold hand, assure her.
- Explain the steps, if she wants:

4.3. Post-procedure Counselling

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

- It ensures that the client has understood post-MR care, the danger signs and what action is to be taken in case of complications.
- It re-enforces the need for continuing the use of the contraceptive method chosen.

- It provides an opportunity to counsel for contraception if the client has not yet decided to do so. In some cases, before the procedure, a client might not be able to make up her mind about contraception, because she is focused on the MR procedure. After the MR procedure, she may be more relaxed and willing to consider some contraceptive methods and select one that is appropriate for her.

4.3.1 Critical Steps in Post-procedure Counselling

1. Continue to ensure privacy and confidentiality and an empathetic attitude.
2. Enquire from the client how she is feeling and reassure in case of any problems. Take care of her emotions and provide psychological support in case she is feeling depressed or guilty.
3. Repeat the information about post-MR care and ensure that the client clearly understands.
4. Repeat the warning signs and actions needed to be taken by her if any. Explain the general symptoms which she may experience after the procedure (mild pain in lower abdomen and mild bleeding, which may continue for 3 to 7 days). The warning signs include: excessive vaginal bleeding, severe pain in lower abdomen, fainting, fever, foul smelling vaginal discharge.
5. Provide medicine/prescription and explain how to take medicine.
6. Explain the importance of follow-up visits and request her to come for follow up on the scheduled date.
7. Provide general advice for self care (no intercourse for 14 days, avoid heavy work for seven days, do not introduce anything in vagina/no douching and maintain personal cleanliness).
8. If the client chooses a contraceptive method during the pre-MR counselling , explain to her the method specific information again. Provide her with the chosen contraceptive method by following the standard procedures. In case the method is not available at the centre, provide information and other assistance for getting the appropriate service elsewhere. In this case, provide her with another interim method of contraception until the chosen method is available to her.
9. If the client is not willing to accept a contraceptive method during pre-MR counselling , try counselling her again. If she is still not willing to accept a contraceptive method, call for follow-up in a week's time and counsel again. If she agrees, encourage her to then bring her spouse or another person for support..

4.3.2 Counselling a client who is being referred to a higher level of facility

It is important to explain about the referral to the client, spouse or relative accompanying the client. Steps for referral are:

1. Explain the reasons why the client is being referred.
2. Explain which facility (referral site) they should go to and explain the procedure that will be done at the referral site.

3. Give a referral letter with details of history, physical examination, the MR procedure and the reason for referral. Request her to inform the action taken subsequently.
4. Instruct the client to report for follow up either to the referral site or to the facility from where she has been referred.
5. Record the information about referral in the health centre records.

4.3.3 Counselling during a follow up visit

Counselling during a follow-up visit provides an opportunity to make sure the client is physically and emotionally well and to ensure the continuation of contraception.

Steps to be followed are:

1. Ask the client about problems after MR, if any.
2. Ask the client if she is comfortable with the contraceptive chosen.
3. In case of a client who had not accepted a contraceptive method, counsel for contraception again.
4. If the client was referred, find out about the procedure that was performed and if any contraceptive method was advised/given. If no contraceptive method was provided, further counsel for contraception and help the client to choose an appropriate method.
5. Record findings/advice provided.

4.3.4 Contraceptive methods following MR procedure

Table 1. Post MR Contraceptive Methods

Method	Timing and medical eligibility for the method after MR	Additional advantages
Barrier methods		
Condoms	As soon as sexual activity is resumed	- Easily available - No hormonal side effects - Prevention against STIs and HIV - User needs to ensure re-supply - Enables men to take responsibility of contraception
Intrauterine Device		
Intra Uterine Device (IUD) -CuT380A (Copper-T)	Inserted immediately after MR if procedure is complete and there is no risk of infection	- Highly effective, immediate effect - Provides long-term contraception - Can be provided by non-physicians - No interference with sex - Immediate return to fertility when removed - No effect on quality or quantity of breast milk

Hormonal Contraception		
Oral Contraceptives	To start immediately after MR even if infection present	- Regulate menstrual cycles - Can be provided by trained FWV/ FWA - No interference with sex - Protection against ectopic pregnancy, endometrial & ovarian carcinoma, benign breast diseases like fibrocystic, and uterine fibroids
Injectables – DMPA (Depomedroxy progesterone acetate)	Administered immediately after MR even if infection present	- Highly effective - Confidential - Can be provided by trained FWV - No interference with sex - No effect on the quality and quantity of breast milk - No oestrogenic side effects
Hormonal implants	Inserted immediately after MR even if infection present	- Highly effective - Confidential - [redacted] - No interference with sex - No effect on the quality and quantity of breast milk - No oestrogenic side effects
Permanent methods		
Tubectomy/ tubal ligation	Can be performed immediately after uncomplicated MR procedure. However, it should be delayed in complicated MR cases with infection, severe bleeding, trauma, or acute haematometra.	- Permanent method - Very effective, immediate effective - No interference with sex - No effect on breast feeding - No long-term side effects
Vasectomy	Performed on males, independent of the MR procedure on the woman	- Permanent method - Very effective, effective after few weeks - No interference with sex - No clinic visits required - No long-term health risks

- Fertility-awareness based methods should be delayed till regular menstrual cycles return.
- Emergency contraception: Women may use emergency contraception within 120 hours of an act of unprotected intercourse to decrease pregnancy risk.

Generally, almost all methods of contraception can be initiated immediately following a MR. Immediate start of contraception after MR refers to the same day as the procedure. As with the initiation of any method of contraception, the woman's medical eligibility for a method should be verified.

Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

Table 2 Post MR tubectomy - Medical eligibility criteria and recommendations

Post MR condition	Category
Uncomplicated	A (Accept)
Post-MR sepsis or fever	D (Delay)
Severe post-MR haemorrhage	D (Delay)
Severe trauma to the genital tract; cervical or vaginal tear at time of MR	D (Delay)
Uterine perforation	S (Special)
Acute haematometra	D (Delay)

Definition of categories:

- A = (Accept) There is no reason to deny sterilization to a person with this condition;
- D = (Delay) The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided;
- S = (Special) The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed.

Reference

Ipas

Medical and Social Eligibility Criteria for Contraceptive Methods. DGFP

Dhaka, Bangladesh. 2006

Pre-MR care

Clinical assessment for eligibility to undergo MR is critical to increase quality of care while providing MR services. Although the majority of women seeking MR is uncomplicated and may receive services at any level of health facility, the assessment helps to identify women who may need special consideration or referral to a higher level facility due to their increased risk of complications.

5.1 Clinical assessment

Clinical assessment has the following components:

5.1.1 Establishing rapport

5.1.2 History taking

5.1.3 Physical examination: General, Systemic, Abdominal and Pelvic

5.1.4 Laboratory tests (if necessary)

Clinical assessment provides the following information:

- General health condition of the client
- Size of the uterus
- Associated gynaecological disorders and infection
- Associated medical problems
- Assessment of need for other services: referral for further treatment, Violence Against Women (VAW), legal help etc.

Details of the medical history and physical exam should be recorded in the woman's medical chart and reviewed by the MR service provider.

5.1.1 Establishing rapport

During the pre-MR assessment, the clinician should reassure the woman of her privacy and confidentiality and establish rapport so that the woman feels comfortable and safe. The health service provider should communicate to the client in a simple language which she understands.

5.1.2 History taking

The following should be included in the personal history (present and past history) and family history:

1) *Personal details*: name age, address/contact detail;
2) *Menstrual history*: length and duration of cycle, flow (excess or normal), LMP;
3) *Obstetric history*: Parity, live births, abortion (induced and spontaneous), previous caesarean section (if any), last child birth/ abortion; fetal death; ectopic pregnancy
4) *Contraceptive history*: type of contraceptive use, how long, reason for discontinuing, if applicable; Contraceptive methods used in the past and experience with these methods;
5) *Sexual history*: History or symptoms of any sexually transmitted infections (STIs)/ reproductive tract infection (RTIs), including HIV/AIDS of patient and her partner; excessive foul smelling vaginal discharge, pain in lower abdomen, abnormal vaginal bleeding, dysparunia (painful intercourse);
6) *Sexual/ domestic violence*:
7) *Medical history*: The following conditions should be included: anaemia, hypertension, heart disease, renal disease, liver disease, diabetes mellitus, epilepsy, sickle cell anaemia, asthma, drug allergies and bleeding disorders, mental health. (Refer: Table 5.1: MR in women with pre existing conditions).
8) *Medications and allergies*: Daily medications; use of recent medications or herbal remedies, allergy to drugs and
9) *Surgical history*: Details of past hospitalizations and surgical operations if any.

5.1.3 Physical Examination

1) General examination
2) Systemic examination
3) Abdominal examination
4) Pelvic Examination (may be performed during the pre-MR assessment or at the time of the MR procedure). Before starting the pelvic examination, inform the woman and take verbal consent from her.

5.1.4 Investigations

i) Ultrasound Examination and Ectopic Pregnancy

Suspected or diagnosed ectopic pregnancy is life-threatening and must be followed up urgently. The woman should be treated or referred as soon as possible to a facility that can confirm diagnosis and treatment.

ii Laboratory Investigations: only if available/necessary

Laboratory investigations are not essential for MR service. However, MR service gives an opportunity for health screening. Some laboratory investigations can be performed based on the woman's history, risk factors and the available resources such as:

- Haemoglobin or haematocrit testing for suspected anaemia;
- Blood group/ Rh testing;
- STI screening, Cervical cancer screening, HIV testing; and
- Other laboratory tests as indicated by medical history (kidney or liver function tests, etc.)

MR with caution:

If any of the following conditions are found, advance preparation may increase the quality and safety of MR. Women should be generally advised to continue daily medications for any chronic condition. Rarely, some women will need referral to a higher level health facility.

Table 5.1: MR in woman with pre-existing conditions

Pre-existing condition	Comments
Age	Neither adolescence nor older age is a contraindication for MR. • Special care should be taken to provide services that meet her needs • Consider cervical priming before MR for relatively younger age
Anaemia	• If haematocrit or haemoglobin very low, treat appropriately
Suspected ectopic pregnancy	• Known or suspected ectopic pregnancy is a contraindication to MR • Evaluate, treat or refer
Uterine scar	There is no increased risk of complications during MR in women with a uterine scar
Cervical stenosis	• Consider MR procedure under ultrasound guidance, using misoprostol to prepare the cervix prior to procedure, or wait till the woman is eight weeks from LMP. May need referral to a higher level health facility
Uterine malformation (e.g. bicornuate uterus)	• MR should only be performed by an experienced provider with caution, may require ultrasound-guided procedure.
Molar pregnancy	• In most cases, molar pregnancy will not be diagnosed prior to MR in early pregnancy. • Women with known or suspected molar pregnancy should have an evacuation of uterus using vacuum aspiration with confirmation of tissue diagnosis and appropriate follow-up. May need referral to a higher level health facility/hospital
Asthma	• The woman should be stable (not having an acute asthmatic attack) prior to MR procedure. • Women should have medications available during treatment. May need referral to a higher level health facility/hospital
Hypertension	• Methergine, an ergotamine derivative, should be used with caution in hypertensive women for treatment of post MR atony. It should be avoided in clients with blood pressure greater than 160/100.
Diabetes	• High blood-glucose levels are not dangerous but ketoacidosis should be avoided • Insulin dose need not to be changed if vacuum aspiration is performed under local anaesthesia.
Haemorrhagic disorder	• If the woman has an active clotting disorder, proceed with caution, preferably in a facility that is able to treat women who are bleeding. • Vacuum aspiration in a facility with blood transfusion facility (if possible) may be a safer option for woman with a known clotting disorder.
Heart disease	• If symptomatic or severe disease, vacuum aspiration may be performed in an operating room and monitored with the assistance of an anaesthetist. May need referral to a higher level health facility.
Seizure disorder	• The woman should take her usual dose of anti-seizure medication on the day of the MR procedure. • Benzodiazepine sedative may be administered before performing an MR • Several anti-epileptic drugs interfere with some forms of combined hormonal contraception
Tobacco chewing, alcohol or drug abuse	• Prepare for a low pain threshold • Consider use of narcotic analgesic and parenteral sedative

Table 5.2: MR in woman with conditions detected during pelvic examination

Uterine Size	Possible Conditions	Line of Action
Bigger than expected but has smooth and soft surface	- Molar pregnancy - Multiple pregnancy - Inaccurate menstrual date	Ultra Sonogram(USG) if available or refer to a appropriate centre
Bigger than expected, irregular and firm	Presence of fibroids with pregnancy	USG if available or refer to an appropriate center
Smaller than expected	- Non pregnant uterus - Inaccurate menstrual date - Ectopic pregnancy - Spontaneous abortion	USG if available or refer to an appropriate center

Who should refer?

