The Expert Advisory Group Meeting held on 140.10.2004 as a follow up the meeting held on the 19th of July 2004 was to suggest recommendations on various issues which needed policy decisions related to the use of selected life saving drugs and interventions in obstetric emergencies by Staff Nurses LHVs and ANMs.

Recommendations of the Expert Advisory Group Meeting on the 14th Oct, 2004

S. No.	Use of selected life saving drugs and interventions in obstetric emergencies	Recommendations of the Expert Advisory Group
1	**Administration of Inj. Oxytocin and Misoprostol:**	It was decided that Tab. Misoprostol would be used as prophylaxis against PPH, **in all deliveries**, as a part of active management of the third stage of labour. • Tab. Misoprostol should be given, sublingually or orally, 600mg (3 tablets of 200 mg each), immediately after the delivery of the baby. If a woman bleeds for more than 10 minutes after deliver, she should be given 10U Inj. Oxytocin preferably by the IV route (when the ANM is trained to give the same)
2	**Administration of Inj. Magnesium sulphate for prevention and management of Eclampsia**	Inj. Magsulf is the drug of choice for controlling eclamptic fits. The first does should be given by the ANM/staff nurse/Medical Officer at the PHC The woman should immediately be referred to a CHC/FRU and not a PHC. This is because in these cases termination of pregnancy will be required, and a PHC may not be equipped for the same. This **first dose should be given as a 50% solution** (this preparation is available in the market). 8cc need to be given to make a total dose of 4 gms. It should be given deep intramuscular in the gluteal region. If this precaution is not taken, it will lead to the development of abscess at the injection site. Before and during transportation for referral, certain supportive treatment needs to be included

		in the protocol for management of case of eclampsia. • Ensure that the woman does not fall down or injuries herself in any manner. • Ensure that her air passages are clear. • If transportation is going to take a long time, catheterization of the woman may be considered. • A soft mouth gag should be put to prevent tongue bite. • It should be ensured that the woman reaches the referral center within 2 hours. This is because a second dose of magnesium sulphate may be required after 2 hours. Hence early and immediate referral is essential. • 22G needles and 10cc syringes also needed to be included in the ANM kit.
3	**Administration of IV infusions to treat shock**	It was universally felt that the administration of IV infusions was a life saving procedure. As haemorrhage was the commonest cause of maternal mortality, the administration of 3ml of fluid for every ml of blood lost could keep the woman alive during the time it took to transport her to the nearest CHC/FRU where blood transfusion facility was available As of now, the ANMs are neither trained nor allowed by the regulatory authorities to establish an IV line. After the discussion, it was decided that: • If the ANM is trained to give IV infusion, she should administer wherever feasible, even at home. • The ANM should start infusion with Ringer Lactate or Dextrose Saline. • If an IV infusion was being started incases of PPH, it was recommended the IV fluid should be augmented with 20U of Oxytocin for every 500 ml bottle of fluid. This could be continued throughout transportation. However, the logistics and feasibility of the ANM being able to carry IV infusion sets and IV fluids to homes need to be explored, and ensured.

4	**Administration of antibiotics:**	The indications for which antibiotic therapy is recommended are: • Premature rupture of membranes • Prolonged labour • Anything requiring manual intervention • UTI • Puerperal sepsis There should be instructions for the ANMJ that after starting the woman on antibiotics, she should inform the PHC Medical Officer.
5	**Administration of anti-hypertensive:**	There was a universal consensus that only the Medical Officer should be allowed to administer anti- hypertensives to a woman with hypertension in pregnancy.
6	**Removal of retained products of conception:**	For incomplete abortion, if bleeding continues, the ANM and staff nurse can perform only digital evacuation of products of conception. However the staff nurse can use MVA under the supervision of the Medical Officer.
7	**Manual removal of placenta (MRP):**	MRP should be carried out only by the Medical Officer in a health facility (PHC/CHC) setting. If the placenta was partially separated (as could be diagnosed by the presence of vaginal bleeding), the ANM should try and see if a part of the placenta could be seen coming out from the os. Then she could assist the removal of the placenta The ANM should be trained in the active management of the third stage of labour.
8	**Conduction of an Assisted Vaginal Delivery (forceps & vacuum extraction**):	Conduction of an assisted vaginal delivery was not possible at the community level due to obvious reasons. Hence it was universally felt that: Assisted vaginal deliveries (i.e. the use of obstetric forceps or vacuum extraction) should be carried out by the Medical Officer only. The ANMs and the staff nurse need to be trained

