BANGLADESH NATIONAL SERVICE DELIVERY GUIDELINE ON MENSTRUAL REGULATION WITH MEDICATION (MRM)

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BANGLADESH NATIONAL SERVICE DELIVERY GUIDELINE ON MENSTRUAL REGULATION WITH MEDICATION (MRM)

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Preface

Menstrual Regulation (MR) procedures are widely available throughout the country at all levels of health facility outlets. In Directorate General of Family Planning (DGFP), MR service is provided at all Union Health and Family Welfare Centres (UH&FWCs), Maternal and Child Health (MCH) unit of Upazilla Health Complex (UHC) and Mother and Child Welfare Centres (MCWCs) by trained service providers. DGFP has been providing MR service since 1979 through Manual Vacuum Aspiration (MVA) technique. MVA requires highly skilled trained staff and well equipped service centres with uninterrupted supply of required logistics and equipment. Through this endeavour, maternal mortality and morbidity due to unsafe MR has declined significantly.

Although MR is safe but an invasive procedure, DGFP has been searching for a non-invasive, more suitable, technologically simple, easy to use alternative of MVA technique. The findings of the acceptability study conducted in Bangladesh using WHO recommended Menstrual Regulation with Medication (MRM) showed high acceptability among Bangladeshi women. We are thankful to National Technical Committee (NTC) for the approval of the WHO recommended regimen to introduce in the National Family Planning Programme.

I believe MRM would be an alternative and additional option to the Bangladeshi women those who need menstrual regulation. I strongly believe that introduction of MRM service in the national MR programme would be able to the further reduction of the maternal morbidity and mortality those are resulted due to unsafe MR.

I would like to thank the Population Council, Marie Stopes Bangladesh and MCH-Services Unit of DGFP along with Obstetrical and Gynaecological Society of Bangladesh (OGSB) for developing the guideline titled "Bangladesh National Service Delivery Guideline on Menstrual Regulation with Medication (MRM)". I have the confidence that this guidebook will open a new horizon for providing reproductive health services to the service providers as well as to the women who are demanding for a non-invasive, easy to use and more private alternative of MVA technique. It is expected that with the introduction of MRM in the national MR programme, the burden of unsafe MR would be reduced and as well as the malpractice.

(Md. Nur Hossain Talukder)
Director General
Directorate General of Family Planning
Acknowledgements

"Bangladesh National Service Delivery Guideline on Menstrual Regulation with Medication (MRM)" has been developed through series of meetings with many individuals and who actively providing MR services. The members of the Obstetrical and Gynecological Society of Bangladesh (OGSB) provided important active role and guidance during the development of the service delivery guideline. It has long been felt by the service providers, program managers, and policy makers to find out a suitable alternative to MVA technique for MR service which is non-invasive.

The Directorate General of Drug Administration (DGDA) has approved Tablet Mifepristone to be used in Bangladesh. After an acceptability study with the WHO recommended combination drugs (Mifepristone and Misoprostol) in Bangladesh the National Technical Committee (NTC) of the Directorate General of Family Planning (DGFP) has approved the regimen for performing Menstrual Regulation in the National MR program.

The combination form of regimen of these two drugs has been practiced globally for decades. This service delivery guideline is mainly adapted from WHO "Clinical practice handbook for: Safe abortion". We also use references from internationally reputed journals, articles and publications from IPAS. Additionally, program implementation strategies of different countries and experiences from MR providing organizations in the country are taken into account.

We are thankful to Professor (Dr.) Rowshan Ara Begum, President, Obstetrical and Gynaecological Society of Bangladesh (OGSB), Professor (Dr.) Farhana Dewan, Secretary General, OGSB and Prof. (Dr.) Latifa Shamsuddin, Former President of OGSB for their active participation, valuable suggestions and guidance to develop this guide book.

We appreciate The Population Council and Marie Stopes Bangladesh and thankful for their technical support and commitment to MRM program that helps to advance the development of this guide book. We are indebted to the members of Project Advisory Committee (PAC) for their continuous inputs during the development of the guidebook and thus giving approval for the guidebook. It is our pleasure to acknowledge the contribution of the Population Council for capacity development and WHO for initial supply of the combination drugs.

Finally, special thanks to the officials of MCH-Services Unit of DGFP for taking the lead in the development process of the guide book titled "Bangladesh National Service Delivery Guideline on Menstrual Regulation with Medication (MRM)".

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Objective of Service Delivery Guideline

Menstrual Regulation program has been implementing under the Directorate General of Family Planning (DGFP) since 1979 through MVA technique predominantly by the midlevel providers Family Welfare Visitors (FWVs) and Female SACMOs. These service providers have been providing MR services with commitment and devotion, which has significantly reduced the maternal morbidity and mortality due to unsafe abortion in the country.

