



Second Edition

Woman-Centered, Comprehensive Abortion Care Trainer's Manual

Disclaimer: The regularly updated *Clinical Updates in Reproductive Health* (www.ipas.org/clinicalupdates) provides Ipas's most up-to-date clinical guidance, which supersedes any guidance that may differ in Ipas curricula or other materials.

ISBN: 1-933095-72-5

© 2014 Ipas.

Produced in the United States of America.

Ipas. (2014). *Woman-centered, comprehensive abortion care: Trainer's manual* (second ed.) K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.

Ipas is a nonprofit organization that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We seek to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care, including contraception and related reproductive health information and care. We strive to foster a legal, policy and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely.

Ipas is a registered 501(c)(3) nonprofit organization. All contributions to Ipas are tax deductible to the full extent allowed by law.

Cover photo credits: © Richard Lord

Illustrations: Stephen C. Edgerton

The illustrations and photographs used in this publication are for illustrative purposes only. No similarity to any actual person, living or dead, is intended.

For more information or to donate to Ipas:

Ipas

P.O. Box 9990

Chapel Hill, NC 27515 USA

1-919-967-7052

info@ipas.org

www.ipas.org

Printed on recycled paper.

Table of Contents

Acknowledgements	viii
About Ipas.....	x
About This Manual	x
Training Materials: Sample schedules, evaluations and certificates.....	xxii
Course Introduction	1
Welcome and introduction	2
Trainers' and participants' roles and responsibilities	4
Group norms and evaluation methods	4
Overview and Guiding Principles	7
Introduction	8
Protecting women's rights in an abortion-care setting	12
Summary and test	14
Materials:	
Charter on Sexual and Reproductive Rights handout	20
Reproductive Rights.....	21
Introduction	22
International human-rights documents related to abortion and postabortion care	24
Abortion laws and policies and barriers that impede access to abortion-related care.....	25
Summary and test	26
Community Linkages	33
Introduction	34
Community Mapping	36
Summary and Test.....	41
Materials:	
Action Plan worksheet	45
Community Profile worksheet.....	46
Community Map Example: My City	50
Uterine Evacuation Methods	53
Introduction	54
Uterine evacuation methods overview and comparison	55
Transitioning to MVA and medical methods (optional activity).....	59

Sustainable supply of MVA and MA	60
Summary and test	60
Materials:	
Uterine Evacuation Methods worksheet.....	71
Transitioning to MVA and Medical Methods worksheet	72
Monitoring to Improve Services	73
Introduction	74
Steps of effective monitoring	76
Summary and test	81
Materials:	
Monitoring Scenario	85
Monitoring Abortion-Related Services worksheet	86
Informed Consent, Information and Counseling	87
Introduction.....	88
Elements of woman-centered, comprehensive abortion care counseling	91
Techniques and plans for effective counseling	98
Summary and test	103
Materials:	
Counseling Skills Checklist	110
Four Corners worksheets.....	112
Counseling Referral worksheet.....	114
Counseling Role Play Scenarios.....	115
Counseling Skills Improvement Plan.....	116
Contraceptive Services	117
Introduction	118
Components of high-quality contraceptive services	121
Effective contraceptive counseling	126
Medical eligibility for contraceptive use after uterine evacuation	129
Skills practice	134
Summary and test	135
Materials:	
Models of Service Delivery worksheet	142
Contraceptive Counseling Skills Checklist.....	143
Counseling Attitudes Skit script	146
Helping the Woman Choose a Method Skit script.....	147
Role Play Scenarios	148

Contraceptive Method Information worksheet	149
Infection Prevention.....	151
Introduction	152
Elements of infection prevention.....	154
Summary and test	162
Materials:	
Infection Prevention Skills Checklist and Action Plan Worksheet.....	166
Making Personal Protective Barriers from Locally Available Materials (optional)	167
Clinical Assessment.....	169
Introduction	170
Completing a client history.....	171
Conducting a physical examination.....	173
Special considerations during clinical assessment.....	177
Considerations for postabortion care.....	179
Role play for skills practice	180
Summary and test	181
Materials:	
Clinical Assessment Skills Checklist.....	187
Clinical Assessment for Postabortion Care Skills Checklist	190
Role Play Scenarios and Role Play Key.	193
Ipas MVA Instruments.....	199
Introduction.....	200
Instrument features and use.....	200
Instrument care and processing	206
Summary and test	213
Materials:	
Ipas Decontamination Statement	220
Instrument Processing Skills Checklist.....	222
Uterine Evacuation With Ipas MVA Plus®	225
Introduction	227
Preparation	228
Pain management.....	228
Uterine evacuation with Ipas MVA Plus	232
Post-procedure care	241
Follow-up care	246
Special considerations: Young women	247

Summary and test	248
Materials:	
Pain Management Plan Case Studies and Key	258
Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training...	260
Supplies for Uterine Evacuation Procedure Demonstration and Simulated Practice.....	263
Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist.....	264
Post-Procedure Care Skills Checklist	268
Follow-Up Care Skills Checklist	269
Postabortion Care (PAC) Post-Procedure Care Skills Checklist	270
Postabortion Care (PAC) Follow-Up Care Skills Checklist	272
Uterine Evacuation With Medical Methods.....	273
Introduction	275
Preparation	276
Regimens	279
Expected effects, side effects, pain management and complications	283
Instructions and care before and after leaving the facility	286
Follow-up care	290
Summary and test	294
Materials:	
Expected and Side Effects Cards	301
Uterine Evacuation with Medical Methods Role Plays (CAC) handout	303
Uterine Evacuation with Medical Methods Role Plays (PAC) handout.....	304
Uterine Evacuation with Medical Methods Skills Checklist - Mifepristone and Misoprostol	305
Uterine Evacuation with Medical Methods Skills Checklist - Misoprostol Only	310
Misoprostol for Treatment of Incomplete Abortion Skills Checklist.....	313
PAC Follow-Up Care Scenerio	316
Complications: Comprehensive Abortion Care.....	319
Introduction	320
Types of complications	320
Complications of vacuum aspiration or medical abortion.....	322
Complications of vacuum aspiration.....	326
Complications of medical abortion	330
Complications in women who present for postabortion care	332
Emergency response	333
Post-procedure care	335
Serious adverse event monitoring	336
Diagnosis and management of complications case study role plays	342
Summary and test	345

Materials:

Serious Adverse Events Skits scripts.....	351
Case Study Role Play Scenerios for Complications: Comprehensive Abortion Care.....	352
Case Studies for Complications: Comprehensive Abortion Care worksheet and answer key ..	353
Management of Complications (CAC) Skills Checklist	358

Complications: Postabortion Care..... 361

Introduction	362
Types of complications	363
Rapid initial assessment and management of shock	364
Secondary assessment for underlying causes of shock	366
Diagnosis and management of specific complications.....	367
Emergency response	374
Post-procedure care	376
Serious adverse event monitoring	377
Diagnosis and management of complications case study role plays	383
Summary and test.....	386

Materials:

Serious Adverse Events Skits script	392
Case Study Role Play Scenerios for Complications: Postabortion Care.....	393
Case Studies for Complications: Postabortion Care worksheet.....	394
Complications Case Studies (PAC) answer key	395
Management of Complications: (PAC) Skills Checklist.....	398

Clinical Practicum..... 401

Introduction	406
Informed consent, information, counseling and contraceptive services	407
Clinical assessment	410
Ipas MVA instrument processing	411
Uterine evacuation procedure with Ipas MVA Plus	412
Uterine evacuation with medical methods	415
Complications	417
Summary and evaluation	418

Materials:

Clinical Practicum Supplies and Equipment list.....	420
Abortion-Related Care Clinical Skills Evaluation Form.....	423

Additional Resources 427

Ipas abortion-related training and service delivery curricula and other resources CD-Rom – Relevant materials for this curriculum:

Woman-Centered, Comprehensive Abortion Care

- Woman-Centered, Comprehensive Abortion Care: Trainer's Manual* (second edition) (pdf file)
- Woman-Centered, Comprehensive Abortion Care: Reference Manual* (second edition) (pdf file)
- Woman-Centered Postabortion Care: Reference Manual* (second edition) (pdf file)
- Additional module activities (pdf file)
- Woman-Centered, Comprehensive Abortion Care PowerPoint presentation (ppt file)
- Woman-Centered Postabortion Care PowerPoint presentation (ppt file)
- Training Materials: Sample schedules, evaluations and certificates (doc files)
- Processing Ipas MVA Plus aspirators and Ipas EasyGrip® cannulae wallchart (pdf file)
- Performing MVA using the Ipas MVA Plus, Ipas 3 mm and Ipas EasyGrip cannulae wallchart (pdf file)
- Training tips for using pelvic models in manual vacuum aspiration (MVA) clinical training
- Protocols for medical abortion (dosage card)
- First-trimester medical abortion – mifepristone and misoprostol wheel
- First-trimester medical abortion – mifepristone only wheel

Medical Abortion Training Package

- Medical Abortion Study Guide* (second edition) (pdf file)
- Medical Abortion Training Guide* (second edition) (pdf file)
- Medical Abortion PowerPoint presentation (ppt file)
- Quiz show PowerPoint and flash plug-in (ppt and swf file)
- MA in Early Pregnancy: Information, Education, and Communication (IEC) Materials and Job Aids

Misoprostol for Treatment of Incomplete Abortion Training and Service Delivery Package

- Misoprostol for Treatment of Incomplete Abortion: An Introductory Guidebook* (pdf file)
- Misoprostol for Treatment of Incomplete Abortion: Training Guide* (pdf file)
- Misoprostol for Treatment of Incomplete Abortion PowerPoint Presentation* (ppt file)
- Misoprostol Use in Postabortion Care: A Service Delivery Toolkit*

Supply Guidance and Tools

- MA Supply Guidance tool and spreadsheet (zip file and xls)
- MVA Sustainable Supply Workbook* (pdf file)
- Planning for Sustainable Supply of MVA Instruments: A Guide for Program Managers* (second edition) (pdf file)
- Stocking Facilities with MVA Equipment According to Caseload* (pdf file)
- Inventory Management for Medicines Used in Abortion-Related Care: Facility Job Aid

Other Training Curricula and Materials

Abortion Care for Young Women: A Training Toolkit (pdf and ppt files)

Effective Training in Reproductive Health: Course Design and Delivery. Reference Manual and Trainer's Manual (pdf and ppt files)

Abortion Attitude Transformation: A Global Values Clarification Toolkit (pdf and ppt files)

Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women (pdf file)

Long-Acting Reversible Contraception for Young Women PowerPoint presentation (ppt file)

Providers as Advocates for Safe Abortion Care: A Trainer's Manual (pdf and ppt files)

Providers as Advocates for Safe Abortion Care: A Trainer's Manual (pdf and ppt files)

WHO Safe Abortion Care: Technical and Policy Guidance for Health Systems (second edition) (pdf file)

WHO Clinical Practice Handbook for Safe Abortion Care (pdf file)

MVA Technique Using the Ipas MVA Plus Aspirator and Ipas Easy Grip Cannulae video (mpg file)

Clinical Updates in Reproductive Health at: www.ipas.org/en/resources

The CD-Rom contains additional resources not listed here. The regularly updated Clinical Updates in Reproductive Health provides Ipas's most up-to-date clinical guidance and supersedes any clinical guidance in Ipas curricula.