		in the use of a partograph, for diagnostic purpose only. This will help her in taking a decision for referral in a case of prolonged labour.
9	**Repair of vaginal and perineal tears:**	Scientific evidence proved that superficial tears do not require any repair, because the outcome was the same whether or not such a tear was sutured. The ANM should be able to recognize a superficial tear, and should be able to distinguish it from deeper tears. She should simply apply pad and pressure on the tear. For second and third degree tears which require repair, the ANM should refer the woman to a higher facility. The Staff Nurse should be allowed to repair a second degree tear at the PHC setting, under the supervision of the Medical Officer. But she too should refer third degree tears after vaginal packing. It was decided that the medical officer and the staff nurse require to be trained in repairing tears, and the ANM requires training in recognizing the degree of tear. No additional material/items thus need to be added to the ANM kit for the repair of vaginal/perineal tears.
Training		
1	**Medical Officer**	The training could take place at the district hospital where 4000 deliveries take place on an average in a year, and where 2 specialists are posted. It was recommended that one month would be appropriate to train the medical officer in the above mentioned skills UNFPA had already developed a training manual, and had even tested it in the state of Gujarat. This training lasted for two weeks. But

		it did not include issues like assisted vaginal deliveries and MRP.
2	**ANM/LHV/Staff Nurse**	It was suggested that the training could be for a period of 4-8 weeks; the number of cases to be seen/assisted should be specified; and that there should be a certification process for the same. For the new batches of ANMs, this training would be included in their curriculum; for the others, it would obviously be an "on-job training." A smaller group to go into the suggestions made by the experts regarding the training.

We may, in the first instance obtain **administrative approval** on the recommendations made by the Expert Advisory Group **for use of selected life saving drugs and interventions in obstetric emergencies by Staff Nurses LHVs and ANMs** before seeking permission from DCG(I).

(Dr. N. Namshum)
AC (MH – I)

DC (MH)

On this file, we are examining the approvals for permitting ANMs to perform certain procedures and use drugs for complications of pregnancy, during and/or after delivery to prevent maternal deaths. These procedures and drugs have been specifically recommended by WHO for use by skilled birth attendants for prevention of maternal deaths. The issues involved have been examined in detail at ps. 2-3 and 6-8/n. The issues were then also discussed in meetings as detailed below:

- In a meeting held at Claridges Hotel, New Delhi on 19.07.2004 and chaired by secretary (FW) in which gynecologists, experts from FOGSI, NGOs and international agencies participated. Minutes of this meeting are at F/A and have been examined at page 9/n. wherein Secy (FW) has approved formation of a smaller Technical Committee to go into the recommendations of this group.
- A meeting of the Expert Advisory Group was convened by DDG (MH) on 14.10.2004. This was followed by a meeting in the Department of FW on 07.12.2004 for finalizing the recommendations to be sent to the Drug Controller General of India for approval.

2. The recommendations of the meeting on 14.10.2004 and 7.12.2004 have been tabulated and are placed in file at pages 263-264/cor. As per column (iii) in these papers, the under mentioned drugs have been recommended by the experts for use by ANMs. It may be mentioned here that the use of these drugs is restricted to specific situations or to be used in one dose only before a referral is made and according to the experts the use of these drugs in such situations is quite safe. It may also be mentioned here that use of these drugs would be permitted to ANMs only after they are adequately trained in the knowledge and skills in the use of these drugs. This training obviously will be undertaken as part of training under the RCH Programme Phase – II. In view of this, we may seek the approval of DCG(I) for use of the drugs by ANMs as mentioned below :-

1. Tab. Misoprostol for Prevention of Post Partum Haemorrhage
2. IV Infusion and injection Oxytocin for management of Post Partum Haemorrhage and shock
3. Injection Magnasium Sulphate for management of Eclampsia
4. Use of Gentamycin IM, Ampicillin and metonidazole orally for prevention of infection (Puerperal sepsis, premature rupture of membranes, prolong labor, any manual intervention)

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