In implementing the MR program, policy makers, program managers, service providers and researchers have observed some areas of program constraints and weaknesses in the quality of care. In many areas while providing MR services, infection prevention protocols, and standard service delivery practice could not be satisfactorily ensured. Clandestine practices of MR remain a threat to maternal health, which results various types of morbid conditions to woman.

It's a long due demand of the clients for a method which is easy to use, non-invasive, having more client compliant and private. The policy makers and program managers are also searching for a method, which is suitable for primary health care setting as an alternative option to Manual Vacuum Aspiration (MVA) technique. WHO recommended combination of Mifepristone and Misoprostol regimen can be considered an appropriate alternative to MVA method.

Considering the global and national perspective and in country acceptability study conducted by DGFP, the Population Council and MSB, the National Technical Committee (NTC) of DGFP has approved the combination regimen of Tab. Mifepristone and Tab. Misoprostol for carrying out Menstrual Regulation and this MRM service can be made available to all health and family planning facilities throughout the country.

To train and educate service providers and to provide consistent information among different cadres of service providers, development of a precise service delivery guideline for carrying out MR with Medication is essential. This service delivery guideline named "Bangladesh National Service Delivery Guideline on Menstrual Regulation with Medication (MRM)" primarily provide strategic directives to MR services through drugs. This guideline will help service providers and program managers in understanding the mode of action of the drugs, precise regimen for carrying out MR with medications, indications and contraindications, routes of drug administration, effectiveness, client eligibility criteria, side-effects and complications and their management. It will also be a quick reference for post MRM contraception choice. It is expected that being trained with this module, the trainees would have adequate knowledge and skills in carrying out MRM services in their facilities and thus could contribute in the reduction of maternal morbidity and mortality due to unsafe MR.
Introduction and Background

MR Program in Bangladesh, Acceptability Study and Approval

In Bangladesh, MR services are widely available in public, private and NGO service delivery centres since 1979. Under the Directorate General of Family Planning (DGFP), Maternal and Child Health Training Institute (MCHTI), Azimpur and Mohammadpur Fertility Services and Training Centre (MFSTC), Mohammadpur at national level; Mother and Child Welfare Centres (MCWCs) at district level; MCH unit of Upazilla Health Complex (UHCs) at upazila level; and Union Health and Family Welfare Centres (UH&FWCs) at union level have the provision of providing MR services through MVA technique using MR syringe. Many reputed NGOs and private clinics also provide MR services.

DGFP in collaboration with Population Council and Marie Stopes Bangladesh (MSB) and with financial assistance from World Health Organization (WHO) and DFID funded STEP-UP project have recently completed a study assessing the acceptability of a combination drugs (Mifepristone and Misoprostol) for safe menstrual regulation. Through this study, a new approach for menstrual regulation is known as Menstrual Regulation with Medication (MRM) is tested which is considered safer, more private, less invasive and low cost than the current MVA technique. The study demonstrated that this combination drug is more acceptable to providers and clients compared to MVA technique. Findings of the study have also showed that 63 percent of the MR seekers preferred MRM over MVA (Rob et al. 2013). Findings further revealed that 95% of women who used MRM were successful in regulating menstruation. In addition, clients who chose MRM over MVA services felt that, MRM was less invasive (54%), less expensive (52%), did not require surgery (34%) and less risky (28%) (Hena et al 2013).

Use of MRM in National Family Planning Program has been approved by the National Technical Committee (NTC) of DGFP. The combination drugs (mifepristone and misoprostol) are available in the country as a kit and several pharmaceuticals are producing it. DGFP wants to ensure that MRM service is made available in all approved health facilities and through trained health care providers where Manual Vacuum Aspiration (MVA) basic training and logistics are available. MR with medication services need to be backed up by surgical MR (MVA) services in case of incomplete MR with drugs. It is expected that maternal morbidity and mortality due to unsafe MR can be reduced further through the training of MVA trained MR service providers on MRM and making the product available at the public facilities.
CHAPTER I
Medical MR with Medication (MRM)

MR can be performed with medications. The drugs, which are used for this purpose, are a combination of Tablet Mifepristone and Tablet Misoprostol. The regime is a combination of these two drugs for Menstrual Regulation and is called Menstrual Regulation Medication (MRM).

Pharmacology and mechanism of action

**Mifepristone**

Mifepristone is a synthetic steroid with anti-progesterone activity results from competitive interaction with progesterone at progesterone-receptor sites. Mifepristone, developed in France and originally known as RU- 486, was first approved for clinical use in 1988. Mifepristone blocks progesterone activity in the uterus leading to detachment of the uterine contents and increases uterine sensitivity to prostaglandins (like misoprostol) and softens the cervix (WHO 2014; IPAS 2013).