Acknowledgments

This second edition of Ipas's Woman-Centered, Comprehensive Abortion Care: Trainer's Manual was revised and updated by the following Ipas staff and consultants:

Katherine L. Turner, USA, editor and lead reviewer

Amanda Huber, USA, editor and lead reviewer

Jennifer Soliman, USA, revision coordinator

Lead revision team:

Alice Mark, USA

Bill Powell, USA

Joan Healy, USA

Our appreciation to Ipas staff and colleagues who provided valuable inputs on the revision:

Alison Edelman, USA

Alyson Hyman, USA

Anna de Guzman, USA

Dalia Brahmi, USA

Joachim Osur, Kenya/Africa Alliance

Laura Castleman, USA

Maria de Bruyn, USA

Makgoale Magwentshu, South Africa

Nadia Shamsuddin, USA

Patrick Djemo, Zambia

Patty Skuster, USA

Sangeeta Batra, India

The first edition of this manual was authored by Alyson G. Hyman, Teresa McInerney and Katherine L. Turner.

Other first edition credits:

Joan Healy, USA, lead reviewer, first edition

Karah Fazekas, USA, administrative assistance, first edition

Veronica Tillberg, USA, administrative assistance, first edition

We give thanks to Ipas staff, consultants and colleagues who contributed to the development of the first edition:

Jean Ahlborg	Christian Fiala	Karen Trueman
Rebecca Cook	Entela Shehu	Julia Cleaver
Marty Jarrell	Colleen Carpenter	Rivka Gordon
Sangeeta Batra	Mosotho Gabriel	Merrill Wolf
Jefferson Drezett	Phan Bich Thuy	Rodica Commendant
Nuriye Nortayli	Laura Castleman	Charlotte Hord Smith
Maria de Bruyn	Ann Gerhardt	

This manual was based in large part on the 2004 Ipas curriculum *Woman-Centered Postabortion Care: Trainer's Manual* by Katherine Turner, Teresa McInerney and Jeannine Herrick.

About Ipas

Ipas is dedicated to the belief that every woman, including young women, has a basic right to reproductive- and sexual-health care and to make her own reproductive and sexual choices. We work globally to increase access to high-quality reproductive-health care and to improve women's ability to exercise their reproductive rights, especially their right to safe, legal abortion. We concentrate on preventing unsafe abortion, improving treatment of its complications and reducing its consequences. We strive for women's empowerment by increasing access to services that enhance their reproductive and sexual health.

The International Conference on Population and Development (ICPD) and its five-year review (ICPD+5) provided a clear mandate to all signatory governments: make abortion-related care safe and accessible to women to the full extent of the law, including young women, in their communities. Ipas is dedicated to scaling up comprehensive abortion care globally and to the full extent of local laws through training, service-delivery improvement, advocacy, linkages between communities and health systems, research and provision of reproductive-health technologies.

Scaling up is defined as achieving universal access to high-quality, sustainable abortion-related care.

Achieving universal access ensures that wherever a woman seeks help when she has unprotected sex, unwanted sex or an unwanted pregnancy, she will find accessible care that she needs, whether it be information, referral, or clinical or related services. Universal access to abortion-related care requires that every public and private facility in a country's health system is trained and equipped and has other measures in place to ensure women's access to abortion-related care, including young women.

Achieving sustainability in abortion-related services requires political leadership, policy development, financial resources and an adequate health-system infrastructure with trained health-care providers.

About This Manual

This manual is a resource for trainers who lead training courses for health care workers delivering all elements of woman-centered, comprehensive abortion care, including postabortion care. It contains all of the instructions and materials needed to help participants develop the knowledge and skills necessary to provide high-quality care.

The training package includes:

Woman-Centered, Comprehensive Abortion Care: Trainer's Manual
(second edition)

Woman-Centered, Comprehensive Abortion Care: Reference Manual
or *Woman-Centered Postabortion Care: Reference Manual* (second editions)

Ipas abortion-related training and service delivery curricula and other resources CD-ROM - the relevant materials for this package include:

Woman-Centered, Comprehensive Abortion Care: Reference Manual or Woman-Centered Postabortion Care Reference Manual (second edition) (pdf file)

Woman-Centered, Comprehensive Abortion Care: Trainer's Manual (second edition) (pdf file)

Additional module activities (pdf file)

Woman-Centered Comprehensive Abortion Care PowerPoint presentation (ppt file)

Woman-Centered Postabortion Care PowerPoint presentation (ppt file)

Training Materials: Sample schedules, evaluations and certificates (doc files)

Processing Ipas MVA Plus aspirators and Ipas Easy Grip cannulae wallchart (pdf file)

Performing MVA using the Ipas MVA Plus, Ipas 3mm and Ipas EasyGrip cannula wallchart (pdf file)

This training package is grounded in four principles:

- Women's rights: Every woman has the right to safe, comprehensive, woman-centered abortion and postabortion care.
- Woman-centered: The goal is to train providers to ask about and focus on each woman's concerns and interests and take a comprehensive approach to meeting her medical and emotional needs.
- Adult education: The manual takes a participatory, participant-centered approach and focuses on competency-based skills acquisition.
- Organized into modules: This allows trainers and organizers to tailor individual courses to the needs of different participants and situations.

Health-care workers in environments where abortion laws and policies are highly restrictive can use Ipas's *Woman-Centered Postabortion Care: Reference Manual*, Second Edition as the companion manual to this trainer's manual, as it provides information on caring for women experiencing complications resulting from unsafe and incomplete abortion. Considerations for postabortion care are included in this trainer's manual.

Minimum requirements for attending the course

The minimum requirements for participants are expressed as prerequisites at the beginning of each module. Trainers might consider adding other prerequisites, such as requiring participants to have a certain amount of work experience or to prepare for the course by reading the *Woman-Centered, Comprehensive Abortion Care: Reference Manual* or *Woman-Centered Postabortion Care: Reference Manual*.

Recording, reporting, certification and legal requirements

Trainers are responsible for assigning someone to record relevant information during the course, such as attendance, results of activities and issues to be resolved.

There are checklists for each skill set covered in the manual, and a separate final evaluation form in the Clinical Practicum module to certify participants as competent in providing abortion-related care. A sample Certificate of Completion and Certificate of Competency are included here; they can be personalized from the Microsoft Word[®] versions on the CD-ROM. Additional criteria for determining competency, such as delivering services for a specified period of time or undergoing additional skills practice, can be developed at the trainer's discretion.

Trainers should determine whether the process for participant certification meets local regulations, and should consider any legal requirements for conducting the onsite service-delivery training included in this curriculum.

Training goal and learning objectives

The overall training goal and learning objectives are listed below. Each module of the training manual also includes learning objectives for the specific knowledge and skills covered.

Training goal: To develop participants' competence to provide high-quality, woman-centered, comprehensive abortion care, which includes postabortion care.

Learning objectives: By the end of this training, participants should be able to:

- Describe the key concepts of woman-centered, comprehensive abortion and elements of postabortion care
- Describe a woman's rights in a comprehensive abortion and postabortion care setting
- Describe the importance and methods of creating linkages with communities
- Describe methods for evacuating the uterus
- Describe the steps for establishing a comprehensive abortion and postabortion care services monitoring system
- Identify the elements of infection prevention
- Describe key concepts related to uterine evacuation with Ipas MVA Plus aspirator and Ipas EasyGrip cannulae including: instrument features and use, pain management, troubleshooting and instrument processing
- Describe key concepts related to uterine evacuation with medical methods including: eligibility, contraindications, regimens, expected

effects, potential side effects and pain management

- Competently perform: counseling and contraceptive services; clinical assessment; uterine evacuation using MVA, including instrument processing; uterine evacuation with medical methods; and post-procedure and follow-up care
- Identify steps for diagnosing and managing complications

Ipas online clinical and service delivery updates and courses

Clinical Updates in Reproductive Health provide up-to-date, evidence-based recommendations and clinical protocols. Available at Ipas's website, www.ipas.org/clinicalupdates.


Ipas University (IpasU) offers free, online, on-demand courses for reproductive health professionals on safe abortion care and postabortion care. These courses can be used for self-guided learning or as the online component of a blended learning model. Trainers may also want to use videos or other embedded materials during their training courses. For the Ipas University course catalog, see www.ipas.org; to register and take courses, please go to www.ipasU.org.

Medical Abortion Matters is a biannual newsletter, created to share global perspectives on medical abortion access, news and research. Subscribe online at: www.ipas.org/newsletters.

Service Delivery Matters is a biannual newsletter sharing technical news and updates including training and service delivery strategies and tools, clinical recommendations, programmatic interventions and research results. It is for health-care providers, trainers, administrators, technical specialists and others who can positively influence how comprehensive abortion care is delivered. Subscribe online at: www.ipas.org/newsletters.

Contents

This Trainer's Manual consists of 15 modules. Ideally, modules should be presented in numerical order. However, some modules will be used individually and can be adapted to fit specific training needs.

If training only on postabortion care, trainers should look for the PAC-only icon , which indicates that a slide, statement or activity may need to be edited for PAC-only settings. Unmarked slides and activities are applicable to trainings on comprehensive abortion care and those focused only on postabortion care.

The first six modules cover quality-of-care issues, women's rights and community linkages, provide an overview of uterine evacuation methods, and provide information about monitoring abortion-care services. Modules 7-15 focus on technical information and are intended for a clinical audience. Trainers can divide up the course with different participants completing different modules according to their responsibilities.

All the clinical information in this manual is up-to-date at the time of publication. For updated clinical guidance, please see the *Clinical Updates in Reproductive Health* series at Ipas's website, www.ipas.org. The scope of this curriculum is first-trimester abortion. Although modified vacuum aspiration and medical methods can be used after the first trimester,

second trimester abortion is not covered in this curriculum. For this information, go to the Ipas website, www.ipas.org, and search for “second-trimester abortion.”