- A person lacking necessary skill/ equipment/ facility, or,
- A health centre/institution not having necessary manpower/ equipment/ facility

When to refer?

- In case of difficult gynaecological or obstetric conditions/complications
- In case of Heart disease, uncontrolled/severe hypertension, diabetes mellitus, epilepsy or other uncontrolled systemic diseases

Where to refer?

To a centre equipped with necessary manpower, equipments, and facilities e.g. Mother and Child Welfare Centre, Medical College Hospital, District Hospitals, MCHTI, MFSTC, BSMMU etc.

Chapter 6

Manual Vacuum Aspiration Technique for Menstrual Regulation

MR is done by a procedure called Manual Vacuum Aspiration (MVA), up to ten (10) completed weeks of missed periods from the first day of the last menstrual period. MVA uses a hand-held syringe to generate a vacuum manually. The syringe is attached to a cannulae ranging from 4 to 10 mm in diameter (based on the weeks of missed periods or size of uterus), which is introduced into the uterine cavity for suction of the uterine products.

Step 1: Before the procedure

- Carry out complete pre-MR assessment including informed written consent to rule out any contraindications.
- Confirm uterine size and position of the uterus to ensure that uterine aspiration is appropriate. Uterine anomalies and other conditions such as large fibroids may make the MR procedure difficult to perform.
- Refer the client to an appropriate facility or modify the aspiration procedure as needed, if pre-existing conditions are detected which may cause or exacerbate complications (refer tables 5.1 and 5.2).

Step 2: Consider the following clinical and procedural issues

- Ensure that proper infection prevention standards are followed.
- Ensure that recommended equipment and supplies are in place.
- Perform cervical preparation if needed, depending on the individual case need. Cervical preparation softens the cervix and makes the dilatation of the cervical canal easy. Cervical preparation is not routinely recommended; however, it is safe and effective in indicated cases where the cervical openings or canal is tight in case of younger women, cervical stenosis, or uterine anomalies and where chances of uterine perforations are higher. Misoprostol may also be used (Table 6.1) as it is readily available and may be administered by the client herself. The client must be counselled that misoprostol for cervical preparation may cause abdominal cramping, bleeding or other systemic side effects.

Table 6.1: Dose, route and timing for misoprostol for cervical preparation for MR

Dose	Route	Timing
400µg	Vaginal	3 hours prior to vacuum aspiration
400µg	Sublingual	2-3 hours prior to vacuum aspiration
Note: Vaginal administration provides equally effective dilatation with fewer systemic side effects than sublingual administration		

Step 3: Administer medications

Prophylactic antibiotics should be given and continued after the procedure to reduce the risk of post MR infection. However, if antibiotics are not available, MR can be performed without them. Additionally, therapeutic antibiotics should be administered for any infection suspected or confirmed by physical examination, but this need not delay the MR.

The following prophylactic antibiotic regimens are commonly used:

- 200-500mg doxycycline orally 1 12 hrly x 1 dose *or*
- 400mg metronidazole orally 1 tab 4 hrly x 3 doses

For initiating the antibiotics before the procedure and continuing after the procedure, the following regimens can be given:

a) Cap doxicycline100 mg 12 hrly/ OR Cap. Amoxicillin 500 mg 8 hrly/ OR Tab Ciprofloxacin 500mg 12 hrly for 7 days; and

b) Tab Metronidazole 400 mg 8 hrly for 2 days

All women should be offered analgesics to reduce pain during the procedure.

Step 4: Prepare appropriate instruments

Instruments, equipments, drugs and supplies necessary for performing MR are mentioned in Chapter 11 (Table 11.1). Equipment should be maintained in good working condition, and properly disinfected. Any instruments inserted in the uterus must be throughly disinfected prior to each use.

The size of the MR cannula is approximately the size of the uterus. Using a right size cannula is important for safe and easy dilation of the cervix, as well as for suction of the uterine products. Using a wrong size cannula may result in difficulty with dilatation of the cervical canal, injury to the cervix, incomplete MR or loss of suction. The range of suggested cannulae sizes relative to uterine size for aspiration is listed in Table 6.2

Table 6.2 Selecting cannula size for MR procedure

Uterine size in weeks	Suggested cannula size
4 - 6 weeks LMP	4 - 7 mm
7 - 10 weeks LMP	5 - 10 mm

Use of MVA has the following additional considerations:

- The aspirator should be checked to make sure it holds a vacuum before starting the procedure and
- Extra spare aspirators should be readily available, in case the first aspirator has technical problems.

Step 5: MR procedure

Before starting the procedure, ensure that the client understands what to expect, clarify any questions, and confirm that she has received her pain medications at the appropriate time.

The procedure then commences with the following steps:

5. a) Starting the MR procedure

1. Ask the client to pass urine and empty her bladder. Then carefully help her onto the procedure table and into the dorsal lithotomy position
2. Have providers wash their hands and put on appropriate barriers, including gloves (infection prevention procedures to be carefully followed)
3. Perform a bimanual examination to confirm or update findings, if an earlier assessment was done. The provider should have an accurate assessment of uterine size and position before performing MR.
4. Place the speculum.

5. b) Antiseptic preparation of the cervix

1. Use an antiseptic-soaked sponge to clean the vagina first.
2. Then wipe the cervical os with another fresh antiseptic-soaked sponge.
3. Follow the "no-touch technique" throughout the procedure as below.

No-touch technique

Reducing infection is accomplished by using sterilized or HLD instruments, administering prophylactic antibiotics and using the no-touch technique. The no-touch technique means that the parts of instruments that enter the uterus should not touch objects or surfaces that are not sterile including vaginal walls, before being inserted.

Thus, during the MR procedure, the provider

- Grasps and touches only the mid-portion of dilators, avoiding the tip;
- Attaches the cannula to the vacuum source without touching the tip of the cannula, and
- Keeps used instruments away from sterile instruments remaining on the tray.

5. c) Perform para-cervical block if needed

See Section on Pain Management.

5. d) Dilatation of the cervix

Cervical dilatation is an essential step if the cervix is closed or insufficiently dilated. Dilatation is not needed when the cervix allows a cannula of appropriate size to fit through the cervical os. Cervical preparation for softening and easy dilatation may be accomplished with the use of misoprostol in specific cases when the cervical os is expected to be tight.

The technique of cervical dilatation is as follows:

1. Carefully examine the position of the uterus and cervix. With the tenaculum placed firmly on the cervix, apply continuous traction to straighten the cervical canal.
2. Use the smallest dilator (or a plastic os finder, if needed and available) to initially find the cervical canal.
3. Dilate gently, never using force, applying the no touch technique with successive mechanical dilators while stabilizing the cervix with gentle traction on the cervical tenaculum.
    - Grasp the narrowest dilator in the middle
    - Hold it between the thumb and index finger with the hand below the tip of the dilator
    - Insert gently until the dilator passes through the internal cervical os
    - With the dilator still grasped in its middle with the thumb and forefinger, withdraw the dilator.
4. Continue with progressively larger dilators until the cervix is dilated to the size required for the selected cannula.

The safety of the dilatation procedure is dependent upon adequate visibility of the cervix, gentle technique and the knowledge of the uterine position. If dilatation is difficult, it is best not to force the dilator. Instead, change the angle or path to identify the cervical canal, or repeat the bimanual exam to verify uterine position. Sometimes changing the speculum to one with a shorter blade can provide more room and flexibility to straighten out the cervical angle. Finally, if dilatation is particularly difficult, consider administering misoprostol and delaying the procedure by approximately three hours, or asking for assistance from a colleague, if available.

5. e) Inserting the cannula

When appropriate cervical dilation is achieved, gently apply traction to the cervix and insert the cannula just past the internal cervical os and into the uterine cavity

- Do not touch the end of the cannula that will be inserted into the uterus (no-touch technique).
- Do not insert the cannula forcefully (to avoid trauma to the cervix or uterus), but gently guide it through the cervical canal.
- Stop the procedure if signs of uterine perforation occur (see chapter 9).

5. f) Aspirate uterine contents

Attach the prepared aspirator syringe to the cannula, holding the volsellum and the end of the cannula in one hand and the aspirator in the other hand.

- Initiate the suction when the cannula tip is mid-uterus; as the uterus contracts, the uterine walls will feel firmer and the uterine fundus will descend.
- Evacuate the contents of the uterus by gently and slowly rotating the cannula 180 degrees in each direction. Blood and tissue will be visible through the cannula. Do not withdraw the opening of the cannula beyond the cervical os, or suction will be lost
- Repeat this procedure until the uterus is empty. The following signs indicate that the uterus is empty:
  - Red or pink foam appears and no more tissue is seen passing through the cannula.
  - A gritty sensation is felt as the cannula passes along the surface of the evacuated uterus.
  - The uterus contracts around the cannula.
  - The client complains of cramping or pain, indicating that the uterus is contracting.
- When the procedure is complete, discontinue the suction, withdraw the cannula from the uterus, remove the cervical volsellum, wipe the cervix with a clean swab and assess the amount of uterine or cervical bleeding.

5. g) Inspect aspirated uterine contents

After the aspiration procedure, the products should be examined to ensure a completed procedure. To inspect the tissue, empty the aspirated contents into an appropriate container (do not push aspirated contents through the cannula, as it will become contaminated).

Inspect the evacuated contents of uterus for the following:

- The quantity and presence of aspirated tissue: villi, decidua and sac/membranes in appropriate quantities based on gestational age;

- Presence of grape-like hydropic villi, which suggest a molar pregnancy;

  If the visual inspection is not conclusive for completed procedure, the tissue should be strained and placed in a transparent container, immersed in water, and viewed with light from beneath. If indicated for abnormal findings, the tissue specimen may also be sent to a pathology laboratory. These patients need follow up.

- If no villi are visible, less tissue than expected was removed from the uterus or the tissue sample is inconclusive, this may indicate: incomplete MR; a spontaneous miscarriage that completed prior to the procedure; a failed MR (all tissue remain within the uterine cavity); ectopic pregnancy; anatomical anomaly: in a bicornuate or septate uterus. These patients need follow up.

- If not absolutely sure that sac/membranes and villi are present on tissue evaluation, then assume none are present and attempt reaspiration and/or evaluate for ectopic pregnancy.

Step 6: Perform any concurrent procedures

When the aspiration procedure is complete, proceed with any concurrent procedures to be conducted, such as inserting an IUD, performing female sterilization or repairing a cervical laceration.

Step 7: Post-procedure steps, including instrument processing

1. Reassure the client that the procedure is finished and that she is no longer pregnant
2. Help her into a comfortable resting position
3. Assist with moving her to the recovery area
4. Immediately process or discard/ensure processing all instruments, including the aspirator syringe and cannula, according to instrument-processing procedures
5. Remove barriers, such as gloves, and wash hands
6. Record the details of the procedure in her medical chart

Step 8: Patient recovery, discharge, post MR care and follow-up

(Please see Chapter 8)

Chapter 7

Pain management

Medication for pain management should be offered to all women before MR. Neglecting this important element needlessly increases women's anxiety and discomfort, potentially lengthening the procedure and compromising her care. Most women undergoing MR will have effective pain relief from a combination of non-pharmacologic measures, oral analgesics, para-cervical block and gentle operative technique.

7.1 Safety of analgesics

Medications used for pain control are one of the few potentially life-threatening aspects of MR care. To maximize their safe use, close attention should be paid to a woman's medical history, allergies, and concurrent medications that might interact with pain medications. The provider must know how to treat the adverse reactions of analgesic methods.

7.2 Guidelines for patient monitoring

When using intravenous (IV) pain management, conscious sedation or general anaesthesia, a provider other than the clinician must be present who is trained (and certified, if legally required) to monitor appropriate respiratory, cardiovascular and neurologic parameters, as well as level of consciousness. The practitioner administering IV pain management must be prepared to provide respiratory support for respiratory suppression. Antidotes and other necessary medications must be available, preferably on an emergency cart, along with instructions on treating adverse reactions.