**Misoprostol**

Misoprostol is a synthetic analogue of prostaglandin E1. Misoprostol stimulates cervical ripening (softening) and uterine contractions, causing uterine evacuation. Misoprostol is inexpensive and available in many countries, including Bangladesh, for the prevention and treatment of gastric ulcers and post-partum haemorrhage. In 2009, misoprostol was added to the WHO Essential Medicines List (EML) for the treatment of incomplete abortion and miscarriage and in 2011 for preventing postpartum haemorrhage. It can also be used for cervical preparation/softening before vacuum aspiration and other intra-uterine procedures, labour induction and treatment of postpartum haemorrhage (WHO 2014).

**Indication**

Recommended combination of Tablet Mifepristone and Tablet Misoprostol can be taken for Menstrual Regulation up to nine weeks of amenorrhea.

**Contraindication**

History of previous allergic reaction to any other drugs, ectopic pregnancy or suspicion of ectopic pregnancy, porphyria, long term steroid use, asthma, or haemorrhagic disorders, chronic adrenal failure, severe anemia, pre-existing heart diseases, or cardiovascular diseases.
Dosage and administration
Tablet Mifepristone and Tablet Misoprostol regimen for MR up to 9 weeks of amenorrhea

<table>
<thead>
<tr>
<th>Last Menstrual Period</th>
<th>Mifepristone dose</th>
<th>Misoprostol dose, route and timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 9 weeks of amenorrhea</td>
<td>200mg (one tablet) orally, single dose</td>
<td>After 24 hours of Mifepristone, Misoprostol 800μg (4 Tablets 200 μg each) buccally, sublingually or vaginally in single dose</td>
</tr>
</tbody>
</table>

Precautions during MRM provision
Providing MRM services may require a higher degree of clinical judgment, skill and follow-up. If any pre-existing medical condition revealed during history taking, refer the woman to a trained doctor or higher centres for further evaluation.

- **If IUD is in place:**
  - Evaluate for the presence of ectopic pregnancy. If negative, remove the IUD and then provide MRM services;

- **Severe uncontrolled asthma or long-term corticosteroid therapy:**
  - No evidence exists regarding use of Mifepristone in steroid-dependent women;
  - Use clinical judgment if no other alternatives to safe MR exist;
  - Increase steroid dose for 3-4 days and monitor the woman very closely;
  - Conditions such as poorly controlled asthma may further worsen;

- **Severe/Unstable health problems including but not limited to haemorrhagic disorders, heart disease and severe anaemia:**
  - No evidence exists on using MRM in women with haemorrhagic disorders, heart diseases, severe anaemia;

- **Ectopic pregnancy:**
  - Women who are pregnant and have a history of ectopic pregnancy, tubal surgery or have an IUD in place are at a significantly elevated risk of ectopic pregnancy;
  - Providers should maintain a high index of suspicion for ectopic pregnancy and carefully evaluate women's risk before providing MRM.

Special considerations
MRM may be given to women who belong to the following categories:

**Young women**

- MRM is safe and effective for adolescents (Phelps 2001).
- MRM has been proved as even more effective in women who have not given birth (primigravida) (Chien 2009; Le Febvre 2008).
- MRM failure was found to be independently associated with women's older age, previous spontaneous abortions, and multi-gravida (Haimov-Kochman 2007).

HIV and AIDS
- Women living with HIV and AIDS may use MRM.
- Women living with HIV or AIDS may be at risk for anemia, especially if they have malaria or taking certain antiretroviral therapies (Gangopadhyay 2011).
- As with any woman, if heavy bleeding occurs, treat promptly with vacuum aspiration.

Breastfeeding
- Women who are breastfeeding may take MRM.
- Low level of Misoprostol has been detected in breast milk after 30 minutes of oral dose with a peak concentration at one hour.
- No harmful effects have been found in infants after maternal Misoprostol ingestion.
- Women who are concerned may breastfeed the child immediately before taking medications or wait four to five hours after their last dose of medication (Vogel 2004; Abdel-Aleem 2003; and Saav 2010).

Sexually transmitted infections (STIs)
- If a woman is found to have an STI at the time she requests MRM, the STI treatment may be started on the same day she receives Mifepristone (Davis & Easterling 2009 and Achilles & Reeves 2011).

Obesity
- There is no difference in efficacy with Mifepristone and Misoprostol among obese women compared to non-obese women (Strafford 2009).
- Thus, no dose adjustment for Mifepristone or Misoprostol is required.