Second edition

This second edition of Ipas's *Woman-Centered, Comprehensive Abortion Care: Reference Manual and Trainer's Manual* is consistent with the World Health Organization's *Safe abortion: Technical and policy guidance for health systems, second edition* (2012). WHO's *Clinical practice handbook for safe abortion care* facilitates the practical application of clinical recommendations in *Safe abortion: Technical and policy guidance for health systems, second edition*. WHO develops recommendations based on evidence and expert opinion to reduce barriers to services, maximize access to care and optimize the quality of care that applies across health systems. Ipas similarly strives to accomplish these goals in our guidance, training and learning materials.

Highlights of changes in the 2012 WHO guidance on safe abortion that are incorporated in the new edition of the *Woman-Centered Comprehensive Abortion Care Reference and Trainer's Manual* include:

- New data on the magnitude of unsafe abortion by region and the impact of legal restrictions on unsafe abortion, especially on young women and adolescents
- Evidence-based clinical guidelines including on pain management and new medical abortion regimens; guidance on second-trimester abortion; and postabortion contraception
- Updated service delivery guidance including safe abortion indicators, issues to consider for periodic evaluation, potential barriers to care and guidance for scaling-up abortion services
- Application of a human rights framework for policymaking and legislation related to abortion

While WHO does not recommend requiring elements of care that may serve as barriers to service delivery or women's access, Ipas provides information and training on comprehensive abortion care so that the full range of a woman's needs can be addressed given the context, standards and resources available in any given health system. For example, while WHO does not recommend a routine follow-up visit following uncomplicated surgical abortion or medical abortion using mifepristone followed by misoprostol, women should be advised that additional services are available to them if needed or desired. In this way, Ipas's *Woman-Centered, Comprehensive Abortion Care* is designed to assist providers in meeting the full range of women's needs when they are seen for abortion care, while still following the WHO and other guidelines based on evidence and expert opinion. Where local guidelines and WHO vary, trainers are asked to clearly distinguish any differences.

This curriculum focuses on provision of abortion by trained health-care providers working in facilities in the formal health-care system. There

is increasing attention on making abortion information and drugs more widely available to women in real and virtual communities outside the formal health system, particularly in settings where women face serious risks due to lack of access to safe services. Ipas has policies, materials and programs to support these efforts. In this second edition, we have included some recommendations on how to increase access and improve linkages between communities and health facilities. For more information on this, please see Additional resources, Community Linkages module.

In this second edition, we address young women's unique needs in an effort to increase abortion service delivery and access. Each year, nearly 22 million women worldwide have an unsafe abortion, almost all of which occur in developing countries. The number of adolescent women globally is approaching 300 million. Adolescents suffer the most from the negative consequences of unsafe abortion. Forty-one percent of unsafe abortions in developing regions are among young women aged 15–24 years, 15 percent among those aged 15–19 years and 26 percent among those aged 20–24 years. Women under the age of 20 make up 70 percent of all hospitalizations from unsafe abortion complications. We note where there is evidence for any clinical or other differences for young versus adult women. Where it is relevant, we also note where there is a lack of evidence. Throughout this manual, we generally refer to young women (ages 10–24). Where the evidence specifically applies to adolescents (ages 10–19, per WHO), we use that term. For more information on abortion care for young women, please see Ipas's *Abortion Care for Young Women: A Training Toolkit*.

Values clarification and attitude transformation (VCAT)

Health-care providers and trainers may hold beliefs and attitudes about abortion that can affect all aspects of service delivery and even cause them to offer care that is clinically substandard or that denies women their rights. For example, providers' bias for one uterine evacuation method over another may cause them to offer only one method rather than offering women a choice.

Many providers are also accustomed to directly performing the abortion procedure. Unlike vacuum aspiration and depending on the protocol, medical abortion can put abortion more in the control of the woman rather than the clinician. In many approved protocols, she can initiate and manage the abortion process at home or another place outside a health-care facility where it is most convenient and comfortable for her. Providers may question women's ability to monitor the abortion process correctly. Providers' discomfort with women, particularly young women, managing the abortion themselves, whether conscious or unconscious, can have an impact on whether and how abortion services are provided.

Activities from Ipas's VCAT toolkit and activities adapted for young women can be implemented to specifically address beliefs and attitudes about abortion. Additional activities have also been adapted for second-trimester abortion and misoprostol for postabortion care. For more information, training activities and tools on abortion VCAT, please see Ipas's *Abortion*


Attitude Transformation: A Values Clarification Toolkit for Global Audiences and other relevant resources on the Ipas website.

Materials

Each module in this Trainer's Manual provides instructions and the materials needed, including handouts, worksheets, case studies, role plays, games, group activities, tests, test keys and skills checklists. The variety of teaching methods is intended to actively involve participants and address different learning styles.

Each module has a corresponding PowerPoint presentation, which can be found on the Trainer's CD-ROM. The PowerPoint presentations can be loaded onto a computer that is connected to a digital projector. Where a digital projector is not available, the slides can be printed from the CD-ROM onto overhead transparencies or made into handouts. A final option is to print one copy of the slides as a presentation guide for the trainer and to direct the participants to follow along in the Reference Manual.

Some modules include planning worksheets which can be used to assist participants in applying new skills and knowledge at their own facilities. At the end of the training, these worksheets can be compiled into an overall implementation plan, which can be used for follow-up and monitoring.

If training only on postabortion care, trainers should look for the PAC-only icon , which indicates that materials may need to be edited for PAC-only settings. Unmarked materials are applicable to trainings on comprehensive abortion care and those focused only on postabortion care.

Knowledge and skills acquisition

The modules help participants achieve knowledge-based objectives. Each module includes theoretical information and opportunities for active practice through role plays and case studies. Each module also includes a knowledge test that can be used for pre- and post-testing. Skills-based objectives are addressed first by simulated practice with coaching and feedback in the classroom and then by hands-on practice during the Clinical Practicum module.

Participants are evaluated using skill checklists which are an integral part of developing and evaluating skills. Checklists can be used as self-assessments at the beginning of modules or as final evaluations, and can be used more than once. For example, the counseling checklist may also be useful in the Contraceptive Services module. It may also be appropriate to combine skills checklists when several skills will be used during the care of the same woman.

References and resources

The most important technical information that appears in the Reference Manual is also included in the Trainer's Manual. Citations listed in the References section of each module can be consulted as needed for background and supplementary information. Additional resources for the Reference and Trainer's Manuals are listed at the end of each manual.

Supplies

Pelvic models and Ipas MVA instruments required for skills practice can be ordered from WomanCare Global at customerservice@womancareglobal.org.

Module format

Each icon appears only once at the beginning of each module.



The **Purpose** indicates the reason for conducting the module.



Prerequisites are the skills and knowledge participants should already have to successfully achieve the objectives of the module.



Objectives are the knowledge, attitudes and skills that participants will have achieved by the end of the module.



Materials are handouts, worksheets or other materials that are needed to facilitate activities. For all modules, trainers should have the following tools available: paper, pencils, pens, flipchart easels, flipchart paper, markers and tape for posting flipchart pages.



Advance preparation indicates the actions trainers need to complete before the module session begins. “Label flipchart” means to write the question or title at the top of the flipchart and “prepare flipchart” means to write the title and other information indicated in the instructions.

Time indicates the total time allotted for the module.



PAC only - indicates content that may need to be edited for PAC-only settings. Unmarked slides and activities are applicable to trainings on comprehensive abortion care and those focused only on postabortion care.

Preparation

Module sessions usually require some advance preparation, described on the first page of each module. Trainers should arrange the room to accommodate the specific activities. For example, for a PowerPoint presentation, the room should be set up so that all participants can see the projection screen.

Flipcharts should be placed where all can see. Small-group work, role plays and practice with models all require different room arrangements.

Trainers should prepare icebreaker and energizer activities. For more information on and examples of icebreakers and energizers, see *Effective Training in Reproductive Health: Course Design and Delivery, Reference Manual* and *Trainer's Manual*.

Instructions include step-by-step trainer instructions for conducting the module. If the trainer is instructed to refer participants to another section within the same module, the module section number is indicated. If the trainer is instructed to refer participants to information in another module, the italicized title of that module and often the section number is shown.

"Say:" followed by italicized text indicates suggested language that can be spoken by the trainer. This text is a guide and can be adapted.

References are included at the end of each module. Supplementary training and reference materials are listed under Additional Resources at the end of the manual. Descriptions of individual studies, direct quotes, and tools adapted from a particular document are cited in the text. All other references for the module are listed after the main text of each module. All websites were last accessed September 2012.

Training considerations

Suggested class size

The number of participants that can be accommodated varies from module to module. There should be enough trainers to provide adequate supervision and sufficient opportunities for all participants to actively participate. Including more participants will increase training time and the number of trainers required as well as decreasing the potential for individual participation.

Estimated total theoretical training time

Trainers should allocate the total amount of time indicated for each module plus time for clinical practice to cover all modules. The amount of time needed for the clinical practice depends on many factors, but should be enough to allow all participants to observe cases, practice under supervision, and be evaluated for competency using the skills checklist and/or skills evaluation forms.

Determining participants' needs

An assessment of the participants' training needs should be conducted prior to the design of this course. The assessment can be done by observing participants perform service skills at their facilities or testing their knowledge in writing. When it is not possible to conduct an assessment in advance, assumptions about the participants' needs may have to be made.

Adapting the training format and content

This package can be adapted to suit particular training situations and local conditions.

In some situations, expansion of the course content may be desirable. The Trainer's CD-ROM includes Additional Module Activities that can be used to expand the scope of content. Some content areas that may be added or supplemented with existing resources are:

- Postabortion contraceptive methods
- Community and service-provider partnerships
- Linkages with reproductive and other health services
- Legal and ethical issues in abortion and postabortion care
- Additional methods of uterine evacuation, such as electric vacuum aspiration.

Trainers should not present different clinical recommendations without also stating Ipas's recommendations as presented in this curriculum. Any deviation from clinical recommendations contained in the training package should be clarified as being at variance with Ipas's standards.

Course schedule

A sample schedule for a woman-centered abortion care training is included in this manual. The sample schedule can also be found in Microsoft Word format on the Trainer's CD-ROM and can be adapted for individual courses. Local adaptations to the schedule are encouraged.

Training in teams

Additional trainers may be helpful for certain activities. Coordination among trainers is critical and should include a clear definition of roles and responsibilities, designation of who will facilitate each session, and a daily debriefing meeting with all trainers. A co-trainer debriefing form can be found in *Effective Training: Course Design and Delivery, Reference Manual*.