Creating a personalised pain management plan with the patient

The individual factors that need to be considered when developing a personalized pain management plan include the following:

- Nature of the planned procedure
- Amount of mechanical cervical dilatation required based on gestational age, young age, history of abortions or repeat MRs, history of procedures leading to scarred cervix etc.
- Pre-existing pain
- Level of anxiety, and patient's requests and needs

- History of allergies, medication and illicit drug use
- Associated medical condition which needs analgesics

Table 7.1: Sources of pain and pain management for MR

SOURCE OF PAIN	PAIN MANAGEMENT OPTIONS *
Anxiety, fear, apprehension • A women opting for MR procedure may feel anxiety, fear or apprehension about her decision or the procedure itself • Anxiety can increase sensitivity to pain • A highly anxious woman may not be able to lie still on the procedure table, potentially compromising her safety	**Non-pharmacological methods** • Verbal support and reassurance • Gentle, smooth operative technique • Providing preferred support measures • Advance notice of each step of the procedure (if she desires) • Encouraging deep, controlled breathing **Pharmacological methods** • Anxiolytics/sedatives eg. diazepam 5-10 mg • Analgesia (eg. ibuprofen 400-800mg) • Conscious sedation or general anaesthesia in some cases **Timing of oral medication** • To ensure the drug is most effective at the time of the procedure, in general, 30-45 minutes in advance administration
Cervical pain due to dilatation • Most women experience some level of pain related to cervical dilatation, transmitted by a network of nerve fibres around the cervix	**Local anaesthetic** Paracervical block using lidocaine (usually 10-20 ml of 0.5 to 1.0%) ** **Administering a para-cervical block** • Inject 1-2 ml of anaesthetic at the cervical site where the tenaculum will be placed (either be 12 o'clock or 6 o'clock depending on the preference of the provider or the presentation of the cervix) • Next, stabilize the cervix with the tenaculum at the anaesthetized site • Use slight traction to move the cervix and define the transition of smooth cervical epithelium to vaginal tissue which delineates the placement for additional injections • Slowly inject 2-5ml lidocaine into a depth of 1-2 cm at 2-4 points at the cervical/vaginal junction (3,5,7 or 9 o'clock) • Aspirate before injecting to avoid intravascular injection • Maximum dose of lidocaine in a paracervical block is 4.5mg/kg/dose or generally 200-300mg (approximately 20ml of 1% or 40 ml of 0.5%)
Uterine cramping due to manipulation and contractions • Almost all women will experience some pain and cramping with uterine manipulation, transmitted by major uterine nerves that follow the uterine ligaments	**Analgesics** (e.g. ibuprofen and/or diclofenac) (note- omeprazol 20 mg, orally may be given before taking oral analgesics to prevent epigastric pain from acidity) **Timing of oral medication** Generally administer 30 - 45 minutes before procedure to ensure the drug will be most effective at the time of the procedure

* Note: A combination of all these methods can be used for pain management

** Note: Local anaesthesia with paracervical block is widely used although it has been poorly studied and lacks supporting evidence

Chapter 8

Post MR care and follow up

The objectives of post MR care are:

- To address any immediate complications of the MR procedure;
- To provide contraceptive information and to offer contraceptive methods and counselling;
- To assess any social and emotional health needs including other sexual and reproductive health (SRH) services that may require additional care, and
- To provide moral or emotional support.

8.1 Post MR procedure care

The following steps immediately following the procedure:

- Check the client's vital signs (pulse, respiration, blood pressure, temperature): The client's vital signs should be assessed when she first arrives in the recovery room after MR with vacuum aspiration, before she is discharged from the facility and at any time if necessary.
- Evaluate lower abdominal pain; Some pain is normal following even uncomplicated MR procedures because the uterus is contracting. Mild analgesics such as NSAIDs help relieve cramping pain following the procedure. Pain that increases in severity over time requires clinical evaluation to rule out haematometra or surgical injury.
- Observe vaginal bleeding which should decrease over time.
- Observe signs of complications including nausea /vomiting/continuous fresh bleeding
- Assess and alleviate post-procedure pain.

The patient should be observed until her vital signs are stable, abdominal pain and bleeding is reduced, she can dress herself and walk comfortably on her own, and can drink fluids without vomitting.

Monitor the patient closely for immediate post-procedure complications such as signs of shock, excessive vaginal bleeding, nausea, vomiting, worsening cramping or pelvic pain and fever.

8.1.1 Conditions requiring immediate attention and treatment

Significant physical decline as reflected in vital signs.

- Dizziness, shortness of breath or fainting, which may be caused by internal or external blood loss.
- Fainting: This may be due to anxiety or due to a transient vasovagal reaction.
- Severe vaginal bleeding: While some post-procedure bleeding is expected, the amount of bleeding should decrease over time. Excessive bleeding may be a sign of incomplete MR, lack of normal uterine tone, cervical laceration or other complications.
- Severe abdominal pain or severe prolonged cramping may be a sign of uterine perforation or post MR hematometra.

8.1.2 Discharge from the health facility

Following an uncomplicated MR procedure, the patient may leave if the vital signs are normal; the patient feels good and is able to get up on her own. She may leave as early as 30 minutes when local anaesthesia is used, but longer recovery periods are generally required when sedation or general anaesthesia is used.

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

- Assess and document the patient's vital signs at discharge;
- Repeat contraceptive counselling if not done pre- procedure, and provide requested contraceptive method;
- Provide clear oral and written discharge instructions as below:
  - Pain management with oral analgesics at discharge, Tab. Paracetamol (500 mgs/8hrly) NSAIDs (for example Ibuprofen: 200-400 mgs/8 hrly) after meals, along with Omeprazol (20mgs/12 hrly) before meals.
  - Antibiotic therapy, if indicated - Cap.Amoxicillin (500 mgs/ 6hrly) OR Cap. Doxacycline (100 mgs/12 hrly) OR Tab Ciprofloxacin (500mg/12 hrly) for 7 days AND Tab. Metronidazol (400 mgs/8 hrly) for 2-5 days.
  - Provide iron tablets for anaemia, if needed;
  - To resume normal diet on the same day;
  - To restrict heavy activity for next three days;
  - To avoid vaginal douching or tampons;
  - To avoid intercourse for seven days, or till bleeding stops;
  - Caution on possibility of getting pregnant almost immediately; and
  - Follow-up visit within one-two weeks, preferably after seven days.
- Explain signs of normal recovery;

- Explain abnormal signs like excessive bleeding, severe abdominal pain, vomiting, and fever and follow up actions needed;
- Discuss who might provide emotional support to the client if needed;
- Address other reproductive health issues: anaemia, reproductive tract infections (RTIs), HIV, domestic violence, cancer screening;
- Refer to other services as determined by assessment of her needs, such as STI/HIV counselling and testing, abuse support services, psychological or social services, or other physician/ specialists.

8.1.3 Signs of Normal Recovery

- Vaginal bleeding: Some spotting or bleeding is normal and should not exceed that in a normal period. A normal menstrual period should resume within four weeks (± 7 days). Delay in menstruation may be due to failed MR, incomplete MR, cervical stenosis or becoming pregnant.
- Nausea and vomiting generally subside within 24 hours.
- Uterine cramping may occur over the next few days, similar to that of a normal menstrual period. Discomfort from cramping may be eased by mild analgesics, warm compress or bath.

8.1.4 Abnormal signs after MR procedure

Ensure that the patient clearly understands the abnormal signs and that she shouldreturn to the hospital or clinic if there is:

- Increased intensity of cramping or abdominal pain;
- Heavy vaginal bleeding;
- Fever;
- Foul smelling vaginal discharge, or
- Fainting.

C) Follow-up Care

The objectives of follow up care after MR are to:

- assess recovery;
- address complication of MR, if any;
- provide moral or emotional support;
- provide contraceptive information and to offer contraceptive methods and counselling, and
- To assess any social and emotional health needs including other sexual and reproductive health (SRH) services that may require additional care.

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

During the follow-up visit, record all details of the visit (use forms) and:

- Welcome the client and help her feel comfortable;
- Inquire about abnormal signs like fever, pelvic or abdominal pain or cramps;
- Assess recovery: Assess the physical status and vital signs. Perform a focused physical exam, depending on whether the client has any complaints, and which may include an abdominal and/ or pelvic examination;
- Assess vaginal bleeding;
- Review any available medical records and referral documents;
- Evaluate the client's emotional status and level of support, providing referrals as needed;
- Give referrals related to other health and social needs, if appropriate;
- Assess fertility goals and need for contraceptive/family planning services. If a contraceptive method has not been previously provided, provide family planning information and counselling and the appropriate contraceptive method, if desired.
- If a contraceptive method was already started:
    - o assess method use, satisfaction or concerns;
    - o If she is satisfied, re-supply as needed, and
    - o If she is not satisfied, help her select another method that will meet her needs
- Schedule next visit, if needed

Chapter 9

Assessment and management of complications of MR procedure

While complications with MR with vacuum aspiration are rare, awareness of their possibility and prompt attention and management when they do occur are vital. Complication may be immediate or delayed.

Complications may be due to anaesthesia, the procedure of MR itself and other causes.

9.1 Complications due to anaesthesia

- Complications may arise from administration of local, intravenous of general anaesthesia.
- Complications and side effects are rare when allergies have been checked and when the anaesthetic is given in the proper dose with the correct technique.
- Mild side effects such as numbness of lips and tongue, metallic taste in mouth, dizziness and light headedness, ringing in ears, difficulty in focusing eyes and itching and rashes are occasionally encountered. They should be observed and must subside before the procedure is commenced.
- Systemic toxic reaction, though very rare, is the most serious complication due to local anaesthesia and is a result of overdose or direct intravascular injection. If the client shows signs of disorientation, muscle twitching and shivering, slurred speech, generalized convulsions and respiratory depression and arrest, manage as follows:

    1. Place the patient's head in low position
    2. Administer oxygen
    3. Apply suction to the throat to maintain patient airway
    4. Obtain IV access
    5. Rapidly infuse fluids
    6. Treat with epinephrine 0.4 mg subcutaneously and Inj. Diazepam 5mg IV slowly. If wheezing is present, an inhaler may be useful
    7. Refer to a higher facility when the patient is stabilized for completion of the procedure

9.2 Complications due to the procedure

9.2.1 Immediate Complications

(1) Haemorrhage:

- *Causes of haemorrhage (excessive bleeding):*
  - Cervical injury
  - Incomplete emptying of uterus
  - Uterine atony
  - Perforation of uterus
- *Management of excessive bleeding: first identify the source of bleeding In case of cervical injury:*
  - Apply pressure with sponge.
  - Suture the injury with sterile No. '0'chromic catgut or any other suitable absorbable suture using round body needle.
- *In case of bleeding from the uterine cavity:*
  - Ensure open airway, assess breathing pulse and blood pressure.
  - Establish IV access.
  - If uterine atony is suspected, give uterotonics and bimanual compression
  - Give Injection Methylergometrine Maleate 0.2 mg. IV or IM or Tab. Misoprostol 400µgm orally/ rectally.
  - If the bleeding continues, start Oxytocin infusion 10-20 units in Normal Saline/ Ringers Lactate 500ml @ 40 to 60 drops per minute.
  - If incomplete evacuation is suspected, repeat vacuum aspiration.
  - If perforation is suspected, give analgesics and prepare for further surgical management (see below) or refer appropriately.

(2) Uterine Perforation

Signs of perforation:

- Sudden loss of resistance with the instrument in uterus;
- Dilator or cannula penetrates further than expected size of uterus;
- Fat/omentum (yellow colored) or bowel seen in the cannula or at the cervix;
- Difficulty in withdrawing cannula;
- Severe abdominal pain, and
- Rapid pulse and fall of blood pressure (signs of shock).

Management of perforation:

- Stop the procedure as soon as possible and remove instruments
- Trendlenberg position (elevate the foot end of the bed and lower the head end)
- Start intravenous fluids
- Start antibiotics
- Give Injection Methylergometrine Maleate 0.2 mg IV
- If the client is not symptomatic, with minimal bleeding, and the perforation was with a small dilator or cannula, continue observation for pain or change in vital signs.
- If the client shows signs of excessive bleeding or trauma, or gradual development of signs of shock, after initial resuscitation refer her to higher facility for definitive treatment.

(3) Fainting/Syncope

Cause of Syncope:

Vasovagal syncope may happen during blood draw, para-cervical block or cervical dilation. The client may complain of light-headedness, dizziness or nausea and her skin may become pale and damp. Her vital signs may show bradycardia (slower pulse rate) with hypotension. Most episodes of syncope resolve spontaneously.

Management of Syncope:

- Stop the procedure.
- Maintain an open airway.
- Avoid aspiration of vomitus by turning the client's head and shoulder to one side.
- Trendlenberg position (elevate the foot end of the bed and lower the head end).
- If the episode is severe or prolonged, administer Inj. Atropine Sulphate 0.6 mg IV.
- if recovery is not immediate, ventilate with an Ambubag and administer Oxygen.
- Start IV fluids and monitor vital signs.
- Finish the procedure once the client is stable.

9.2.2 Delayed Complications

(1) Incomplete Evacuation

This is an uncommon complication when vacuum aspiration is done by a skilled provider. Patients usually present within two weeks of the procedure with lower abdominal pain and bleeding. Signs of infection may also be present. Incomplete evacuation may be prevented by proper surgical technique and visual inspection of uterine aspirate. It is managed by repeating the procedure under antibiotic cover to complete the evacuation, with attention to the possibility of haemorrhage or infection.