Hepatitis
- There is no clear evidence available on the use of Mifepristone and Misoprostol in patients with Hepatitis. But it will depend on the assessment of the provider for severity of the impaired liver function.
CHAPTER II
Counselling, Informed Choice and Decision Making

Provide information
Information is a necessary component of any medical care and should always be provided to women seeking menstrual regulation. Within a minimum, this should include,

- Information on the methods and pain management options;
- What will be done before, during and after the procedure, including any tests that may be performed;
- What an acceptor is likely to experience (e.g. pain and bleeding) and how long the process is likely to take;
- How to recognize potential complications, and how and where to seek help, if required;
- When an acceptor will be able to resume her normal activities, including sexual intercourse;
- Follow-up care, including future prevention of unintended pregnancy;
- Legal or reporting requirements (written consent).

Most women, who have accepted MRM will not suffer any long-term effects (e.g. adverse outcomes in subsequent pregnancies, negative psychological consequences, breast cancer) on their general or reproductive health as a consequence.

Offer counselling
Counselling is a focused, interactive process through which one voluntarily receives support, additional information and guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings and perceptions. When providing counselling, remember to:

- communicate information in simple and understandable language;
- maintain privacy;
- support and ensure adequate response to the questions and needs of the woman;
- Avoid imposing personal values, beliefs and judgements.

Help in decision-making
If a woman chooses to have menstrual regulation service and the choice of methods is available, she should be allowed to choose among the methods that are appropriate for her, based on the period of amenorrhea and medical condition. Adequate and scientifically accurate information about potential risk factors, advantages and disadvantages and complications of each available method is the key to help the woman in making a decision for choosing a method for menstrual regulation.
<table>
<thead>
<tr>
<th><strong>Comparison between Manual Vacuum Aspiration and MRM procedures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manual Vacuum Aspiration</strong></td>
</tr>
<tr>
<td><strong>What is it?</strong></td>
</tr>
<tr>
<td>A procedure that uses manual suction equipment to evacuate uterine contents</td>
</tr>
<tr>
<td><strong>How does it work?</strong></td>
</tr>
<tr>
<td>The uterine contents are removed from the uterus with a flexible plastic cannula, inserted to the uterus through the vagina and is aspirated using a plastic syringe under negative pressure</td>
</tr>
<tr>
<td><strong>When can it be performed?</strong></td>
</tr>
<tr>
<td>In between 6-12 weeks of amenorrhea</td>
</tr>
<tr>
<td><strong>Where can it be used?</strong></td>
</tr>
<tr>
<td>In a health-care facility</td>
</tr>
<tr>
<td><strong>How effective is it?</strong></td>
</tr>
<tr>
<td>97%-99.5%</td>
</tr>
<tr>
<td><strong>What are the common side effects?</strong></td>
</tr>
<tr>
<td>Bleeding and pain</td>
</tr>
<tr>
<td><strong>What are possible complications?</strong></td>
</tr>
<tr>
<td>Rare complications include: - injury to the uterus or cervix - excessive bleeding (incomplete) - infection - blood collection in the uterus - perforation - Failed MVA occurs in less than 1% of women</td>
</tr>
</tbody>
</table>
CHAPTER III
Client Screening and Selection

History taking
Taking accurate history from a client is one of the important parts of providing MRM services. Clinical history taking helps to determine the best possible options of MR methods either medical or surgical, identify risk factors and contraindications.

<table>
<thead>
<tr>
<th>Personal History</th>
<th>Name, age and contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric history</td>
<td>Para</td>
</tr>
<tr>
<td></td>
<td>Number of live births (if applicable)</td>
</tr>
<tr>
<td></td>
<td>Any history of ectopic pregnancy</td>
</tr>
<tr>
<td>Gynaecologic history</td>
<td>Date of last menstrual period (LMP)</td>
</tr>
<tr>
<td></td>
<td>Menstrual cycle pattern</td>
</tr>
<tr>
<td></td>
<td>Menstrual period</td>
</tr>
<tr>
<td></td>
<td>History or symptoms of any sexually transmitted infection, reproductive tract infection (RTI), HIV/AIDS</td>
</tr>
<tr>
<td></td>
<td>Contraceptive history</td>
</tr>
<tr>
<td>Surgical/medical history</td>
<td>Chronic diseases, such as hypertension, seizure disorders</td>
</tr>
<tr>
<td></td>
<td>Blood-clotting disorders, liver disease, heart disease</td>
</tr>
<tr>
<td></td>
<td>Diabetes, sickle-cellanemia, asthma</td>
</tr>
<tr>
<td></td>
<td>Details of past hospitalizations</td>
</tr>
<tr>
<td></td>
<td>Details of past surgical operations</td>
</tr>
<tr>
<td>Medications and allergies</td>
<td>Daily medications</td>
</tr>
<tr>
<td></td>
<td>Use of recent medications or herbal remedies</td>
</tr>
<tr>
<td></td>
<td>Allergy to medications</td>
</tr>
</tbody>
</table>
**Physical Examination**