Evaluation of the training

Evaluate the training by collecting feedback from participants and trainers at the end of each day and at the end of the course. When trainers review feedback from participants daily, they can often make immediate improvements to the course. (Daily Evaluation and End-of-Course Evaluation forms are included here and in Microsoft Word on the Trainer's CD-ROM.)

Characteristics of effective training

Regardless of the purpose or intended audience, all effective training courses share certain characteristics:

- Trainers and participants understand the purpose of the training and what participants are expected to do at the end of the course.
- Training methods enable participants to meet the objectives.
- Training builds on the existing skills and experience.

- New knowledge and skills are presented in a context that is meaningful and relevant.
- Participants are actively engaged in the learning process.
- Training utilizes an effective mix of training methods.
- Participants have the opportunity to practice applying new knowledge and skills.
- Participants receive constructive feedback.
- Trainers accept feedback from participants and use this feedback to make improvements.
- Training is evaluated to measure the extent to which trainers and participants met the objectives.

Please see Ipas's *Effective Training in Reproductive Health: Course Design and Delivery* for more on effective training methods and design.

References

- Ipas. (2014). *Woman-centered postabortion care: Reference manual, second edition* (K. L. Turner & A. Huber Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual, second ed.* (K. L. Turner & A. Huber Eds.). Chapel Hill, NC: Ipas.
- Plan. 2007. *Because I am a Girl: The State of the World's Girls 2007*. London: Plan.
- Shah, Iqbal H and Elisabeth Åhman. 2012. Unsafe abortion differentials in 2008 by age and developing country region: High burden among young women. *Reproductive Health Matters*. 20 (39): 169-173.
- Turner, K. L., Andersen, K. L., Pearson, E., & George, A. (2013). *Values Clarification to Improve Abortion Knowledge, Attitudes and Intentions: Global Evaluation Results*. Manuscript submitted for publication. Ipas.
- Turner, Katherine L, Evelina Börjesson, Amanda Huber and Cansas Mulligan. 2011. *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas. <http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-care-for-young-women--A-training-toolkit.aspx>
- Turner, K. L., & Page, K. C. (2008). *Abortion attitude transformation: A values clarification toolkit for global audiences* (pp. 172). Chapel Hill, NC: Ipas.
- United Nations Population Fund (2000). *The state of world population 2000: Lives together, worlds apart*. New York, NY: UNFPA.
- Wegs, C., Turner, K., & Randall-David, B. (2003). *Effective training in reproductive health: Course design and delivery: Reference manual*. Chapel Hill, NC: Ipas.
- World Health Organization (2012). *Safe abortion: Technical and policy guidance for health systems, (Second Edition ed.)*. Geneva: World Health Organization.
- World Health Organization (2014). *Clinical practice handbook for safe abortion*. Geneva: World Health Organization.

Training Schedule: Woman-Centered, Comprehensive Abortion Care

This sample schedule is designed to prepare participants to provide woman-centered, comprehensive abortion care. It includes all modules in the training curriculum. For a sample schedule for woman-centered abortion care using medical abortion only, please see Ipas's *Medical Abortion Training Guide*.

Woman-Centered, Comprehensive Abortion Care Training Schedule (includes PAC)					
Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
<p>Course Introduction (45 min)</p> <p>Icebreaker</p> <p>Overview and Guiding Principles (1 hr, 15 min)</p> <p>Break</p> <p>Reproductive Rights</p>	<p>Icebreaker</p> <p>Uterine Evacuation Methods (1 hr, 20 mins with optional activity)</p> <p>Monitoring to Improve Services (1 hr)</p> <p>Break</p> <p>Informed Consent, Information and Counseling (1 hr, 45 min)</p>	<p>Icebreaker</p> <p>Infection Prevention (1 hr, 30 min)</p> <p>Break</p> <p>Clinical Assessment (2 hrs)</p>	<p>Icebreaker</p> <p>Uterine Evacuation Procedure With Ipas MVA Plus – Continued (4 hrs)</p> <p>Break as needed</p>	<p>Icebreaker</p> <p>Uterine Evacuation With Medical Methods (2hrs, 30 min)</p> <p>Break</p> <p>Complications: CAC (1 hr, 45 min)</p>	<p>Icebreaker</p> <p>Clinical Practicum</p>
Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
<p>Energizer</p> <p>Reproductive Rights – Continued (2 hours total)</p> <p>Break</p> <p>Community Linkages (1hr, 30 min)</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Informed Consent, Information and Counseling – Continued (1 hr, 45 min)</p> <p>Break</p> <p>Contraceptive Services (2 hrs, 45 min)</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Uterine Evacuation Procedure With Ipas MVA Plus (4 hrs)</p> <p>Break as needed</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Uterine Evacuation With Medical Methods (4 hrs)</p> <p>Break as needed</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Clinical Practicum</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Clinical Practicum</p> <p>Course Evaluation</p> <p>Closing Ceremony</p>

Training Schedule: Woman-Centered Postabortion Care

This sample schedule is designed to prepare participants to provide woman-centered postabortion care. It includes all modules in the training curriculum.

Woman-Centered Postabortion Care Training Schedule (PAC Only)					
Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
<p>Course Introduction (45 min)</p> <p>Icebreaker</p> <p>Overview and Guiding Principles (1 hr, 15 min)</p> <p>Break</p> <p>Reproductive Rights</p>	<p>Icebreaker</p> <p>Uterine Evacuation Methods (1 hr, 20 mins with optional activity)</p> <p>Monitoring to Improve Services (1 hr)</p> <p>Break</p> <p>Informed Consent, Information and Counseling (1 hr, 45 min)</p>	<p>Icebreaker</p> <p>Infection Prevention (1 hr, 30 min)</p> <p>Break</p> <p>Clinical Assessment (2 hrs)</p> <p>Ipas MVA Instruments (1hr, 30 min)</p>	<p>Icebreaker</p> <p>Uterine Evacuation Procedure With Ipas MVA Plus–Continued (4 hrs)</p> <p>Break as needed</p>	<p>Icebreaker</p> <p>Uterine Evacuation with Medical Methods (2hrs, 30 min)</p> <p>Break</p> <p>Complications: PAC (1 hr, 45 min)</p>	<p>Icebreaker</p> <p>Clinical Practicum</p>
Lunch	Lunch	Lunch	Lunch	Lunch	Lunch
<p>Energizer</p> <p>Reproductive Rights – Continued (2 hours total)</p> <p>Break</p> <p>Community Linkages (1hr, 30 min)</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Informed Consent, Information and Counseling – Continued (1 hr, 45 min)</p> <p>Break</p> <p>Contraceptive Services (3 hrs)</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Uterine Evacuation Procedure With Ipas MVA Plus (4 hrs)</p> <p>Break as needed</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Uterine Evacuation with Medical Methods (4 hrs)</p> <p>Break as needed</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Clinical Practicum</p> <p>Daily Evaluation</p> <p>Trainers Debrief</p>	<p>Energizer</p> <p>Clinical Practicum</p> <p>Daily Evaluation</p> <p>Course Evaluation</p> <p>Closing Ceremony</p>

Woman-Centered, Comprehensive Abortion Care Daily Evaluation

Please respond to the following questions about the modules covered today.

1. When were you most engaged and interested today and why?
2. Which module topics were most useful to your work?
3. What topics would you have liked to cover in more detail?
4. What topics would you have liked to remove from today's schedule?
5. Were the objectives for each module met? If not, why not?
6. What one important concept did you take away from the modules covered today?

Please complete the following phrases.

1. The trainers were ...
2. The training atmosphere can be described as ...
3. The sequence or flow of activities was ...
4. If I were leading the course, I would have done differently ...

Overall rating of today's session on a scale of 1 to 5 (1=not good, 5=great) _____

Woman-Centered, Comprehensive Abortion Care End-of-Course Evaluation

Dates _____ Location _____

Trainers _____

Training Goal: To develop participants' competence to provide high-quality, woman-centered, comprehensive abortion care.

Learning Objectives: At the end of this training course, participants will be able to:

- Describe the key concepts of woman-centered, comprehensive abortion care and elements of postabortion care
- Describe a woman's rights in an abortion- and postabortion-care setting
- Describe the importance of creating linkages with communities and ways to do so
- Describe methods for evacuating the uterus
- Describe the steps for establishing an abortion- and postabortion -care services monitoring system
- Identify the elements of infection prevention
- Describe key concepts related to uterine evacuation with Ipas MVA Plus aspirator and Ipas EasyGrip cannulae including: instrument features and use, pain management, troubleshooting and instrument processing
- Describe key concepts related to uterine evacuation with medical methods including: eligibility, contraindications, regimens, expected effects, side effects and pain management
- Competently perform: counseling and contraceptive services; clinical assessment; uterine evacuation using MVA, including instrument processing; uterine evacuation with medical methods; and post-procedure and follow-up care
- Identify steps for diagnosing and managing complications

Please rate the course on each item below using the following scale. Please use the comments section to provide more information about the rating and suggestions for improvement

4 = strongly agree 3 = agree 2 = disagree 1 = strongly disagree	Rating
1. The course fulfilled its goal and objectives (see above). <i>Comments:</i>	_____
2. The course was well-organized. <i>Comments:</i>	_____
3. The trainers were responsive to participants' needs. <i>Comments:</i>	_____

3. The trainers were responsive to participants' needs.

Comments:

4. The trainers used effective training methods.

Comments:

5. The training materials (handouts, slides, worksheets, tests, etc.) were effective.

Comments:

6. There were adequate opportunities for discussion.

Comments:

7. The physical facilities were conducive to learning and sharing.

Comments:

8. The travel, lodging and other logistical arrangements were satisfactory.

Comments:

9. Because of this course, I have a better understanding of high-quality, woman-centered abortion care.

Comments:

10. Because of this training, I will provide high-quality, woman-centered abortion care when I provide abortion services.

Comments:

Name at least three specific things you will do differently as a result of this course to provide high-quality, woman-centered abortion-care services.


1.

2.

3.

What suggestions can you offer to improve this course in the future?