(2) Failed MR

Failed attempts at MR are very rare, but are more likely in women with uterine anomalies, too short LMP and an inexperienced provider.

(3) Infection

Infection rarely occurs following properly performed procedure. The rate of infection can be reduced by providing prophylactic antibiotics, observing a no-touch technique, ensuring complete uterine evacuation and disinfecting instruments correctly.

The symptoms of infection generally appear within two to three days after the procedure. The signs of infection are fever, abdominal pain, pelvic tenderness, sub involution of uterus and bleeding per vaginum/foul smelling discharge. In severe cases, the patient may present with sign of peritonitis or septic shock.

Antibiotics regimens for treatment of pelvic inflammatory disease should be followed. Women who are able to comply with therapy and are tolerating oral medications may have outpatient treatment; while women who are severely ill, immunocompromised or have signs of a pelvic abscess require parenteral (injectable) antibiotics, hospital admission and / or referral.

2. Other complications

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

Menstrual disturbances: Amenorrhoea and hypomenorrhoea may result after an MR. Ashermann's syndrome is very uncommon after MVA, reported at a rate of 16/100,000. Ashermann's syndrome may present with changes in menstrual bleeding, cyclic cramping or infertility. Adhesiolysis and insertion of copper-T may be done. Hysteroscopic adhesiolysis is now the management of choice for intrauterine adhesions.

Emotional or psychological problems: Special support and counselling is needed for women who have undergone MR due to fetal anomalies or have conceived after rape.

Other rare complications of MR: In patients who have undergone repeat MR procedures some rare complication like haematometra, cervical stenosis, infertility resulting from tubal block/ Ashermann's syndrome, chronic PID, recurrent abortion, ectopic pregnancy maybe seen.

Reference

From *MVA for uterine evacuation: Pain Management*, Ipas, 2009
WHO clinical practice guidelines for CAC
Hakim-Elahi OBGyn 1990