**General examination**
- General appearance
- Vital signs: temperature, pulse rate, respiration, blood pressure (BP)
- Signs of anaemia, jaundice and oedema
- General physical examination (as indicated)- weight, sign of malnutrition (if present), lethargy, weakness

**Abdominal examination**
- Inspect the abdomen whether there is any scar mark or any visible mass is seen
- Palpate the abdomen to feel any tenderness (if present) or mass; or size of the uterus (if palpable)

**Pelvic examination** *(speculum and bimanual examination)*
- Examine the external genitalia for any abnormalities or infection

**Speculum examination**
- Inspect the cervix and vagina
  - cervical os is open or closed
  - cervical os look like nullipara or multipara
  - look for signs of infection, such as pus or other discharge from the cervical os; if pus or other discharge is present, take sample for culture if possible and administer antibiotics before any procedure
  - cervical cytology/VIA test may be performed at this point, if indicated and available
  - IUD thread (if seen)

**Bimanual examination**
- Note the size, shape, position and mobility of the uterus
- Assess for adnexal masses
- Assess for tenderness of uterus on palpation or with motion of the cervix, and/or tenderness in the posterior fornix, which may indicate infection
- Confirm size of the uterus
Limitations to pregnancy dating (by uterine size on physical examination)

- Uterine malformations/Fibroid;
- Multiple gestation;
- Marked uterine retroversion;
- Obesity;
- Molar pregnancy.

Key considerations

A uterus that is smaller than expected may indicate:
- The woman is not pregnant;
- Inaccurate menstrual dating;
- Ectopic pregnancy or abnormal intrauterine pregnancy, e.g. spontaneous or missed abortion.

A uterus that is larger than expected may indicate:
- Inaccurate menstrual dating;
- Multiple gestation;
- Uterine abnormalities, such as fibroid;
- Molar pregnancy.

Laboratory and other investigations

Important: Routine laboratory testing is not a prerequisite for MRM services.

The following tests, when available and if applicable, may be performed on the basis of individual risk factors, findings on physical examination and available resources:

- Haemoglobin (Hb) or haematocrit for suspected anaemia;
- Rhesus (Rh)-testing, in Rh-negative women;
- HIV testing/counselling (if facility available);
- STI screening (usually performed during the pelvic examination);
- Other laboratory tests as indicated by medical history (kidney or liver function tests, etc.).

Discussing contraceptive options

Immediate initiation of contraception following MRM has been shown to both improve adherence and reduce the risk of unintended pregnancy.

Provide information and offer counselling on use of FP method

- Inform MRM acceptors that ovulation can return within 2 weeks following MRM putting them at risk of pregnancy unless an effective contraceptive method is used.
- Advise MRM acceptors on an effective contraceptive method.
• If the MRM accept or is interested in contraception, she requires accurate information to assist her in choosing the most appropriate contraceptive method to meet her needs.

• If a woman is seeking an MRM following what she considers to be a contraceptive failure, discuss whether the method might have been used incorrectly and thus how to use it correctly, or whether it might be appropriate for her to change to a different method.

• Ultimately, the final decision about whether to use contraception, and thus identification of a method which would be used, is the choice of a woman alone. It is important to remember that a woman’s acceptance of a contraceptive method must not be a precondition for providing her the MRM service.
CHAPTER IV
Administration of MRM

Administration of MRM

- MRM clients will receive the first drug Tablet Mifepristone 200 mg orally at the facility and ask to stay for maximum half an hour for monitoring potential side effects particularly vomiting, when the client might expel out the drug. If there is vomiting after 15 minutes of ingestion, repeat dose should not be provided.
- Clients will be given a choice of taking the second drug of Tablet Misoprostol 800 µg, at the facility or at home, 24 hours after taking the first drug.
- Clients who choose second drug to be taken at the facility will be asked to return to the facility after 24 to 48 hours (depending on time of first dose).
- Ensure that the woman has access to private toilets while waiting for the bleeding to occur.
- Clients who chose self-administration of the second dose will be given four Tablets of Misoprostol and counselled on proper buccal technique (placing tablets between gums and cheek) or other routes.

Home use of misoprostol: some considerations

- Ensure that the MRM acceptor understands when and how to use the misoprostol tablets before going home;
- Ensure that the MRM acceptor understands when and how to self-administer pain medication. Other pain-relieving measures should be reviewed with each woman for use as she prefers;
- Ensure that the MRM acceptor understands how to contact a health-care provider whether she has any questions, concerns or complications or not;
- Educate MRM acceptor on possible side effects and inform about safety measure in case of an emergency;
- Inform about when she should report to the health facility in case of emergency or follow up or for contraceptive method.