General comments and suggestions:



*Woman-Centered,
Comprehensive Abortion Care*

Certificate of Participation

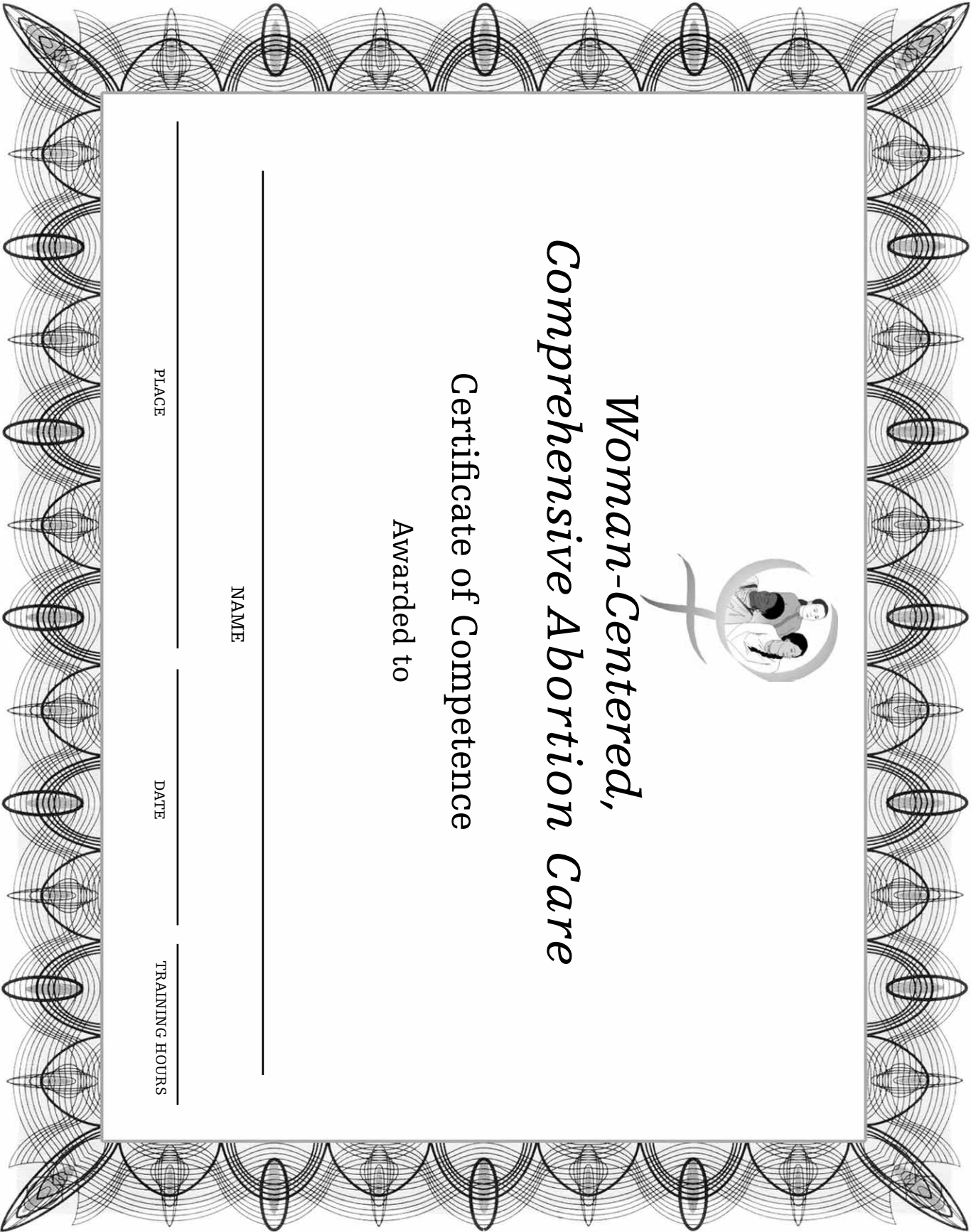
Awarded to


NAME

PLACE

DATE

TRAINING HOURS





*Woman-Centered,
Comprehensive Abortion Care*

Certificate of Competence

Awarded to

NAME _____

PLACE _____ DATE _____ TRAINING HOURS _____

Course Introduction



Purpose:

The purpose of this module is to:

- Welcome participants and discuss their expectations
- Orient participants to the course goal, objectives and agenda
- Clarify trainer and participant roles
- Establish group norms
- Invite participants to provide ongoing evaluation of the course



Prerequisites:

There are no prerequisites for this module.



Objectives:

By the end of this module, participants should be able to:

1. State their expectations for the course
2. Describe the course goal, objectives and schedule
3. Identify trainers' and participants' roles and responsibilities
4. Identify the group norms
5. Name the evaluation methods that will be used at different points in the course



Materials:

- ☐ Course Schedule handout



Advance preparation:

- ☐ Confer with local officials to determine whether an opening ceremony is warranted and how it should be conducted
- ☐ Prepare course schedule (see sample schedule)
- ☐ Make copies of Course Schedule handout

- ☐ Prepare flipchart: Training Goal
- ☐ Prepare flipchart: Learning Objectives
- ☐ Label flipchart: Course Expectations
- ☐ Label flipchart: Parking Lot
- ☐ Prepare flipchart: Training Methods Used
- ☐ Label flipchart: Trainers' Roles
- ☐ Label flipchart: Participants' Roles
- ☐ Label flipchart: Group Norms
- ☐ Prepare flipchart: Course Evaluation Methods
- ☐ Prepare suggestion box and cards

Note to trainer: Some participants may have concerns or fears related to provision of abortion-related care that may need to be addressed. Trainers may want to facilitate a Hopes and Hesitations activity to address those. Instructions for this activity can be found in Ipas's *Abortion attitude transformation: A values clarification toolkit for global audiences*.

Time: 45 minutes

1. Welcome and introduction

Welcome participants to the course. Introduce yourself and the module.

- Provide background on your clinical and training experience and professional affiliations.
- Ask participants to state their names and briefly give some information about themselves.

Post flipcharts with course goal and objectives.

Training goal: To develop participants' competence to provide high-quality, woman-centered, comprehensive abortion care, which includes postabortion care.

Learning objectives: By the end of this training, participants should be able to:

- Describe the key concepts of woman-centered, comprehensive abortion and elements of postabortion care
- Describe a woman's rights in a comprehensive abortion and postabortion care setting
- Describe the importance and methods of creating linkages with communities
- Describe methods for evacuating the uterus

- Describe the steps for establishing a comprehensive abortion care services monitoring system
- Identify the elements of infection prevention
- Describe key concepts related to uterine evacuation with Ipas MVA Plus® aspirator and Ipas EasyGrip® cannulae including: instrument features and use, pain management, troubleshooting and instrument processing
- Describe key concepts related to uterine evacuation with medical methods including: eligibility, contraindications, regimens, expected effects, potential side effects and pain management
- Competently perform: counseling and contraceptive services; clinical assessment; uterine evacuation using MVA, including instrument processing; uterine evacuation with medical methods; and post-procedure and follow-up care
- Identify steps for diagnosing and managing complications

Keep these flipcharts posted throughout the course.

- Explain that each module has a unique list of objectives.

Post flipchart: *Course Expectations*

Say: *What are you hoping to learn in this course?*

- Write responses on the flipchart without responding, and thank participants for sharing
- Review the list of course expectations, identify which are likely to be met and acknowledge any that may be beyond the scope of the course.
- Keep this list and review with participants at the end of the course to ensure that all realistic expectations were met.

Distribute handout: *Course Schedule*

- Briefly describe the content areas that will be covered.
- Discuss changes that could be made to meet participants' expectations.
- Solicit and address concerns about the schedule.

Post flipchart: *Parking Lot*

- Explain that this "parking lot" (also called a "garden") will be posted throughout the course. When topics come up that would be better addressed at a later time, trainers and participants will write them there.
- Explain that you will set aside time at certain points to review and address the contents of the parking lot.

Show and discuss slide: *Training Methods Used*

- Course is based on adult-learning principles and the adult-learning cycle.
- Diverse training methods facilitate knowledge and skills acquisition for all learning styles.
- Simulated and clinical practice using skills checklists helps participants reach competency.

2. Trainers' and participants' roles and responsibilities

- Ask participants to describe the roles they believe trainers should play during a training course.

Show Slide: *Trainers' Roles*

- Discuss any of these that were not mentioned:
 - Provide information
 - Ask and answer questions
 - Facilitate discussions and activities
 - Keep the group on task and on time
 - Model effective training and clinical skills
 - Maintain a productive learning environment
- Remind participants to provide ongoing feedback about the trainers' effectiveness.
- Ask participants to describe their roles during a training course.

Show slide: *Participants' Roles*

- Discuss any of these that were not mentioned:
 - Participate fully according to individual and group comfort levels and group norms
 - Share knowledge and experiences
 - Take responsibility for own learning by asking for clarification or additional help

3. Group norms and evaluation methods

Post flipchart: *Group Norms*

Say: Group norms are mutually agreed upon guidelines that help create a safe and respectful learning environment, guide the direction of the work and enable effective and efficient completion of tasks.

Ask participants to suggest group norms and write them on the flipchart.

- If participants have difficulty, offer one or two of these examples:
 - Speak one at a time; allow each person time to talk.
 - Maintain confidentiality.
 - Agree to disagree, but do so respectfully.
 - Value each person's unique opinions and perspectives.
 - Take risks; challenge yourself.
 - Start and end on time.
 - Turn off cell phones or put on vibrate.
 - Speak for yourself, not other people.
 - Support those who may have anxiety talking about difficult topics.
 - Take responsibility for your learning (ask for clarification, solicit help or give feedback).
 - Have fun even though the topic is serious.
 - Refrain from participating if a certain topic or activity feels uncomfortable.
- Continue adding norms until participants do not have any more suggestions.
- Ask participants which norms they don't understand and clarify them.
- Ask everyone to agree to what is on the list and to raise their hands to show their commitment to maintaining these norms. Note that everyone has agreed to abide by the norms.
- Post the list where everyone can see it and explain how it will be used.
 - The list will be posted during the entire course.
 - Participants should refer to the norms as needed.
 - Participants should agree to monitor themselves and raise concerns when they believe individuals are not abiding by the norms.

Note to trainer: If at some point during the course you detect that a participant is not abiding by the group norms, you can stop the discussion or activity and ask participants to review the agreed upon norms.

Show and discuss slide: *Course Evaluation Methods*

- Describe the methods of evaluation that will be used throughout the course.

Methods	When Used
Suggestion box	Throughout the course
Informal feedback to trainers	Throughout the course
Skills checklists	With each skill-based activity
Knowledge test	At the end of each module
Daily evaluation	At the end of each day
Trainers' debriefing session	At the end of each day
Written course evaluation	At the end of the course

Present the Suggestion Box.

- Place index cards and pens next to it.
- Invite participants to write comments on the cards and place them in the box
- Names do not need to be included.
- Invite participants to offer feedback to trainers.
- Suggest they give feedback in private.