Chart 9.1: Assessing and managing potentially life-threatening MR complications

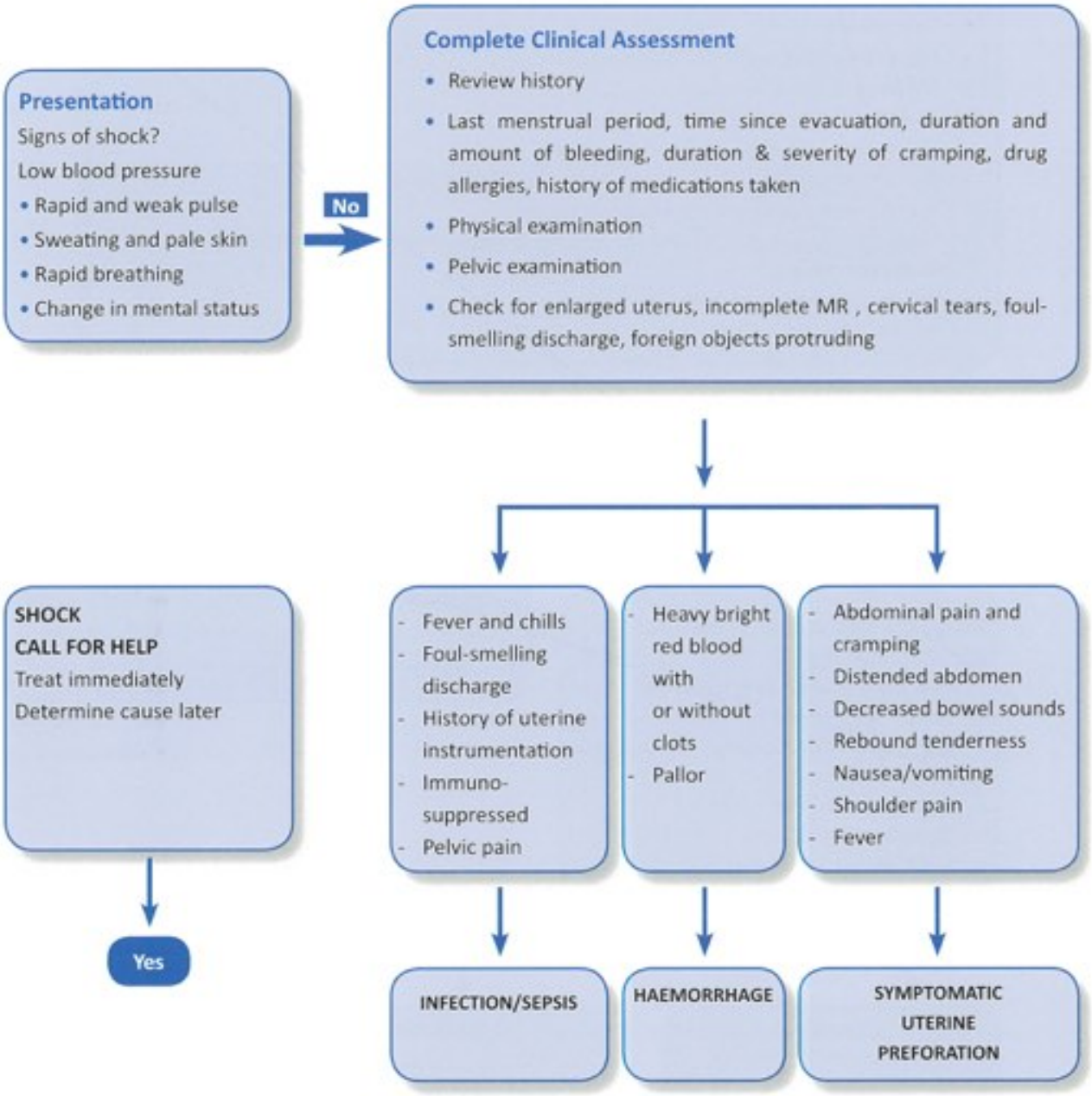


Chart 9.2: Management of shock

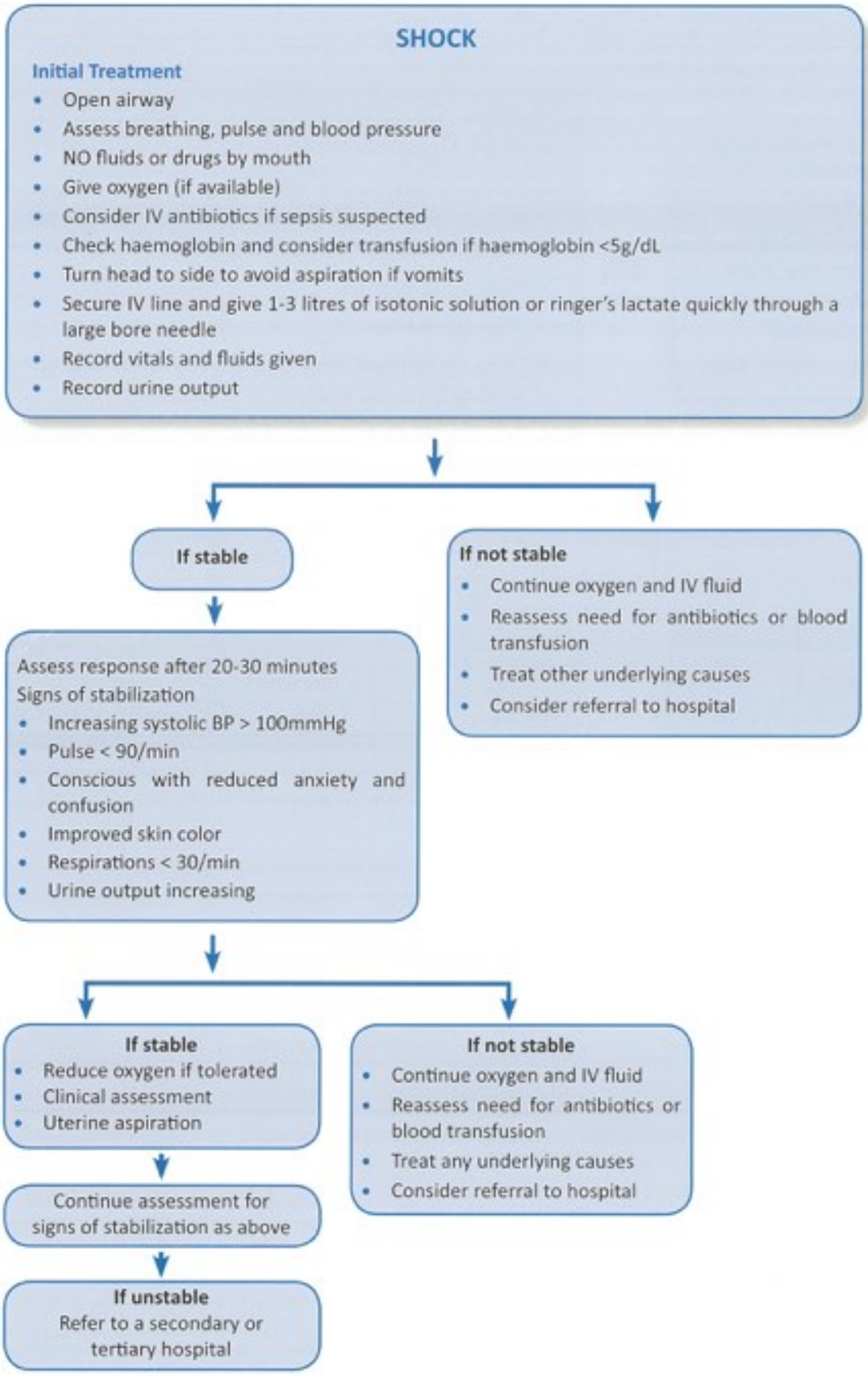


Chart 9.3: Management of haemorrhage

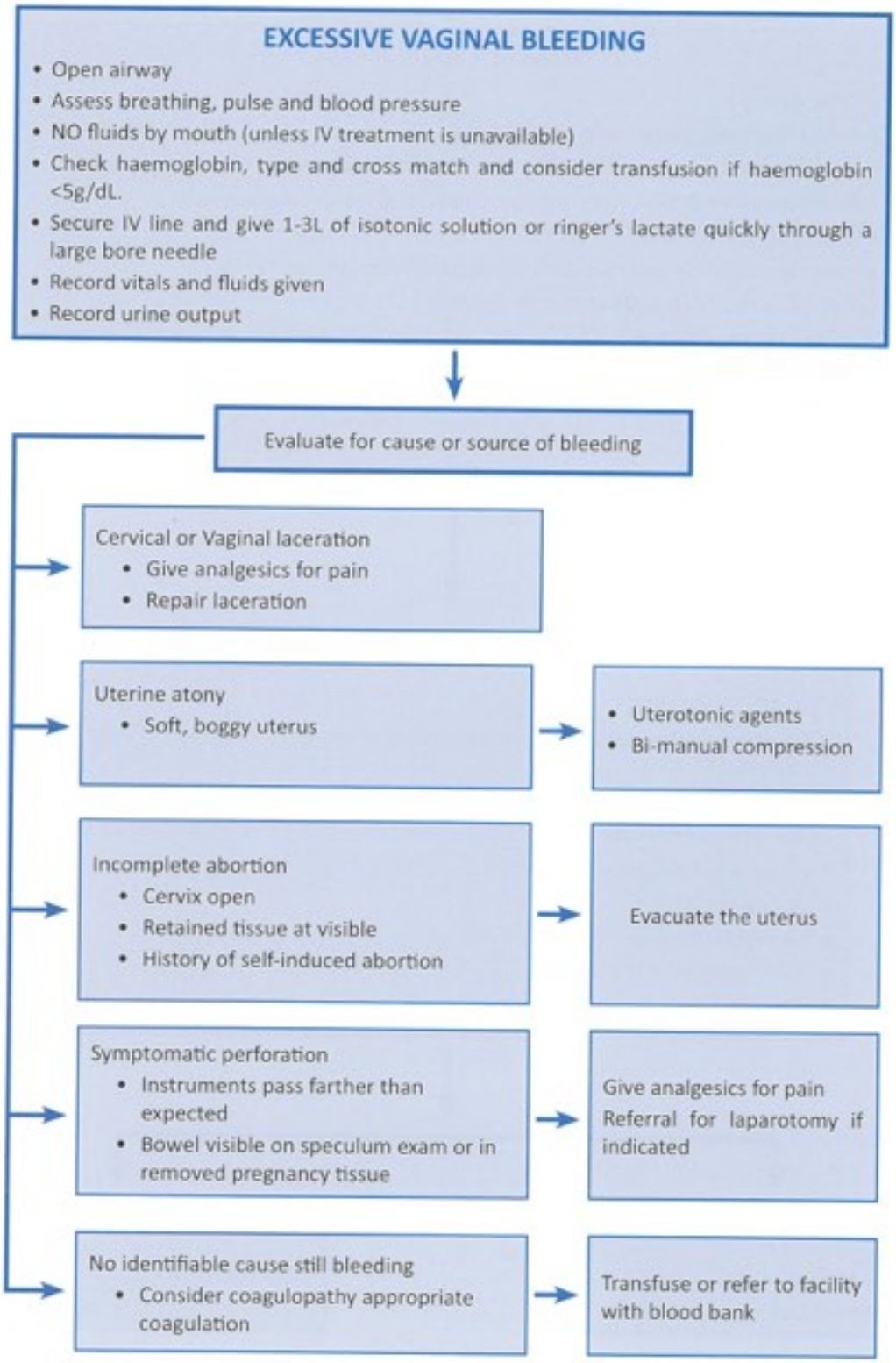


Chart 9.4: Management of sepsis

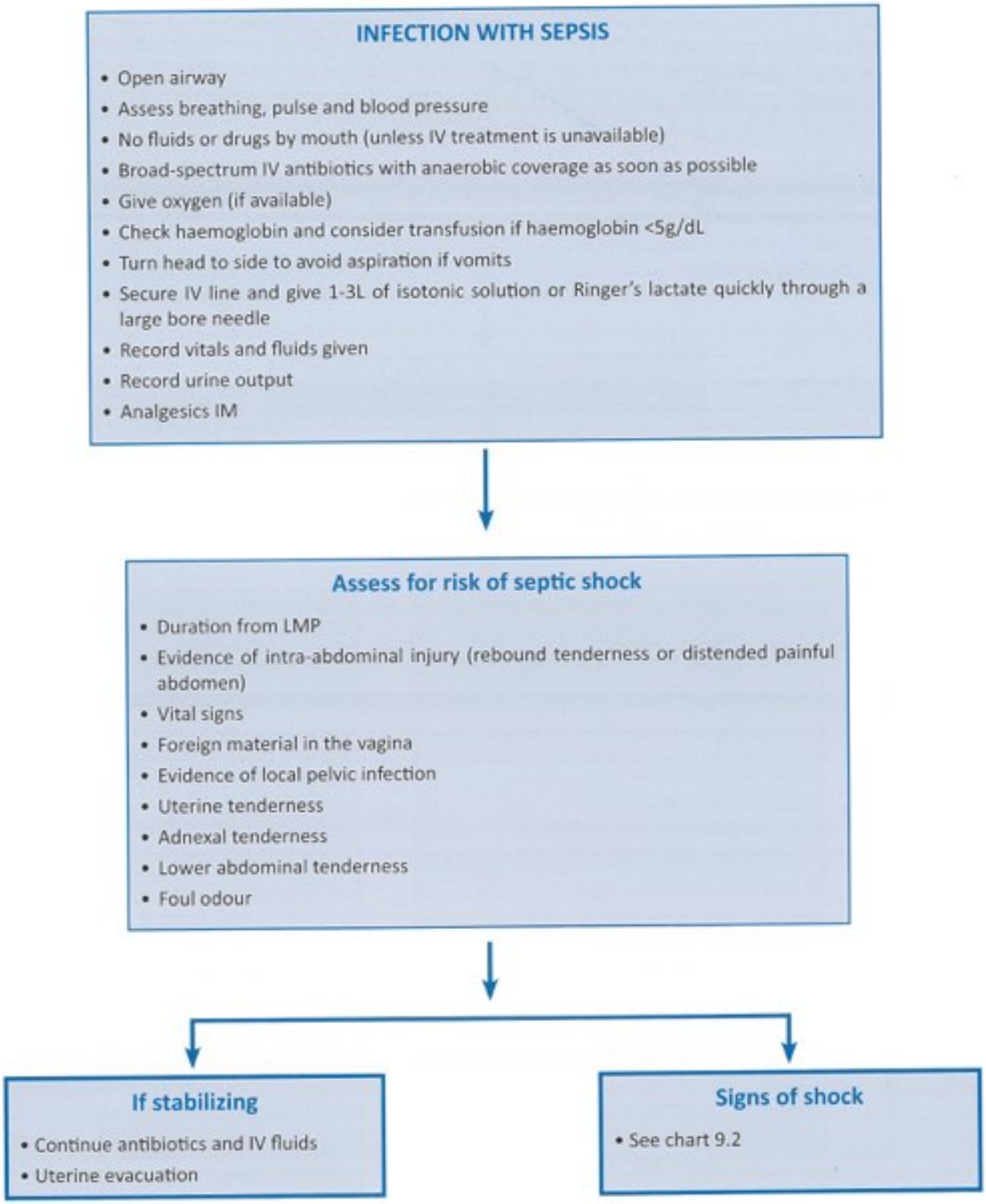
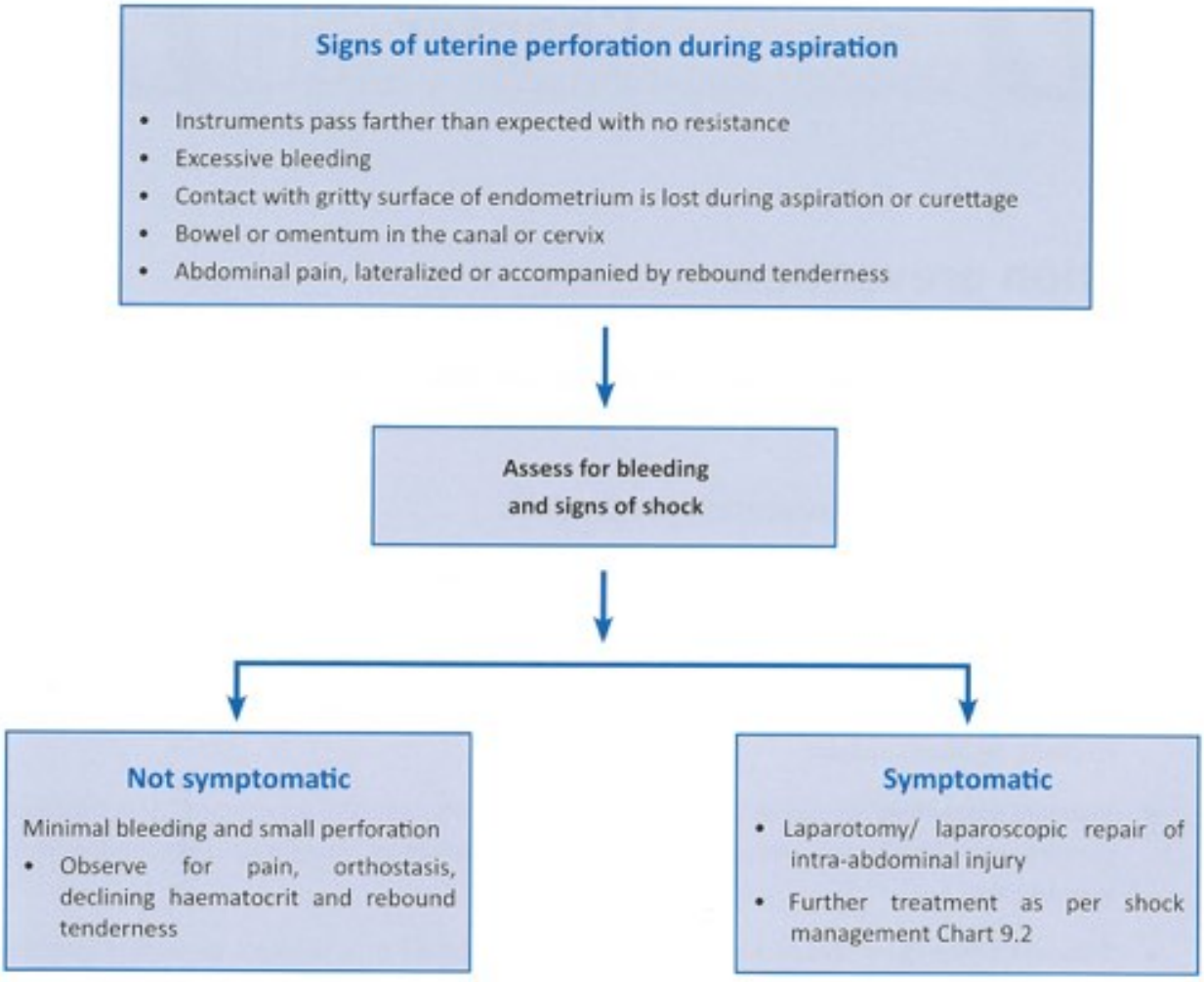


Chart 9.5: Management of uterine perforation



Chapter 10

Infection prevention

Infection prevention (IP) standards focus on preventing infections to patients from pathogens that are primarily transmitted through blood and other body fluids in a health-care facility.

10.1 Standard Infection prevention precautions

Standard precautions for infection prevention should be understood and practised by all medical and paramedical staff providing MR services.

- *Standard precautions*, also called *universal precautions*, are to be ensured as a way to minimize, or eliminate, transmission of disease from client to health service provider, health service provider to client, or client to client.
- Standard precautions should be applied in all situations where health service providers anticipate contact with blood, any body fluid other than perspiration, non-intact skin; and mucous membranes.
- Standard precautions should be strictly followed, regardless of a person's presumed infection status or diagnosis.

10.2 Standard Infection prevention practices

The essentials of infection prevention in MR procedure are the same as that applied to any condition involving surgical intervention. IP practices help to minimize infection from pathogens as well as transmission of hepatitis B & C, STIs and HIV. All staff should be frequently monitored for adherence to infection prevention practices as detailed below:

a) Proper hand washing;

b) Using personal protective barriers;

c) Proper handling of sharp items;

d) Proper handling and processing of instruments and materials;

e) Aseptic technique before, during and after procedure;

f) Meticulous surgical technique;

g) Appropriate use of antibiotics;

h) Safe waste disposal;

i) Environmental cleanliness, and

j) Maintenance of personal hygiene.

10.2.1 Proper hand washing

Hand washing with soap and running water should be routine before and after each contact. Hand washing is essential after handling potentially contaminated items, even if gloves are worn, as the gloves may have small holes and hence may not provide complete protection.

While washing hands, one should:

1. Rub both hands together and between fingers, nail beds, wrist to facilitate better cleaning as shown in figure 10.1.
2. Use running water through wash basin and tap or container/ bucket with mug, to enable better cleaning of hands, and
3. Air dry hands or use a clean personal towel/paper tissue if available.

Figure 10.1: WHO Guidelines on Hand Hygiene in Health Care

Surgical hand preparation techniques with an alcohol-based hand rub formulation

The handrubbing technique for surgical hand preparation must be performed on perfectly clean, dry hands.
On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water.
After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

Surgical procedures may be carried out one after the other without the need for handwashing, provided that the handrubbing technique for surgical hand preparation is followed (Images 1 to 17).

1

Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the dispenser

2

Dip the fingertips of your right hand in the handrub to decontaminate under the nails (5 seconds)

3

Images 3–7: Smear the handrub on the right forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds)

4

See legend for Image 3

5

See legend for Image 3

6

See legend for Image 3

7

See legend for Image 3

8

Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your right hand, using the elbow of your other arm to operate the dispenser

9

Dip the fingertips of your left hand in the handrub to decontaminate under the nails (5 seconds)

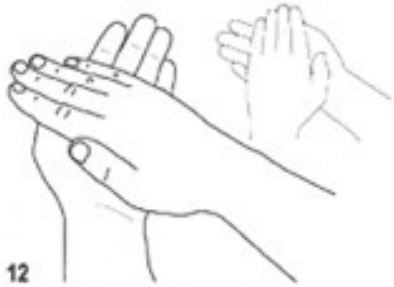
Figure 10.1: Surgical hand preparation techniques with an alcohol-based hand rub formulation (Cont.)

10

Smear the handrub on the left forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds)

11

Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the distributor. Rub both hands at the same time up to the wrists, and ensure that all the steps represented in Images 12-17 are followed (20-30 seconds)



12

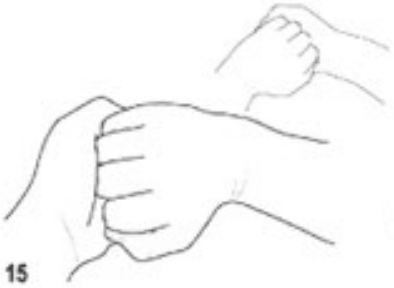
Cover the whole surface of the hands up to the wrist with alcohol-based handrub, rubbing palm against palm with a rotating movement

13

Rub the back of the left hand, including the wrist, moving the right palm back and forth, and vice-versa

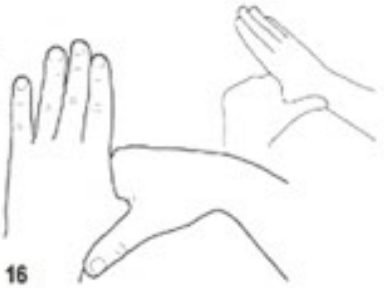
14

Rub palm against palm back and forth with fingers interlinked



15

Rub the back of the fingers by holding them in the palm of the other hand with a sideways back and forth movement



16

Rub the thumb of the left hand by rotating it in the clasped palm of the right hand and vice versa

17

When the hands are dry, sterile surgical clothing and gloves can be donned

Repeat the above-illustrated sequence (average duration, 60 sec) according to the number of times corresponding to the total duration recommended by the manufacturer for surgical hand preparation with an alcohol-based handrub.