IMPORTANT TO REMEMBER

- Mifepristone is always administered orally
- Misoprostol to be administered through buccally, sublingually or per vaginally
- Antibiotic prophylaxis is not necessary
## Administration of Misoprostol tablets

<table>
<thead>
<tr>
<th>Route</th>
<th>Instruction for use</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Buccal</strong></td>
<td>Pills are placed between the cheek and gums and swallowed any remnants with water after 30 minutes</td>
<td>More fever and chills than with the vaginal route</td>
</tr>
<tr>
<td><strong>Sub Lingual</strong></td>
<td>Pills are placed under the tongue; swallow any remnants with water after 30 minutes</td>
<td></td>
</tr>
<tr>
<td><strong>Vaginal</strong></td>
<td>- The woman empties her bladder and lies down&lt;br&gt;- If a provider is inserting pills, the provider washes hands and puts on clean gloves&lt;br&gt;- Four Tablet Misoprostol are to be inserted through vagina at the posterior fornix&lt;br&gt;- After lying down for 30 minutes, the woman should get up and go to home</td>
<td>- The pills need to be inserted at the posterior fornix&lt;br&gt;- Often the pills will not dissolve but the medication is still absorbed&lt;br&gt;- Fragments of the pills may remain visible for many hours&lt;br&gt;- If pills fall out when a woman stands up or goes to the bathroom, further pills need not to be reinserted; the active medicine has absorbed by that time</td>
</tr>
</tbody>
</table>
Offer supportive care prior to and during the process

Ensure that MRM acceptors have access to information and services to support successful completion of the procedure, address common side-effects and manage any complications that may arise.

- Discuss about the pain and bleeding associated with the process. Explain the possibility of heavy bleeding with clots, passage of the products and have pain that may be significantly stronger than normal menstrual cramps for some women.
- It is essential that the woman knows how to seek medical attention for:
  - Prolonged or heavy bleeding. For example, soaking more than two large pads per hour for two consecutive hours;
  - Fever lasting more than 24 hours;
  - Feeling unwell for more than 24 hours after misoprostol administration;
  - If amenorrhea continues 48 hours after Misoprostol tablet (Failed MRM).

## Side-effects and their managements

<table>
<thead>
<tr>
<th>Description</th>
<th>Management</th>
</tr>
</thead>
</table>
| **Pain**    | - Respectful, non-judgmental communication  
- Verbal support and reassurance  
- Thorough explanation of what to expect  
- The presence of a support person who can remain with her during the process (only if she desires it)  
- Hot water bottle or heating pad  
- NSAIDs, such as Ibuprofen |
| **Bleeding** | - Create reasonable expectations for the amount and duration of bleeding  
- If there is evidence of haemodynamic compromise, start IV fluids and refer  
- Vacuum aspiration for profuse bleeding  
- Blood transfusion, if required (rare) |
| **Fever** (repeated doses of misoprostol may cause temperature elevation) | - Antipyretic drugs, such as paracetamol  
- If fever persists for more than 24 hours after misoprostol intake, further assessment is warranted |
| **Nausea and vomiting** | - Self-limiting.  
- Reassure, provide anti-emetics if necessary  
- If there is vomiting after 15 minutes of ingestion, repeat dose should not be provided. |
Pelvic infection
Symptoms will be:

- **Unusual or foul-smelling vaginal discharge**; especially if accompanied by severe cramps or abdominal pain.

- **Severe abdominal pain** that occurs any day after the day Misoprostol is taken

- **Feeling very sick**, with or without fever, and persistent severe nausea or vomiting

- If infection is suspected, perform physical examination

- If infection is confirmed:
  - Provide antibiotics and
  - Perform uterine evacuation and
  - Hospitalize if necessary
  - Refer if necessary
CHAPTER V
Post MRM Service and Contraception

Prior to discharge from the health-care facility

- Provide clear oral and written instructions at discharge, including:
  - Sexual intercourse should be avoided for 2 weeks;
  - Avoid douching or placing anything in the vagina for 2 weeks;
  - Vaginal bleeding may occur for 2 weeks after normally completed MRM. Women may experience light bleeding or spotting following MRM, heavier bleeding occurs with MRM which generally lasts for 9 days on average, but can last up to 45 days in rare cases;

- MRM acceptor should return to the hospital or clinic if she experiences:
  - Increased intensity of cramping or abdominal pain;
  - Prolonged or heavy bleeding. For example, soaking more than two large pads per hour for two consecutive hours;
  - Fever lasting for more than 24 hours;
  - Feeling unwell for more than 24 hours after misoprostol administration.
  - If amenorrhea continues 48 hours after Misoprostol tablet (Failed MRM).