Say: During each skill-based activity, participants will be given a skills checklist to help them or an observer assess whether they have completed the steps correctly. These checklists will be used during the clinical practicum to assess competence.

Tell participants that at the end of each module, they will complete a knowledge test.

Explain that at the end of the day, trainers will meet to debrief, discussing what went well and what needs improvement.

- Review the cards in the suggestion box, any informal feedback given and the results of skills checklists and knowledge tests.
- Make any necessary adjustments to the course content or process.
- At the end of the course, participants will complete a written course evaluation.

Present facility set-up and other logistical information, such as:

- Location of bathrooms and telephones
- Venue for breaks and lunch
- Invite participants to make any other announcements

Ask participants if they have any questions

- Answer questions.

Thank the participants for their participation.

Overview and Guiding Principles



Purpose:

This module provides an overview of the fundamental elements of woman-centered, comprehensive abortion care, which includes postabortion care, and the rights of women of all ages in an abortion and postabortion care setting.



Prerequisites:

There are no prerequisites for this module.



Objectives:

By the end of this module, participants should be able to:

1. Describe woman-centered, comprehensive abortion care and its three key elements
2. Describe the five essential elements of postabortion care
3. Describe a woman's rights in an abortion and postabortion care setting



Materials:

- ☐ Charter on Sexual and Reproductive Rights handout
- ☐ Basket to hold paper strips for activity on reproductive rights
- ☐ Chime or timer
- ☐ Knowledge test and test key



Advance preparation:

- ☐ Make copies of *Charter on Sexual and Reproductive Rights* handout and knowledge test.
- ☐ Prepare flipchart: Instructions for Rights Matching activity.
- ☐ Prepare Rights and Definitions paper strips for Rights Matching activity.
- ☐ Research and be prepared to speak about local and national laws that could impact abortion and postabortion care services.

- ❑ Familiarize yourself with the World Health Organization's (WHO) *Safe Abortion: Technical and Policy Guidance for Health Systems*, Second Edition.

Time: 1 hour 15 minutes

1. Introduction

Greet participants. Introduce yourself and the module.

Show slide: *Purpose*

Say: This module provides an overview of the fundamental elements of woman-centered, comprehensive abortion care, which includes postabortion care, and the rights of women of all ages in an abortion and postabortion care setting.

Show slide: *Objectives*

- Describe woman-centered, comprehensive abortion care and its three key elements
- Describe the five essential elements of postabortion care
- Describe a woman's rights in an abortion and postabortion care setting

P *Say: This module provides an overview of the guiding principles of woman-centered, comprehensive abortion care, which includes postabortion care, and is a prerequisite for all other modules. We will discuss reproductive rights in greater detail in a separate module.*

P Ask participants to raise their hand if they know a woman who has terminated an unwanted pregnancy or needed treatment for abortion complications. Note the number of people who raise their hand. Ask participants to comment on this. Remark on how common an experience abortion is for women and couples over their lifetimes.

P *Say: Unwanted pregnancy and abortion are very common occurrences and have been throughout human history. Most of us have had direct or indirect experience with a woman or couple facing an unwanted pregnancy who decided to have an abortion. We may also know women who had miscarriages requiring treatment or had medical reasons to terminate a desired pregnancy. We will be addressing these experiences and learn how to provide high-quality, comprehensive abortion care.*

Show and discuss slide: *Public Health Rationale for Preventing Unsafe Abortion*

"The number of declarations and resolutions signed by countries over the past two decades indicates a growing consensus that unsafe abortion is an important cause of maternal death that can, and should, be prevented through the promotion of sexuality education, family planning, safe abortion services to the full extent of the law, and post-abortion care in all cases. The consensus also exists that post-abortion

care should always be provided, and that expanding access to modern contraception is critical to the prevention of unplanned pregnancy and unsafe abortion. Thus, the public health rationale for preventing unsafe abortion is clear and unambiguous.” (WHO)

P Show slide and discuss: *Abortion Is A Safe Medical Procedure*

WHO also states, “When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure.”

Discuss the correct interpretation of WHO's definition of Unsafe Abortion

Show Slide: *WHO's Definition of Unsafe Abortion*

- A procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both

Show Slide: *Correct Interpretation of WHO Definition*

- Nothing predetermines who should be considered “safe” provider, appropriate skills or standards
- Guidelines evolve with different evidence
- Different for medical and surgical methods
- Depends on pregnancy duration
- Risk runs along a continuum

Reinforce the point that what is considered “safe” should be interpreted in line with current WHO technical and policy guidance and that underlying social determinants should be considered when determining risks.

P Introduce Woman-Centered, Comprehensive Abortion Care with the following information.

Show slide and discuss: *Woman-Centered, Comprehensive Abortion Care (CAC)*

- Woman-centered, comprehensive abortion care is an approach to abortion-related services that takes into account women's individual physical and emotional health needs and circumstances and ability to access care. It includes induced abortion; treatment of incomplete, missed or unsafe abortion; compassionate counseling; contraceptive services; related sexual and reproductive health services provided onsite or via referrals to accessible facilities and community-service provider partnerships.

Show slide and discuss: *Woman-Centered, Comprehensive Abortion Care (CAC) (cont).*

- Includes a range of health services that help women exercise their sexual and reproductive rights.

- Includes appropriate services provided regardless of women's age or marital status.

Show slide and discuss: *Postabortion Care*

- Woman-centered, comprehensive abortion care includes postabortion care, which is a series of medical and related interventions designed to manage the complications of spontaneous and induced abortions, both safe and unsafe, and address women's related health-care needs.
 - This module serves as the foundation for the curriculum on woman-centered, comprehensive abortion care.

We are going to discuss three key elements of woman-centered abortion care: choice, access and quality. Local laws and policies and their interpretation will impact how well these three elements are instituted.

P Show and discuss slide: *Framework for Woman-Centered Care*

Three key elements of woman-centered, comprehensive abortion care:

- Choice
- Access
- Quality

Show and discuss slide: *Choice*

- If and when to become pregnant
- Whether to continue or terminate a pregnancy

P • Which available abortion or postabortion care procedures, contraceptives, providers and facilities she will use

P *Say: What actions do people take that compromise a woman's autonomy and restrict her ability to make choices about her pregnancy?*

- Answers might include:
 - Pressure or coercion by family members
 - Providers or facilities charging high fees
 - Services provided only if a woman agrees to sterilization or IUD insertion
 - Providers refusing to serve young or unmarried women

Say: How have you seen women's choices limited in these ways in your setting?

- Take a few answers.

Show and discuss slide: *Supporting Choice*

Health-care providers support a woman's choice by:

- Giving complete and accurate information
- Offering the opportunity to ask questions and express concerns
- Recognizing her right to a choice, regardless of age, marital status or other characteristics

Show and discuss slide: *Access*

Accessible services are:

- Affordable
- Delivered in a timely manner
- Easily reached in local communities
- Respectfully and confidentially provided

Say: *What kinds of things limit a woman's access to abortion services?*

P

- Answers might include:
 - Restrictive laws and policies, such as requiring third party consent, or other administrative obstacles
 - Providers' refusal to provide care, even to the extent allowed by local laws and policies
 - Judgmental attitudes of health-care workers and providers
 - Societal stigma associated with seeking abortion or postabortion care
 - Societal expectations for women to produce children
 - Women's financial dependence on other family members
 - Excessive traveling time to access services

Say: *How have you seen women's access to abortion limited in these ways in your setting?*

- Take a few answers.

Show and discuss slide: *Quality*

- Offer information and counseling to support fully-informed choices
- Provide services tailored to individual needs and social circumstances, including for young and unmarried women
- Use recommended uterine evacuation methods and protocols
- Provide desired contraceptive methods and services

Show and discuss slide: *Quality (cont.)*

- Offer other related sexual and reproductive health services
- Ensure confidentiality, privacy, and respectful interactions

- Monitor services, including adverse events, for quality improvement, with participation from community members

Say: How do you see these three key elements—choice, access and quality—interacting in your setting?

- Take a few answers and discuss.

Say: The five essential elements of postabortion care encompass clinical and emotional care as well as partnerships with the community.

Show and discuss slide: *The Five Elements of Postabortion Care*

1. *Treatment of incomplete, missed or unsafe abortion*
2. *Compassionate counseling* to identify and respond to women's emotional and physical health needs and other concerns
3. *Contraceptive and family-planning services* to help women prevent an unwanted pregnancy or practice birth spacing
4. *Related sexual and reproductive health services* that are preferably provided onsite or via referrals to accessible facilities
5. *Community-service provider partnerships to help women prevent* unwanted pregnancies and unsafe abortion, mobilize resources to help women receive appropriate and timely care for abortion-related complications and ensure health services reflect and meet community expectations and needs

Say: This module also presents information on the rights of women to comprehensive abortion care, including postabortion care, and discusses how health-care workers' views and practices affect rights and services.

2. Protecting women's rights in an abortion-care setting

Say: We are now going to look more closely at the topic of sexual and reproductive rights.

Explain that this next activity is based on the International Planned Parenthood Federation's (IPPF) *Charter on Sexual and Reproductive Rights*.

- IPPF's *Charter on Sexual and Reproductive Rights* is based on 12 internationally recognized human rights.
- The Charter applies internationally agreed-upon language from human-rights treaties, (which have the status of international law) to sexual and reproductive health and rights.

Post flipchart: Instructions for Rights Matching Activity

- Explain the instructions and keep them posted throughout the activity.
 - Each of the sexual and reproductive rights, numbered one through 12, is listed on a strip of paper.

- The corresponding descriptions of those rights are listed on a second set of paper strips.
- Each person will choose a paper strip and then find the person who holds the matching right or its description.
- The pairs will discuss the right and its description and answer the following questions and then report their responses to the large group:

P

- » What is one way that health-care workers can ensure this right is upheld in abortion or postabortion care service delivery?
- » How can health-care workers ensure this right is upheld specifically for young and unmarried women?

- Provide this example: One possible response for the right to decide whether or when to have children is: ensure contraceptive services are accessible to all women who want them. For young and unmarried women, ensure service delivery policies include provision regardless of age or marital status and remove all barriers to access so that young and unmarried women can easily access and use contraceptive services.
- Pass around a basket with the paper strips and ask each participant to take one strip.
- When everyone has a strip, instruct them to begin by finding the match to their strip.
- After ten minutes, sound chime to bring pairs back to the larger group.
- Distribute *Charter on Sexual and Reproductive Rights* handout.
- Have each pair read their right, its description and their two responses.