10.2.2 Using personal protective barriers

Personal protective barriers should be used to protect both the service provider and the patient from the risks of cross-infection. This includes items like gloves, plastic aprons, gowns, masks, head cover; eye covers (glasses) and footwear. Gloves should be worn whenever there might be contact with blood and body fluids, mucous membranes or non-intact skin. They are not a substitute for hand washing. They should be put on immediately before the procedure and then removed after completion of all related activities.

1. Gloves should be worn and replaced between contacts with different patients and between vaginal (or rectal) examinations of the same patient.
2. After completing care of one client and removing gloves, the health provider should always wash hands, as gloves may have undetected holes in them.
3. Wearing barriers such as gowns, gloves, plastic aprons, gowns, masks, head covers, eyewear and footwear should be mandatory.
4. Appropriate protective barriers must be worn whenever there is the possibility of contact with blood or other body fluids.

10.2.3 Proper handling and disposal of sharp instruments (sharps) blades and needles:

It is vital that sharp items like syringes, needles, scissors etc. used during the procedure be handled with great care to avoid chances of injury.

1. The greatest hazard is of HIV, Hepatitis-B and C, and other infection transmission in health care settings, through skin puncture with contaminated needles or 'sharps'. Most 'sharps' injuries involving such transmission are through deep injuries with hollow-bore needles which frequently occur when needles are recapped, cleaned, disposed of, or inappropriately discarded.
2. Do not reuse, recap or bend needles after use.
3. Puncture-resistant disposal containers must be available and readily accessible for the disposal of 'sharps'. These can be burned in a closed incinerator or buried in a deep pit.
4. Support staff should wear thick utility gloves while handling instruments especially during cleaning process and disposing
5. Added precautions to prevent 'sharps' injuries include wearing gloves, having an adequate light source when treating women, locating 'sharps' containers directly at the point of use, never discarding 'sharps' in general waste, and keeping 'sharps' out of the reach of children. Whenever possible, needle holders should be used when suturing.
6. Put all sharp instruments in a puncture proof container after use.

10.2.4 Proper handling and processing of instruments and materials:

There are four steps of instrument processing: decontamination, cleaning, sterilization/high level disinfection and storage. Immediately after use, all reusable surgical instruments used in MR should be sent for cleaning and sterilization. Medical equipment and supplies intended for single use should not be reused and should be discarded. Where central services for instrument processing are not available, or in resource-poor settings, the following procedures are recommended:

Decontamination and cleaning:

1. Physical cleaning of instruments is the most important step to ensure proper final decontamination.
2. Aspirators, cannulae and adapters are not safe to handle with bare hands until cleaned.
3. Instruments should be kept wet until cleaning as it is difficult to completely remove all contaminants from dry devices.
4. After soaking, wash all surfaces thoroughly in running water with detergent. Detergent is preferable to soap, which can leave a residue.
5. Aspirators must be disassembled before cleaning and further processing.
6. Detachable adapters must be removed from cannulae.
7. A disinfectant such as freshly prepared 0.5% chlorine solution can be used
8. Ensure that instruments/equipments used during the procedure, be processed adequately for reuse.

Sterilization:

Sterilization can be done by pressurized steam (autoclaving) or High Level Disinfection.

After proper cleaning, all instruments should then be sterilized (preferred) or disinfected with a high-level disinfectant (where sterilization is not possible or feasible).

Health workers should always refer to the instructions for use of all items being disinfected to ensure they are using the appropriate form of disinfection. Additionally, always follow the manufacturer's instructions for all products used in the disinfection process.

1. *Sterilization by boiling:*

   Boil in a covered container/boiler for 30 minutes. Ensure that the instruments are completely immersed in water.

2. *Sterilization by autoclave:*

   Autoclaving kills all microorganisms, including bacterial endospores such as those that cause tetanus and gas gangrene.

   - Rubber gloves:

   Autoclave at 121 degree centigrade under a pressure of 15 lb./sq. inch for 20 minutes.

   - Plastic MR canulla and aspirator syringe:

Some manufacturers produce aspirators and cannulae made of high-grade plastics that are engineered to be sterilized in an autoclave, while other plastic instruments will crack and melt when exposed to high heat for sterilization.

- Metallic instruments:

Autoclave at 121 degree centigrade under a pressure of 15 lb./sq. inch for 20 minutes

3. *Sterilization by High Level Disinfectant:*

High-level disinfection (HLD) destroys all microorganisms including hepatitis-B virus and HIV, but does not reliably kill bacterial endospores.

- Sterilization can be done by multi hour soaks (>5 hours) in fresh glutaraldehyde solution.
- HLD can be achieved by shorter soaks in glutaraldehyde or bleach (0.5% sodium hypochlorite) solutions.
- Instruments that were cold processed (soaked in solutions) must be thoroughly rinsed in boiled or sterile water. Glutaraldehyde can result in chemical burns if instruments are not cleaned properly.
- Remove with HLD forceps and air-dry on High Level Disinfected (HLD) tray.
- The use of phenol or antiseptics will not achieve high-level disinfection.

10.2.5 Aseptic technique – 'no-touch' technique:

Strict asepsis must be observed during operative procedure.

Prior to any MR procedure, the client's cervix should be cleaned with an antiseptic like povidon-iodine or clorhexidine.

Use of antiseptics and decontaminants

- Antiseptics (povidone iodine, iodine, chlorhexidine) may be used to clean the vulva before performing MR. Before introducing the canula inside the cervical canal, the cervix must be cleaned with antiseptic.
- Decontaminants (0.5% chlorine solution) should be used to decontaminate the instruments and surfaces and spillage of blood or body fluid, followed by washing with water to prevent corrosive effect of chlorine.

10.2.6 Meticulous surgical technique:

Proper selection of Cannulae size and ensuring completeness of evacuation of uterine content prevents sepsis.

10.2.7 Appropriate use of antibiotics:

Antibiotics should be used rationally. Prophylactic antibiotics are recommended in MR.

10.2.8 Safe waste disposal:

After completing the procedure, infectious and non-infectious waste should be segregated.

- Infectious waste can include human tissue such as aspirates, body fluids, and materials containing blood or body fluids, such as bandages, surgical sponges, needles, blood tubes and pipettes.
- Uterine aspirate should be treated as infectious waste.
- Any disposable material that has come in contact with body fluids should be considered infectious waste and disposed off properly.
- Solid waste that is contaminated with blood, body fluids, and laboratory specimens or body tissue should be placed in leak proof containers and incinerated, or buried in a 7 foot deep pit, at least 30 feet away from a water source. Liquid waste such as blood or body fluid should be poured down a drain connected to an adequately treated sewer or pit latrine.
- General, non-infectious waste can be disposed in the municipality waste bins.

10.2.9 Environmental cleanliness:

Everything in the clinical setting, including instruments and equipment, must be kept clean and dry at all times. Surfaces and spillage are to be cleaned immediately. General cleanliness and routine housekeeping are to be ensured.

10.2.10 Maintenance of personal hygiene:

All health care providers in MR clinic should follow the principles of personal hygiene such as cleanliness, wearing clean clothes, keeping nails short.

10.3 Management of occupational exposure to blood or body fluids (Post Exposure Prophylaxis):

In the event that a health-care worker is exposed to blood or other body fluids in any way, follow these procedures:

- If the exposure caused a bleeding wound, briefly allow the wound to bleed.
- Immediately flush the exposed area with clean water. Wash wounds and skin thoroughly with soap and water.
- Flush the mucous membranes (nose, eyes, mouth) with water or saline only.
- Evaluate type of exposure and risk and manage accordingly.
- Record the exposure and actions taken (post-exposure prophylaxis) according to facility protocols.

Chapter 11

Infrastructure, Essential equipments, Drugs & Supplies

A. Infrastructure required for vacuum aspiration (VA) procedure

MR using vacuum aspiration (VA) can be performed in all the service centres of DGFP, medical college hospitals, district hospitals and NGOs and private clinics, with a setting equivalent to a basic outpatient procedure room, or a minor or major operation theatre. The advantage of VA, when compared with D&C (dilatation and curettage) is that it can be performed safely at the most basic facility with minimal essential equipments and supplies.

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

a. Essential Equipments / Instruments:

The facility offering MR using VA should essentially have the following equipments / instruments for performing MVA procedures:-

- Sim's and/ or Cusco's speculum
- Volsellum / Tenaculum/ Allis forceps
- Sponge holding forceps
- Proper light source / torch
- MVA : Single valve aspirator
- Canullae of different sizes with adapter
- Hegar's dilators: sizes 4-10
- Sharp curette
- Kidney tray or suitable receptacle for emptying the contents of the syringe
- Strainer for tissues
- Plastic bucket for chlorine solution for soaking contaminated instruments until they can be cleaned and processed.

- Equipment for resuscitation: Ambu bag/ Oral airway/ Oxygen cylinder
- Equipment for infection prevention and sterilization: Autoclave/ Boiler/ Cidex tray

b. Essential Supplies:

- Antiseptic solution: Povidone iodine solution/Clorhexidine
- Sterile cotton swabs/ Gauze pieces
- Sterile gloves (small, medium, large)
- Clean perineal sheet (desirable)
- Disposable syringe with needle for administration of paracervical block and other drugs
- Chlorine solution/Bleaching powder
- Silicone for lubricating syringes, if needed

c. Essential Drugs:

1. Antibiotic: Ampicillin/ Amoxicillin /Ciprofloxacin/ Metronidazole
2. Analgesic Paracetamol/Ibuprufen/ Diclofenac/ Pentazocine/ or a suitable alternative
3. Local anaesthetic: Injection lidocaine (1–2 per cent)
4. Injection Diazepam
5. Uterotonics: Injection Oxytocin and Methylergometrine Maleate
6. Tab Misoprostol for cervical ripening
7. Normal saline/ Dextrose 5 per cent in Normal Saline/ Ringer lactate solution with IV sets and cannulae

d. Drugs for Treatment of Emergencies (preferable):

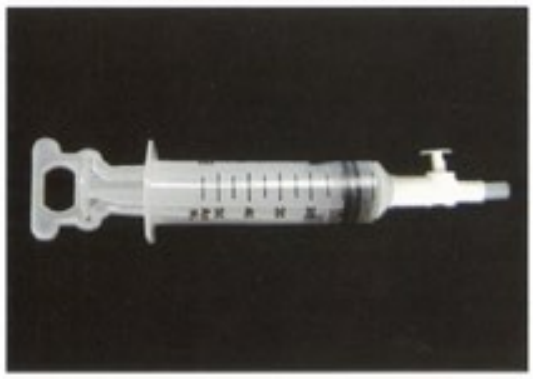
1. Injection Adrenaline
2. Injection Aminophyline
3. Injection Sodium bicarbonate 7.5 per cent
4. Injection Calcium gluconate 10 per cent
5. Antiemetics: Injection Metclopramide or a suitable alternative
6. Antihistaminics Injection Promethazine hydrochlodride or a suitable alternative
7. Steroid Injection Hydrocortisone Succinate
8. Injection Frusemide
9. Injection Dopamine
10. Injection Atropine

Table 11.1 Drugs, supplies and equipment for MR

Procedural step	Drugs and supplies	Equipment
Clinical assessment	• Clean examination gloves	• Speculum • Blood pressure equipment • Stethoscope
VA procedure	• Clean water • Detergent or soap • Pain medications, such as analgesics and anxiolytics • Cervical preparation agent (e.g., isoprostol tablets) when indicated • Gloves • Gown, face protection • Needle, syringe, lidocaine for Para-cervical block • Gauze sponges or cotton balls • Antiseptic solution to prepare the cervix • Sterilization or high-level decontamination solutions and materials • Pulse oxymeter if using conscious sedation or general anaesthesia	• Speculum (where available, wide mouth to increase exposure of the cervix and short to avoid pushing the cervix away) • Volsellum/Tenaculum (atraumatic when available) • Dilators up to 37 mm or equivalent circumference • Step-wise sized cannulae up to 10mm • MVA aspirator (for MVA) • Sponge forceps • Stainless steel bowl for prepping solution • Instrument tray • Bowl/container and strainer for evacuated products
Recovery	• Sanitary napkins or cotton wool • Analgesics • Antibiotics • Information on post-procedure self-care • Contraceptive methods and information and/or referral	• Blood pressure equipment • Stethoscope
In case of complications	• Oxygen and ambulatory ventilator bag • Appropriate antagonists to medications used for pain • IV line and fluids • Clear referral mechanisms to higher-level facility, when needed • Uterotonics	• On-site access to an ultrasound machine (optional) • Long needle driver and suture • Scissors