- Review the risk of becoming pregnant before her next menses, and the possibility of fertility return within 2 weeks following MRM.
- Provide contraceptive information and offer contraceptive counselling to MRM acceptors who desire it:
  - Assist her in choosing the most appropriate contraceptive method to meet her needs whether she could adopt it;
  - Provide the chosen contraceptive method (or refer her if her chosen method is not available). Ensure that MRM acceptor understands how her selected method works, when to start it and how she can obtain future supplies.

- Provide iron tablets for anaemia, if needed.
- Provide any pain medications, if needed.
- Provide emotional support, if needed.
- Refer to other services as determined by assessment of her needs, such as STI/HIV, voluntary counselling and testing, abuse support services, psychological or social services, or other physician specialists.
• Mandatory follow-up visit:
  • Routine follow-up is not necessary following an uncomplicated MRM using Mifepristone and Misoprostol; however, MRM acceptor should be checked to ensure that MRM procedure is complete. Therefore, she should be offered a follow-up visit after 14 days from the starting of MRM process and to provide further contraceptive counselling and method or to address any medical concerns.
  • Women are advised to return for follow-up, if there is no bleeding or on-going amenorrhoea within 48 hours after taking of the second dose of MRM (Misoprostol 800μg):
    • At the mandatory follow-up visit:
      - Assess MRM acceptor’s recovery and confirm completion of the procedure;
      - Review any available medical records and referral documents;
      - Ask about any symptoms she has experienced since the procedure;
      - Perform a focused physical examination in response to any complaints;
      - Assess MRM acceptor’s fertility goals and need for contraceptive services;
  • If no method was started prior to discharge from the facility, provide information and offer counselling and the appropriate contraceptive method, if desired by the MRM acceptor;
  • if a contraceptive method was already started:
    - Assess about the method used, satisfaction or concerns;
    - If she is satisfied, resupply as needed;
    - If she is not satisfied, help her select another method that will meet her needs.
  • Refer to other services, as determined by assessment of her needs for additional sexual and reproductive health services, and facilitate any necessary referrals.

Optional follow-up visit

There is no medical need for a mandatory routine follow-up after having MRM. However, MRM acceptors may be offer an optional follow-up visit after the procedures to provide further contraceptive counselling and methods or further emotional support or to address any medical concerns. If an optional follow-up visit is scheduled, it should be after 14 days. At the optional follow-up appointment:

• Assess for the completion of MRM procedure: use of clinical signs and symptoms along with bimanual examination can confirm completeness of the process;
• If MRM acceptor reports with symptoms like that before the procedure and/or has only minimal bleeding after taking the medications as directed:
  - on-going amenorrhea should be suspected and further evaluation could include pelvic examination, demonstrating a growing uterus;
  - offer vacuum aspiration or repeat administration of misoprostol to complete the process;
- MRM acceptor reports prolonged or excessive bleeding and cramping, and ongoing amenorrhoea is not suspected:
  - consider a diagnosis of ectopic pregnancy and manage appropriately;
  - offer repeat Misoprostol or vacuum aspiration to complete the process;

**Post-MRM Contraception**

Generally, almost all methods of contraception can be initiated immediately following MRM. Immediate start of contraception after MRM refers to the day the first pill of an MRM regimen is taken. As with the initiation of any method of contraception, the woman's medical eligibility for a method should be verified.

<table>
<thead>
<tr>
<th>Contraceptive method</th>
<th>Initiation timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral contraceptive pills, Condom</td>
<td>Day 1 of MRM regimen</td>
</tr>
<tr>
<td>Implant</td>
<td>Day 1 of the MRM regimen</td>
</tr>
<tr>
<td>Injection</td>
<td>Day 1 of the MRM regimen</td>
</tr>
<tr>
<td>IUD</td>
<td>After 14 days of MRM. Ensure that the woman is not pregnant.</td>
</tr>
<tr>
<td>Sterilization</td>
<td>After 14 days of MRM. Ensure that the woman is not pregnant.</td>
</tr>
<tr>
<td>Natural family planning</td>
<td>Following one post MR menstruation in a woman with a history of regular periods.</td>
</tr>
</tbody>
</table>

**Important to Note**

- An IUD should not be inserted if MRM is complicated with infection.
- Condom use may start with the very first act of sexual intercourse after MRM.
- Fertility-awareness-based methods should be delayed until regular menstrual cycle return.
- Female surgical sterilization can be performed immediately after uncomplicated MRM. However it should be delayed if MRM is complicated with infection, severe haemorrhage, trauma or acute haematoma.
- Vasectomy can be performed at any time.
- Emergency contraception: women may use emergency contraceptive pills (ECP) of an act of unprotected sexual intercourse, to decrease pregnancy risk.
- Withdrawal use may start with the very first act of sexual intercourse, after MRM.
CHAPTER VI
Complication Management and Referral

Assessment and management of Post MRM complications

Potentially life-threatening complications are rare following MRM but complications may still occur, even when all the necessary precautions are taken.