P

Say: These are four of the most important rights that relate to providing abortion and postabortion care.

P

Show slide: Four Key Rights Related to Abortion and Postabortion-Care Services

- The right to life
- The right to privacy
- The right to information and education
- The right to decide whether or when to have children

P

Say: Now let's discuss how to ensure women's rights are upheld in an abortion and postabortion care setting.

P

Lead a brief, interactive discussion on upholding women's rights in an abortion-related care setting.

- Refer participants to the *WHO Safe Abortion: Technical and Policy Guidance for Health Systems, Second Edition*, in particular the sections on women's health and human rights, to review how the service provision in their facilities compares to the WHO guidance. Ask for specific examples of how they can improve their service delivery practices to ensure that they are upholding women's rights.
- Refer participants to Section 3.0 in the Reference Manual.

P Show and discuss slide: *Support Rights in an Abortion-Related Care Setting*

- Have empathy and respect for all women, regardless of age or marital status.
- Maintain positive interactions.
- Respect privacy and confidentiality.
- Adhere to the voluntary, informed consent process.

Say: Health-care workers' attitudes and beliefs affect the quality of care delivered.

Show and discuss slide: *Health-Care Workers' Attitudes and Beliefs*

- Abortion values clarification is recommended to help providers separate personal biases from the professional attitudes and behaviors they should display in the facility.
- "Training should be competency based and address health-care provider attitudes and ethical issues ..."
- "In addition to skills training, participating in values clarification exercises can help providers differentiate their own personal beliefs and attitudes from the needs of women ..." (WHO, 2012)

This issue is covered throughout the curriculum and in detail in the Informed Consent, Information and Counseling module.

Say: Now that we've discussed the key elements of abortion and postabortion care and women's rights to care, we will review the module objectives and you can test your knowledge.

3. Summary and test

Ask participants for key points covered in this module. Use the objectives as a reference.

What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.

- Collect tests.
- Review correct answers from the test key.

Thank participants for their participation.

References

- Alan Guttmacher Institute, & World Health Organization. (2012). *Facts on Induced Abortion Worldwide*. New York, NY: Alan Guttmacher Institute.
- Burns, A. A., Lovich, R., Maxwell, J., & Shapiro, K. (2012). *Where Women Have No Doctor: A Health Guide for Women*. Retrieved from http://en.hesperian.org/hhg/Where_Women_Have_No_Doctor
- Cook, R. J., & Dickens, B. M. (2000). *Considerations for formulating reproductive health laws, second edition*. Geneva: World Health Organization.
- Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: origins, evolution and future directions. *International Family Planning Perspectives*, 29(3), 106-111.
- Creinin, M. D., Schwartz, J. L., Guido, R. S., & Pyram, H. C. (2001). Early pregnancy failure: current management concepts. *Obstetrical and Gynecological Survey*, 56(2), 105-113.
- Family Health International. (1999). Client-provider interaction: Family planning counseling. *Contraceptive Technology and Reproductive Health Series*. Retrieved from <http://www.fhi360.org/sites/default/files/webpages/Modules/CPI/s1pg1.htm>
- Ganatra, B., Tunçalp, O., Bart Johnson, H., Johnson, B.R., Gülmezoglu, A.M. & Temmerman M. (2014). From concept to measurement: Operationalizing WHO's definition of unsafe abortion. *Bull World Health Organ*, 92, 155.
- Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., & Shah, I. H. (2006). Unsafe abortion: the preventable pandemic. *Lancet*, 368(9550), 1908-1919.
- Hall, J. A., Roter, D. L., & Katz, N. R. (1988). Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care*, 26(7), 657-675.
- International Planned Parenthood Federation. (1996). *The IPPF Charter on Sexual and Reproductive Rights*. London, UK: International Planned Parenthood Federation.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- John, J. (1991). Improving quality through patient-provider communication. *Journal of Health Care Marketing*, 11(4), 51-60.
- Leonard, A. H., & Winkler, J. (1991). A quality of care framework for abortion care. *Advances in Abortion Care*, 1(1).
- Postabortion Care (PAC) Consortium. (2013). Postabortion Care (PAC) Consortium. Retrieved from <http://www.pac-consortium.org/>
- United Nations. (1995). *Programme of Action of the Fourth World Conference on Women*. Paper presented at the Fourth World Conference on Women, Beijing, China.
- United Nations. (1994, 5-13 September 1994). *Programme of Action of the United Nations International Conference on Population and Development*. Paper presented at the International Conference on Population and Development, Cairo, Egypt.

United Nations. (1994). *Programme of Action of the United Nations International Conference on Population and Development*. Retrieved from <http://www.un.org/popin/icpd/conference/offeng/poa.html>

United Nations. (1995). *Programme of Action of the Fourth World Conference on Women*. Retrieved from <http://www.un.org/womenwatch/daw/beijing/platform/>

United Nations. (1999). *Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session of the General Assembly, Including Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*. (A/S-21/5/Add.1). New York, NY: United Nations.

United Nations General Assembly. (2000). *United National Millennium Declaration*. (55/2). New York, NY: United Nations.

United Nations Secretary-General. (2010). *Global strategy for women's and children's health*. Geneva, Switzerland: United Nations.

Winkler, J., & Gringle, R. E. (1999). *Postabortion family planning: A two-day training curriculum guide for improving counseling and services*. Chapel Hill, NC: Ipas.

World Health Organization (2012). *Safe abortion: Technical and policy guidance for health systems* (second ed.). Geneva, Switzerland: World Health Organization.

Yellen, E., & Davis, G. C. (2001). Patient satisfaction in ambulatory surgery. *Association of Operating Room Nurses (AORN) Journal*, 74(4), 483-498.

Knowledge Test Key

1. False
2. False
3. True
4. False
5. True
6. False
7. a, c, d, e
8. a, c, e
9. Provide information and counseling to support fully informed choices; Offer services tailored to individual needs and social circumstances, including for young women; Use recommended methods and protocols; Provide contraceptive methods and services; Provide or refer for other reproductive health services; Ensure confidentiality, privacy, and respectful interactions; Monitor services, including adverse events, for quality improvement, with participation from community members

Overview and Guiding Principles

Knowledge Test

Circle True or False

1. True or False Human-rights principles are different and separate from woman-centered abortion-related care and rights.
2. True or False Health-care workers' attitudes and beliefs do not affect the quality of care delivered.
3. True or False Many women needing abortion-related care are in vulnerable situations that make it difficult for them to exercise autonomy.
4. True or False A comprehensive woman-centered approach to abortion-related care focuses solely on women's physical health needs.
5. True or False Regardless of national abortion laws or policies, all health systems are faced with women needing abortion-related care.
6. True or False One practice that supports young woman's rights in abortion-related care is requiring parental, guardian or other third party consent.
7. Circle the four rights that are part of IPPF's Charter:
 - a. The right to information and education
 - b. The right to refuse treatment
 - c. The right to decide whether or when to have children
 - d. The right to life
 - e. The right to privacy

- ☐ 8. Circle the three key elements of woman-centered, comprehensive abortion care:
- a. quality
 - b. trust
 - c. choice
 - d. justice
 - e. access

9. List two ways to ensure high-quality abortion-related care.

Charter on Sexual and Reproductive Rights

Rights	Description
1. The Right to Life	No woman's life should be put at risk by reason of pregnancy.
2. The Right to Liberty and Security of the Person	No person should be subjected to female genital mutilation, forced pregnancy, sterilization or abortion.
3. The Right to Equality and to be Free from all Forms of Discrimination	Equality and freedom from discrimination in one's sexual and reproductive life.
4. The Right to Privacy	All sexual and reproductive health-care services should be confidential and all women have the right to autonomous reproductive choices.
5. The Right to Freedom of Thought	Includes freedom from the restrictive interpretation of religious texts, beliefs, philosophies and customs as tools to curtail freedom of thought on sexual- and reproductive-health care and other issues.
6. The Right to Information and Education	Relating to sexual and reproductive health for all, including access to full information on the benefits, risks and effectiveness of all methods of fertility regulation, in order that all decisions taken are made on the basis of full, free and informed consent.
7. The Right to Choose Whether or Not to Marry and to Found and Plan a Family	Recognizes that all persons have the right to protection against a requirement to marry without that person's full, free and informed consent.
8. The Right to Decide Whether or When to Have Children	Recognizes that all persons have the right to decide freely and responsibly. the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right and further recognizes that special protection should be accorded to women during a reasonable period before and after childbirth
9. The Right to Health Care and Health Protection	Includes the right of health-care clients to the highest possible quality of health care, and the right to be free from traditional practices which are harmful to health.
10. The Right to the Benefits of Scientific Progress	Includes the right of sexual and reproductive health-service clients to new reproductive-health technologies that are safe, effective and acceptable.
11. The Right to Freedom of Assembly and Political Participation	Includes the right of all persons to seek to influence communities and governments to prioritize sexual and reproductive health and rights
12. The Right to be Free from Torture and Ill-Treatment	Including the rights of all women, men and young people to protection from violence, sexual exploitation and abuse.

International Planned Parenthood Federation.(1996). *IPPF Charter on Sexual and Reproductive Rights, Vision 2000*. London: IPPF.

Reproductive Rights



Purpose:

This module covers the knowledge and attitudes regarding reproductive rights that health-care staff must have in order to support woman-centered, comprehensive abortion care.



Prerequisites:

- ☐ Participants should already be able describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care.



Objectives:

By the end of this module, participants should be able to:

1. Identify relevant international human-rights documents and their significance for abortion and postabortion care
2. Identify barriers that impede women's access to safe, legal abortion care in participants' settings
3. Identify possible actions to take to improve women's access to comprehensive abortion care, including postabortion care, in participants' settings



Materials:

- ☐ Make copies of handout: Sexual and Reproductive Rights of Young People (from Ipas's *Abortion Care For Young Women: A Training Toolkit*, pp. 63-64)
- ☐ Knowledge Test And Test Key



Advance preparation:

- ☐ Familiarize yourself thoroughly with the Reference Manual, *Reproductive Rights* module.
- ☐ Compile, review and have copies of national abortion-related laws, policies and regulations.
- ☐ Consider inviting a local reproductive rights expert who is supportive of comprehensive abortion care and have them explain policy

statements and how they use international statements to advocate for reproductive rights locally. If you invite a speaker, more time will be needed for this module.

- ❑ Make a flipchart or slide with instructions for the activities.
- ❑ If needed, invite additional facilitators to assist with facilitating small group discussion or select more experienced participants in advance. Facilitators will need to be given instructions and briefed on the topic and materials.
- ❑ Make copies of knowledge tests.