Figure 11.1: Instruments for MR procedure by Manual Vacuum Aspiration (MVA)

MVA equipment: Single Valve (SV) Aspirator



MR suction cannulae of different sizes

Annexes:

Annex 1

List of Participants of Stakeholders Workshop and Contributors:

I. Participants of Stakeholders Workshop

1. Director PHC, DGHS
2. Director, MCH-Services, DGFP
3. Director and Superintendent, IEM/Planning/MFSTC/MCHTI, DGFP
4. Director Khulna/Rajshahi/Barisal/Sylhet division, DGFP
5. Chairman, Department of Obstetrics and Gynaecology, BSMMU, Dhaka
6. Head, Department of Obstetrics and Gynaecology, Dhaka Medical College
7. Deputy Director/Programme manager MCH/Services/CA&SS, MCH-S Unit, DGFP
8. Deputy Director, MP/PM, IEM unit, DGFP
9. Deputy Director, District Family Planning Office Pabna/Comilla/Sherpur, DGFP
10. Assistant Director (CC) and Regional Supervisor (FPCST/QAT), Dhaka/Sylhet/Jessore region
11. Assistant Director, Services/ MCH, MCH-S Unit, DGFP
12. DG/Director/Executive Director /President, FPAB,BAPSA/OGSB/RHSTEP/MSCS
13. President/Member Secretary, BPMPA
14. Representative of Funding agencies/Donor(EKN)
15. WHO Staff from Country Office in Bangladesh
16. Medical Officer (Clinic), Barisal/Rajshahi District, DGFP
17. Medical Officer (MCH-FP), Mirpur, Dhaka/Sadar upazilla, Comilla, DGFP
18. Upazila Family Planning Officer, Mirpur, Dhaka/Sadar upazila, Comilla, DGFP

II List of Contributors:

1. Participants of Stakeholders Workshop
2. WHO staff from Head quarters, South East Asia Regional Office and Bangladesh Country Office

Annex 2

List of References:

1. Existing guidelines of different MR stakeholders in Bangladesh, relevant materials and documents (national, regional and international) and recent evidence-based information, and
2. Review of the relevant national laws and existing regulations in the context of menstrual regulation.

This document is the outcome of adaptation of the WHO Guidance document 'Safe abortion: Technical and Policy Guidance for Health Systems, 2nd edition, Geneva, World Health Organization, 2012' (forthcoming) to Bangladesh setting.

Annex 3

Bangladesh Penal Code:

Annexure 3.1: Memoranda issued on MR by GOB

3.1.1 Memorandum issued on MR Programme by GOB

Government of the Peoples Republic of Bangladesh

Population Control and Family Planning Division

Population Building, Azimpur, Dhaka

Memo No. 5-14/MCH-FP/Trg/79 Dated: 06.12.79

To

All Deputy Directors

Family Planning

Subject: M R Programme

It appears that some amount of confusion prevails amongst the field functionaries regarding the status of official policy regarding Menstrual Regulation (M.R). As a consequence, many field programmes are not reporting the number of MR cases performed within the in jurisdiction. It is therefore, categorically stated that MR is one the methods of the official FP programme. It is included in the official policy, necessary budget provisions have been made for the methods and required equipments (MR Syringes) are procured through the support of international agencies. Population Control and Family Planning Division also arranged training of medical and paramedical personnel through different projects supported by Pathfinder fund.

We are enclosing herewith a legal interpretation of the institute of law, to dispel the prevailing doubts about the legality of the procedure.

While clarifying the status as above, it is re-emphasized that all Deputy Directors of the districts will maintain a regular stock of MR syringes in the district headquarters and supply them to all medical and paramedical persons performing MR. All the Deputy Directors are also requested to immediately enquire with all medical and paramedical personnel performing MR, if they are in need of re-supply of MR syringes.

Please note that other supplies necessary for MR programme are available in the normal IUD clinics.

Sd/

Col. L.A. Khan

Director General (Imp.)

Population Control & Family Planning Division, Dhaka

Memo No. 5-14/MCH-FP/Trg/79

Dated: 06.12.79

Copy forwarded for information and necessary action to:

1. P.S to the Honorable Minister in-charge Health, Population Control & Family Planning
2. P.S to the Honorable Deputy Ministry of Health, Population Control & Family Planning
3. P.S to Secretary, Population Control & Family Planning Division
4. All Directors of this Division
5. Directors (Imp.) Dhaka/Rajshahi/Chttagong/Khulna Division
6. Deputy Commissioners
7. Civil Surgeons
8. Superintendent, All Medical College Hospitals
9. Professor, Obstetric & Gynecology, All Medical Colleges
10. President, BAVS Clinic, Dhaka for information and necessary action

Sd/- 3-12-79

Dr. Aminul Islam

Deputy Director (MCH-FP & Trg.)

Population Control & Family Planning Division, Dhaka

10.2.7 Appropriate use of antibiotics:

Antibiotics should be used rationally. Prophylactic antibiotics are recommended in MR.

10.2.8 Safe waste disposal:

After completing the procedure, infectious and non-infectious waste should be segregated.

- Infectious waste can include human tissue such as aspirates, body fluids, and materials containing blood or body fluids, such as bandages, surgical sponges, needles, blood tubes and pipettes.
- Uterine aspirate should be treated as infectious waste.
- Any disposable material that has come in contact with body fluids should be considered infectious waste and disposed off properly.
- Solid waste that is contaminated with blood, body fluids, and laboratory specimens or body tissue should be placed in leak proof containers and incinerated, or buried in a 7 foot deep pit, at least 30 feet away from a water source. Liquid waste such as blood or body fluid should be poured down a drain connected to an adequately treated sewer or pit latrine.
- General, non-infectious waste can be disposed in the municipality waste bins.

10.2.9 Environmental cleanliness:

Everything in the clinical setting, including instruments and equipment, must be kept clean and dry at all times. Surfaces and spillage are to be cleaned immediately. General cleanliness and routine housekeeping are to be ensured.

10.2.10 Maintenance of personal hygiene:

All health care providers in MR clinic should follow the principles of personal hygiene such as cleanliness, wearing clean clothes, keeping nails short.

10.3 Management of occupational exposure to blood or body fluids (Post Exposure Prophylaxis):

In the event that a health-care worker is exposed to blood or other body fluids in any way, follow these procedures:

- If the exposure caused a bleeding wound, briefly allow the wound to bleed.
- Immediately flush the exposed area with clean water. Wash wounds and skin thoroughly with soap and water.
- Flush the mucous membranes (nose, eyes, mouth) with water or saline only.
- Evaluate type of exposure and risk and manage accordingly.
- Record the exposure and actions taken (post-exposure prophylaxis) according to facility protocols.

Chapter 11

Infrastructure, Essential equipments, Drugs & Supplies

A. Infrastructure required for vacuum aspiration (VA) procedure

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

a. Essential Equipments / Instruments:

The facility offering MR using VA should essentially have the following equipments / instruments for performing MVA procedures:-

- Sim's and/ or Cusco's speculum
- Volsellum / Tenaculum/ Allis forceps
- Sponge holding forceps
- Proper light source / torch
- MVA : Single valve aspirator
- Canullae of different sizes with adapter
- Hegar's dilators: sizes 4-10
- Sharp curette
- Kidney tray or suitable receptacle for emptying the contents of the syringe
- Strainer for tissues
- Plastic bucket for chlorine solution for soaking contaminated instruments until they can be cleaned and processed.

- Equipment for resuscitation: Ambu bag/ Oral airway/ Oxygen cylinder
- Equipment for infection prevention and sterilization: Autoclave/ Boiler/ Cidex tray

b. Essential Supplies:

- Antiseptic solution: Povidone iodine solution/Clorhexidine
- Sterile cotton swabs/ Gauze pieces
- Sterile gloves (small, medium, large)
- Clean perineal sheet (desirable)
- Disposable syringe with needle for administration of paracervical block and other drugs
- Chlorine solution/Bleaching powder
- Silicone for lubricating syringes, if needed

c. Essential Drugs:

1. Antibiotic: Ampicillin/ Amoxicillin /Ciprofloxacin/ Metronidazole
2. Analgesic Paracetamol/Ibuprufen/ Diclofenac/ Pentazocine/ or a suitable alternative
3. Local anaesthetic: Injection lidocaine (1–2 per cent)
4. Injection Diazepam
5. Uterotonics: Injection Oxytocin and Methylergometrine Maleate
6. Tab Misoprostol for cervical ripening
7. Normal saline/ Dextrose 5 per cent in Normal Saline/ Ringer lactate solution with IV sets and cannulae

d. Drugs for Treatment of Emergencies (preferable):

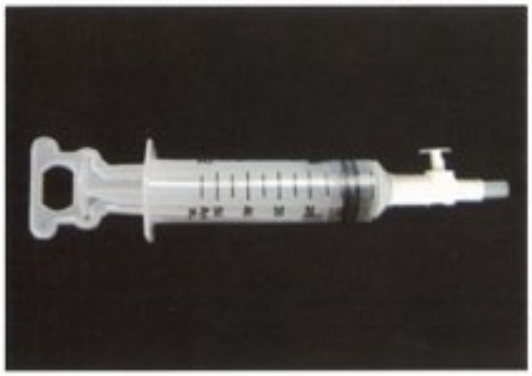
1. Injection Adrenaline
2. Injection Aminophyline
3. Injection Sodium bicarbonate 7.5 per cent
4. Injection Calcium gluconate 10 per cent
5. Antiemetics: Injection Metclopramide or a suitable alternative
6. Antihistaminics Injection Promethazine hydrochlodride or a suitable alternative
7. Steroid Injection Hydrocortisone Succinate
8. Injection Frusemide
9. Injection Dopamine
10. Injection Atropine

Table 11.1 Drugs, supplies and equipment for MR

Procedural step	Drugs and supplies	Equipment
Clinical assessment	• Clean examination gloves	• Speculum • Blood pressure equipment • Stethoscope
VA procedure	• Clean water • Detergent or soap • Pain medications, such as analgesics and anxiolytics • Cervical preparation agent (e.g., isoprostol tablets) when indicated • Gloves • Gown, face protection • Needle, syringe, lidocaine for Para-cervical block • Gauze sponges or cotton balls • Antiseptic solution to prepare the cervix • Sterilization or high-level decontamination solutions and materials • Pulse oxymeter if using conscious sedation or general anaesthesia	• Speculum (where available, wide mouth to increase exposure of the cervix and short to avoid pushing the cervix away) • Volsellum/Tenaculum (atraumatic when available) • Dilators up to 37 mm or equivalent circumference • Step-wise sized cannulae up to 10mm • MVA aspirator (for MVA) • Sponge forceps • Stainless steel bowl for prepping solution • Instrument tray • Bowl/container and strainer for evacuated products
Recovery	• Sanitary napkins or cotton wool • Analgesics • Antibiotics • Information on post-procedure self-care • Contraceptive methods and information and/or referral	• Blood pressure equipment • Stethoscope
In case of complications	• Oxygen and ambulatory ventilator bag • Appropriate antagonists to medications used for pain • IV line and fluids • Clear referral mechanisms to higher-level facility, when needed • Uterotonics	• On-site access to an ultrasound machine (optional) • Long needle driver and suture • Scissors

Figure 11.1: Instruments for MR procedure by Manual Vacuum Aspiration (MVA)

MVA equipment: Single Valve (SV) Aspirator



MR suction cannulae of different sizes

Annexes:

Annex 1

List of Participants of Stakeholders Workshop and Contributors:

I. Participants of Stakeholders Workshop

1. Director PHC, DGHS
2. Director, MCH-Services, DGFP
3. Director and Superintendent, IEM/Planning/MFSTC/MCHTI, DGFP
4. Director Khulna/Rajshahi/Barisal/Sylhet division, DGFP
5. Chairman, Department of Obstetrics and Gynaecology, BSMMU, Dhaka
6. Head, Department of Obstetrics and Gynaecology, Dhaka Medical College
7. Deputy Director/Programme manager MCH/Services/CA&SS, MCH-S Unit, DGFP
8. Deputy Director, MP/PM, IEM unit, DGFP
9. Deputy Director, District Family Planning Office Pabna/Comilla/Sherpur, DGFP
10. Assistant Director (CC) and Regional Supervisor (FPCST/QAT), Dhaka/Sylhet/Jessore region
11. Assistant Director, Services/ MCH, MCH-S Unit, DGFP
12. DG/Director/Executive Director /President, FPAB,BAPSA/OGSB/RHSTEP/MSCS
13. President/Member Secretary, BPMPA
14. Representative of Funding agencies/Donor(EKN)
15. WHO Staff from Country Office in Bangladesh
16. Medical Officer (Clinic), Barisal/Rajshahi District, DGFP
17. Medical Officer (MCH-FP), Mirpur, Dhaka/Sadar upazilla, Comilla, DGFP
18. Upazila Family Planning Officer, Mirpur, Dhaka/Sadar upazila, Comilla, DGFP

II List of Contributors:

1. Participants of Stakeholders Workshop
2. WHO staff from Head quarters, South East Asia Regional Office and Bangladesh Country Office

Annex 2

List of References:

1. Existing guidelines of different MR stakeholders in Bangladesh, relevant materials and documents (national, regional and international) and recent evidence-based information, and
2. Review of the relevant national laws and existing regulations in the context of menstrual regulation.