When MRM are obtained from unskilled providers or locations, complications are much more common. Some women seeking subsequent care may be seriously ill and need immediate emergency attention for life-threatening conditions. Rare complications include: excessive bleeding, infection, incomplete MRM occurs in 5% of women and on-going amenorrhea/failed MRM continues in less than 1% of women.

On-going amenorrhea

- Women with continuing signs of amenorrhea or clinical signs of failed MRM should be offered a uterine evacuation by MVA technique at the facility (if the facility provide MVA service), otherwise refer the client to another facility, where the service is available. Failed MRM must be completed. The following management options can be done for on-going amenorrhoea: cases of on-going amenorrhoea should be advised for MVA up to 12 weeks of amenorrhea (either at the centre or at the next level of care);
- Cases of failed MRM may be managed either expectantly, with an additional dose of misoprostol (Misoprostol 800µg i.e. 4 Tablets 200 µg each) or MVA (WHO 2015; Wiebe et al 2002);
- Refer to appropriate facility.

Incomplete MRM

Common symptoms of incomplete MRM include vaginal bleeding and abdominal pain. The following management options can be done for incomplete MRM:

- Incomplete MRM may be managed by the same way of other incomplete abortion.
- Clinically stable patients have the following option:
  - Manual vacuum aspiration: (for uterine size of up to 12 weeks' LMP);
- The decision should be based upon the clinical condition of the MRM acceptor and her preferences for treatment.
Refer client to higher centres if following conditions are observed

- Excessive bleeding that soaks more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, light-headedness and increasing fatigue.
- Fever that occurs in any day after the day misoprostol is taken.
- Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain.
- Severe abdominal pain that occurs in any day after the day misoprostol is taken.
- Feeling very sick with or without fever, and persistent severe nausea or vomiting after the day misoprostol is used.

Complications may occur that are not specific to MRM

These include:

- Anaphylaxis
- Asthmatic reactions
- Shock

These complications should be treated as they would be following any other procedure.
CHAPTER VII

Logistic Management and Reporting

MRM service should offer from the centre where supply of MRM drugs and MVA performing instruments are available and the service providers are trained on MVA.

- Tablet Mifepristone and tablet Misoprostol should be stored in a cool and dry place, protected from light. Although it is stable at room temperature, the potency of misoprostol can degrade over time depending on its packaging or if it is exposed to high heat or humidity (Hall 2011).

- Periodic check for expiry date of these drugs should be maintained and write it to any place where it can be seen very easily. Always make sure that the drug, giving to a client is not date expired.

- Maintain a separate register book for keeping all records.

- Monthly performance report should be prepared from the register according to the existing reporting format and send it to the higher authorities.

- Reporting format should be signed by the supervisor and the name and the address of the service centre and the reporting month should clearly be mentioned on the top of the reporting format.
CHAPTER VIII
A Generic MRM Training Program Schedule

A day long training program on MRM is designed to impart knowledge and skills to the physicians, Family Welfare Visitors (FWVs), Female SACMOs and Paramedics who have received Basic MR training. The objectives of the MRM training program include:

Objectives

After getting the MRM training, participants would be able to:

1. Explain the recommended schedules (regimen) of MRM drugs
2. Describe indications, contraindications and precautions to use MRM drugs
3. State the probable side effects of MRM drugs and their management
4. Able to help women to make informed choice between MR with MVA and MR with medication
5. Able to make women understand clearly what to expect during the process of MRM, including threatening signs which may require further medical care
6. Able to make women recognizing the need for urgent follow-up care
7. Identify personnel, facility, record-keeping, report writing and supplies requirements needed to provide MRM service

The MRM Training Program will be conducted by a pool of trainers comprised of obstetric and gynaecological consultants and experienced program specialists. MRM training will be for one day long based on the contents of "Bangladesh National Service Delivery Guideline on Menstrual Regulation with Medication (MRM)". The contents of the service delivery guideline focus on the basic information necessary for the provision of MRM services including development of skills on MRM. The major components of the training program include:

- Pre-training knowledge assessment of the participants (self-administered)
- Interactive participatory learning sessions on MRM (utilizing multiple facilitators)
- Post- training knowledge assessment of the participants (self-administered)
References