This document is the outcome of adaptation of the WHO Guidance document 'Safe abortion: Technical and Policy Guidance for Health Systems, 2nd edition, Geneva, World Health Organization, 2012' (forthcoming) to Bangladesh setting.

Annex 3

Bangladesh Penal Code:

Annexure 3.1: Memoranda issued on MR by GOB

3.1.1 Memorandum issued on MR Programme by GOB

Government of the Peoples Republic of Bangladesh

Population Control and Family Planning Division

Population Building, Azimpur, Dhaka

Memo No. 5-14/MCH-FP/Trg/79 Dated: 06.12.79

To

All Deputy Directors

Family Planning

Subject: M R Programme

It appears that some amount of confusion prevails amongst the field functionaries regarding the status of official policy regarding Menstrual Regulation (M.R). As a consequence, many field programmes are not reporting the number of MR cases performed within the in jurisdiction. It is therefore, categorically stated that MR is one the methods of the official FP programme. It is included in the official policy, necessary budget provisions have been made for the methods and required equipments (MR Syringes) are procured through the support of international agencies. Population Control and Family Planning Division also arranged training of medical and paramedical personnel through different projects supported by Pathfinder fund.

We are enclosing herewith a legal interpretation of the institute of law, to dispel the prevailing doubts about the legality of the procedure.

While clarifying the status as above, it is re-emphasized that all Deputy Directors of the districts will maintain a regular stock of MR syringes in the district headquarters and supply them to all medical and paramedical persons performing MR. All the Deputy Directors are also requested to immediately enquire with all medical and paramedical personnel performing MR, if they are in need of re-supply of MR syringes.

Please note that other supplies necessary for MR programme are available in the normal IUD clinics.

Sd/

Col. L.A. Khan

Director General (Imp.)

Population Control & Family Planning Division, Dhaka

Memo No. 5-14/MCH-FP/Trg/79 Dated: 06.12.79

Copy forwarded for information and necessary action to:

1. P.S to the Honorable Minister in-charge Health, Population Control & Family Planning
2. P.S to the Honorable Deputy Ministry of Health, Population Control & Family Planning
3. P.S to Secretary, Population Control & Family Planning Division
4. All Directors of this Division
5. Directors (Imp.) Dhaka/Rajshahi/Chttagong/Khulna Division
6. Deputy Commissioners
7. Civil Surgeons
8. Superintendent, All Medical College Hospitals
9. Professor, Obstetric & Gynecology, All Medical Colleges
10. President, BAVS Clinic, Dhaka for information and necessary action

Sd/- 3-12-79

Dr. Aminul Islam

Deputy Director (MCH-FP & Trg.)

Population Control & Family Planning Division, Dhaka

3.1.2 Memorandum on Guidelines for Menstrual Regulation (MR)

Government of the People's Republic of Bangladesh

Population Control and Family Planning Division

Population Building, Azimpur, Dhaka-5

Memo No. 5-14/MCH-FP/Trg/80 Dated: 25.1.80

Memorandum

Guidelines for Menstrual Regulation (MR)

Consequent upon the increase in demand for menstrual regulation (MR) services throughout the country, the following standard guidelines are laid down to regulate the service and ensure technical standards;

1. **MR can be performed by:**

   a. Any registered medical practitioner, who has specific training on MR procedure in any recognized MR clinic in the country, or has experience of working in the obstetric department of any recognized medical hospital where as a part of his/her normal duty he/she was trained in the procedure of vacuum aspiration.

   b. A Family Welfare Visitor (FWV) or any of the category of paramedical personnel, who have undergone a formal paramedical training course in any recognized institution, and thereafter obtained a specific training in the MR procedure in any recognized MR clinic.

2. **Criteria for MR training:**

   The Deputy Director in the district or the Civil Surgeons may organize programme to train Family Welfare Visitors (FWVs) at their own initiative, fulfilling the following criteria;

   a. Duration of training: The MR training programme for the FWVs should be for a minimum period of one week, two weeks will be preferred.

   b. Training programme should include didactic lectures and demonstrations with emphasis on basic reproductive anatomy and physiology, bimanual pelvic examination, actual technique of the procedure and recognition of pregnancy tissue, sterilization of equipment and management of common problems and record keeping.

   c. Number of procedures: the paramedics, during the course of training, should perform, under supervision, 20 pelvic examinations and 20 MR procedures. However, the final assessment as regards the capacity of the paramedic to perform the procedure properly would have to be certified by the trainer.

   d. Trainer: Paramedics must be trained under the supervision of a doctor who has received recognized MR procedure training.

3. On completion of training, the Deputy Director of the district or Assistant Director (MCH) will establish a supervision system for the trained FWV, by a trained or experienced doctor available in the thana. This would include referral system by FWVs in case of clinical complications.
4. Under normal circumstances, an FWV should perform MR only up to 8 weeks from LMP (4 weeks of missed period). Any case with longer durations must be referred to a trained doctor.
5. Deputy Director, Family Planning in the districts must maintain adequate stocks of MR kits which should include MR syringe, gynaecological aspiration kit, speculum, tenaculum, volsellum forceps, flash light, menstrual calendar etc. He should be able to supply them to any trainee doctor or paramedic on demand.
6. Deputy Director, Family Planning in the districts must arrange adequate follow-up of the trainer.
   a. Random inspection of the facilities and performance of trained doctors and paramedics and
   b. Reporting system by doctors and paramedics on performance of MR on a regular basis.

Sd/
Director (MCH-FP & Trg.)
Population Control & Family Planning
Division, Dhaka

File No. P-146

Memo No. 5-14/MCH-FP/Trg/80/358/1(96) Dated: 25-1-80

Copy forwarded for information and necessary action to:

1. P.S to the Honorable Minister of Health & Population Control and Family Planning.
2. P.S to the Honorable Deputy Minister of Health & F.P
3. P.S to the Secretary Health Division/Population Control and Family Planning Division
4. Director General /NIPORT/Director Health Service P/C
5. Deputy Secretary Administration./ Coordination or Population Control and Family Planning Division
6. Director MIS/IEM/L & S / of Population Control and Family Planning Division
7. All Divisional Directors (Imp)
8. All Deputy Commissioner
9. All Civil Surgeons
10. All Deputy Director, Family Planning Office
11. Deputy Director, TEMO
12. All Assistant Directors (MCH-FP), Population Control & Family Planning Office
13. All Vol. Agencies

Sd./
Deputy Director (MCH-FP & Trg.)
Population Control & Family Planning
Division, Dhaka

3.1.3 Office Memorandum on launch of MR training and services programme

Government of the Peoples Republic of Bangladesh

Ministry of Health and Population Control

(Coordination Branch)

Bangladesh Secretariat, Dhaka

No. PC/S-2/COORDR/77/83 Date: 22.9.83

Office Memorandum

The undersigned is directed to say that it has been decided to launch a programme namely "Menstrual Regulation Training and Services Programme" in order to impart appropriate training on Menstrual Regulation (MR) along with adequate service providing facilities. The project will be located in nine medical colleges & hospitals and sadar hospitals of the country with a head office at Dhaka. The Population Crisis Committee, a foreign voluntary US-based organization, has shown interest to provide funding to this programme. The Pathfinder Fund has so long been providing financial support to these medical colleges and hospitals and sadar hospitals for MR Programme and they have now declined to continue the assistance due to US congressional pressure.

The Programme will be managed and operated by an executive council headed by the Secretary, Ministry of Health and Population Control as its Chairman and Joint Secretary, Population Control Wing, Director General, Directorate of Health Services, Director General, Directorate of Population Control, Representatives of Medical Colleges, Representative of Bangladesh Association for Prevention of Septic Abortion (BAPSA) as members and Project Director of the Project as Member Secretary. For all purposes, this is a Government-sponsored programme but has been kept outside the purview of the ADP since the donor agency likes to operate the Programme outside the Government mechanism to ensure operational flexibility of the innovative and pilot programme.

Mohammadpur Fertility Services and Training Centre which is a Government sponsored autonomous project and has already been exempted from the registration under the Foreign Donation (Voluntary Activities) Regulation may receive fund directly from the Population Crisis Committee, United States of America (USA). Details of the scheme are enclosed herewith.

External Resources Division is, therefore, requested to kindly convey their clearance for the Foreign Donation which is around taka 14 lacs a year.

(Jalaluddin Ahmed)
Joint Secretary
Population Control Wing
Additional Secretary
(Janab Khondker Mahbub-e-Rabbani)
External Resources Division
Sher-e-Bangla Nagar, Dhaka

3.1.4 Notification on Management and operation of the MR training and services programme

Government of the People's Republic of Bangladesh

Ministry of Health and Population Control

(Population Control Wing)

Bangladesh Secretariat, Dhaka

No. PC/S-2 (Coord) 77/83/376 Dated 4th October, 1983

Notification

The Government has been pleased to constitute an Executive Council for the management and operation of the Project "Menstrual Regulation Training and Services Programme" with the following members:

Composition

1)	Secretary, Ministry of Health and Population Control	Chairman
2)	Additional Secretary/Joint Secretary, Population Control Wing, Ministry of Health and Population Control	Vice-Chairman
3)	Director General, Health Services	Member
4)	Director General, Directorate of Population Control	Member
5)	Deputy Secretary (Coordination), Population	Member
6)	Representative of Bangladesh Association for Prevention of Septic Abortion (BAPSA) (A Voluntary Organization).	Member
7)	Representative of Donor Agency, if any	Member
8)	One Specialist in Obstetrics & Gynaecology (To be nominated by the Chairman)	Member
9)	Project Director, Menstrual Regulation Training & Services Programme	Member Secretary

2. The terms of reference of the Council will be as follows:
   a. To take policy decisions and provide guidelines for training and services on Menstrual Regulation (MR);
   b. Overall management and coordination of the programme activities;
   c. Approval of the budget and monitoring of the activities of the programme, and
   d. To evolve the procedure to make the programme self-reliant and facilitate future expansion of the programme activities.
3. The Council will meet at least once in two months and if any member feels it necessary
4. This will come into effect from 1 October 1983.

(Babul Chakraborty)
Senior Scale Section Officer (Coord-II)

Distribution:

1. Secretary, Ministry of Health & Population Control and Chairman of the Executive Council
2. Addition Secretary, Ministry of Health & Population Control
3. Director General, Health Services, 105-106, Motijheel C/A Dhaka
4. Director General, Directorate of Population Control
5. Deputy Secretary (Coord), Population Control Wing
6. President, Bangladesh Association for Prevention of Septic Abortion (BAPSA), 19-E, Green Road, Dhaka
7. Representative of Donor Agency
8. Project Director, Menstrual Regulation Training and Services Programme
9. Specialist in Obstetrics & Gynaecology

NO. PC/S-2 (Coord) 77/23/37601(2) Dated 4th October, 1983

Copy for favour of information to:

1. P.S. to the Minister for Health & Population Control
2. Additional Secretary, External Resources Division, Sher-e-Bangla Nagar, Dhaka. This has reference to ERD's Memo No. ERD/NGO/FC-170/83/689 Dated 27.9.83

(Signed Babul Chakraborty)

Annexure 3.2: Sample of Informed Consent Form for Menstrual Regulation Procedure

I, the undersigned, wish to undergo Menstrual Regulation (MR) procedure, and state the following:

1. I have received detail information about all of my options, including MR, regarding the current state of stoppage of menstruation.
2. I am informed that, like many medical procedures, there are some risks and side-effects of MR. These risks and side-effects have been thoroughly explained to me.
3. All the above information has been explained to me in a language I can understand.
4. I have requested the MR procedure on my own with free will, without coercion or inducement.

Client's name	Client's Signature/Thumb Print	Date

Name of Provider/Counselor	Signature of Provider/ Counselor

Design by: Md. Habibur Rahman (Emon), Printed by: Evergreen Printing & Packaging