Note to trainer: For materials and activities that focus specifically on the rights of young women to abortion-related care, please see Module 3: A Rights-Based Approach to Care in *Ipas's Abortion Care For Young Women: A Training Toolkit*.

Time: 2 hours

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

- This module covers the knowledge and attitudes regarding reproductive rights required to support woman-centered, comprehensive abortion care.

Show slide: *Objectives*

- By the end of this module, participants should be able to:
 1. Identify relevant international human-rights documents and their significance for abortion and postabortion care
 2. Identify barriers that impede women's access to safe, legal abortion care in participants' settings
 3. Identify possible actions to take to improve women's access to comprehensive abortion care, including postabortion care, in participants' settings
- Ask participants if they have heard of the United Nations International Conference on Population and Development (ICPD) that was held in September of 1994, often referred to as the "Cairo conference."
- Ask 1-2 participants to share very briefly how this conference was significant for reproductive rights.
- Show slides and ask a participant to read the definition of reproductive health and rights from the ICPD Programme of Action, also in Section 2.0 of the Reference Manual:

"Reproductive health is a state of complete physical, mental and social

well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. ... Reproductive rights embrace certain human rights that are already recognized in national laws, international human-rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human-rights documents."

- Ask participants to name the key words in this definition. Write answers on a flipchart and discuss their significance.

Inform participants that this definition was carefully crafted to be comprehensive and include key concepts. This statement from the ICPD Programme of Action provides the foundation for reproductive rights.

Show slides and ask participants to read the specific rights and how they relate to abortion. They are also listed in Section 2.0 of the Reference Manual:

- *The right to decide whether and when to have children* - Women should have access to the contraceptive methods they want and to decide when to terminate a pregnancy.
- *The right to life* - Women should not die due to unsafe abortion.
- *The right to health* - Women should not suffer short- and long-term injuries due to unsafe abortion.
- *The right to dignity and bodily integrity* - Young women should be able to consent to their own uterine evacuation procedure.
- *The right to freedom from discrimination* - For example, uterine evacuation is a procedure only women and not men need.
- *The right to freedom from inhuman and degrading treatment* - For example, this is upheld when abortion or postabortion care is denied or provided in a judgmental and punitive manner.
- *The right to the benefits of scientific progress* - For example, this right is upheld when providers use WHO-recommended uterine evacuation methods.
- *The right to freedom of opinion and expression* - For example, this right is upheld when people voice their support for safe abortion care.

Instruct participants to form pairs and assign each pair a right. Ask them to briefly discuss how this right is sometimes disrespected by health-care workers in their attitudes and practices and how this negatively impacts women seeking and providers performing abortion-related care.

Show and discuss slide: *Health-Care Workers and Reproductive Rights*

- Health-care workers play a critical role in helping women exercise their reproductive rights.
- Health-care workers need to be supported to adopt attitudes and practices that respect women's reproductive rights.

2. International human-rights documents related to abortion and postabortion care

Refer participants to Sections 2.1 through 2.3 of the Reference Manual and briefly discuss treaties and agreements, global commitments and statements from policymaking bodies.

Distribute handout: Sexual and Reproductive Rights of Young People and briefly discuss the conventions and covenants that uphold young people's rights and how these relate to abortion-related care.

Show slide and explain: *International Treaties and Agreements*

- Outline the principles of universal human rights
- Provide the basis for women's, including young women's, sexual and reproductive rights within a human-rights framework
- When adopted by governments, enforce human rights in different areas of life
- Providers can learn which treaties have been ratified by their government
- Providers can use treaties to advance health-care policies that protect women's health
- Advocacy is needed for health-care policies that ensure provision of and access to high-quality health-care for young and unmarried women

Explain that while conventions and treaties are the foundation for international human rights, consensus statements and declarations made at conferences sponsored by the United Nations (UN) focus on more specific aspects of women's—including young women's—sexual and reproductive rights.

- Mention a few of the most important of these consensus statements and declarations from Section 2.2 of the Reference Manual.
- Cite the ICPD and ICPD+5 statements, emphasizing paragraph 63(iii).

Tell participants that there are important statements from policymaking bodies that relate to reproductive rights.

- Explain that statements from the World Health Organization (WHO), UNAIDS and professional associations like the International

Federation of Gynecologists and Obstetricians (FIGO) convey the authority and consensus of respected health-care experts, but that they are not legally binding.

- Refer to guidance documents from WHO and other UN agencies listed in the Reference Manual. These provide a framework and commitments for maternal, reproductive and child health programs at a country level.

Ask participants to summarize what they have learned about international human-rights documents and how they relate to comprehensive abortion care.

Note to trainer: If you have invited a reproductive rights expert who is supportive of comprehensive abortion care, have them explain how they use international policy statements to advocate for reproductive rights locally. If you invite a speaker, more time will be needed for this module.

P 3. Abortion laws and policies and barriers that impede access to abortion-related care

Say: Now we will discuss in more detail barriers that inhibit access to abortion-related care. We will start by looking at laws and policies.

Review local and/or national laws and policies related to comprehensive abortion care, such as the example in the box in Section 3.1 of the Reference Manual.

Show slide: *World Abortion Laws*

- Almost all countries permit abortion in some circumstances, including one or more of the following:
 - To save a woman's life
 - To preserve physical health
 - To preserve mental health
 - In situations of rape or incest
 - In cases of fetal impairment
 - For economic or social reasons
 - On request

Point out that although abortion may be legal for certain indications, this does not mean it is accessible.

Explain the next activity on barriers that impede access to care.

- On a flipchart, draw an image of a woman on one side and a health-care facility on the other side. In between the drawing of the woman and the facility, list the following items that restrict women's access to care:

1. Narrow interpretations of the law
 2. Restrictions that affect access
 3. Provider shortages
 4. Technological limitations
 5. Conscientious refusal of care
 6. Provider attitudes
- Divide participants into small groups and assign each group a topic. Ask each small group to list several examples of how their assigned topic can present barriers to abortion-related care in their setting and ways to overcome each barrier they identified.
 - Participants can use Section 3.0 of the Reference Manual as a resource.
 - Give the small groups 15 minutes for discussion.
 - Assemble the small groups back into a large group.
 - Each small group should take turns reporting 1-2 key barriers and actions to overcome them.
 - After all groups have reported, encourage them to think about actions they can take individually or as a group to move toward the goal of access to comprehensive abortion care.

Note to trainer: To provide more of a specific focus on the rights of young women to abortion-related care, you can share materials and lead activities from Module 3: A Rights-Based Approach to Care in Ipas's *Abortion Care For Young Women: A Training Toolkit*.

4. Summary and test

Ask participants to name key points from this module. Use the objectives as a reference.

Say: What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Suggest that participants review the Ipas document *Human Rights, Unwanted Pregnancy and Abortion-Related Care* as well as other additional resources listed in the Reference Manual.

Thank participants for their participation.

References

- Alan Guttmacher Institute. (1999). *Sharing responsibility: women, society & abortion worldwide*. New York, NY: The Alan Guttmacher Institute.
- Alan Guttmacher Institute. (2009). *Abortion worldwide: A decade of uneven progress*. New York, NY: The Alan Guttmacher Institute.
- Association of Reproductive Health Professionals. (2012). Position Statements. 2013, from <http://www.arhp.org/About-Us/Position-Statements>
- Boklage, C. E. 1990. Survival probability of human conceptions from fertilization to term. *International Journal of Fertility*, 35: 75–94.
- Center for Reproductive Law and Policy, & Groupe de recherche femmes etlois au Senegal. (1999). *Women of the World: Laws and Policies Affecting Their Reproductive Lives: Francophone Africa*. New York, NY: Center for Reproductive Law and Policy.
- Center for Reproductive Rights. (2006). *Bringing rights to bear: An Advocate's Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*. New York, NY: Center for Reproductive Rights.
- Cook, Rebecca J., Bernard M. Dickens and Mahmoud F. Fathalla. 2003. *Reproductive health and human rights: Integrating medicine, ethics, and law*. New York, Oxford University Press.
- International Confederation of Midwives. (2008). *Midwives' provision of abortion-related services*. The Hague, Netherlands: International Confederation of Midwives.
- International Federation of Gynecology and Obstetrics. (2011). Consensus statement on uterine evacuation (pp. 2). London, UK: International Federation of Gynecology and Obstetrics.
- Ipas. (2002). *Human rights, unwanted pregnancy, and abortion-related care: Reference information and illustrative cases* M. de Bruyn (Ed.) Chapel Hill, NC: Ipas.
- Ipas, & Karolinska Institute: Division of International Health. (2002). *Deciding women's lives are worth saving: Expanding the role of midlevel providers in safe abortion care*. (Vol. 7). Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (Second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (Second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- International Federation of Obstetrics and Gynecology (FIGO) Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health. (2012). *Ethical issues in obstetrics and gynecology*. International Federation of Obstetrics and Gynecology (FIGO). Retrieved from: www.figo.org/files/figo-corp/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf
- International Federation of Obstetrics and Gynecology (FIGO). (2012). *Integrating human rights and women's health competencies for practice*. FIGO. Retrieved from <http://www.figo.org/files/figo-corp/Introduction%20to%20HRWH%20Framework.pdf>
- Joint United Nations Programme on HIV/AIDS (UNAIDS). (2011). *Community innovation: Achieving sexual and reproductive health and rights for women and girls through the HIV response*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS).
- Klugman, B. and Budlender, D. (2001). *Advocating for abortion access: Eleven country studies*. Johan-

nesburg, South Africa: Women's Health Project.

Latin American Federation of Obstetric and Gynecological Societies (FLASOG). (2002). *Recommendations of the General Assembly, 17th Congress*. Paper presented at the XVII FLASOG Latin American Congress of Obstetrics and Gynaecology, Santa Cruz, Bolivia.

Lichter, D. T., McLaughlin, D. K., & Ribar, D. C. (1998). State abortion policy, geographic access to abortion providers and changing family formation. *Family Planning Perspectives*, 30(6), 281-287.

Office of the High Commissioner for Human Rights (OHCHR). (2013). United Nations Human Rights Council: Background information on the Human Rights Council. Retrieved from <http://www.ohchr.org/EN/HRBodies/HRC/Pages/AboutCouncil.aspx>

Office of the United Nations High Commissioner for Human Rights, & Joint United Nations Programme on HIV/AIDS (UNAIDS). (2006). *International guidelines on HIV/AIDS and human rights, 2006 consolidated version*. Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS).

Office of the United Nations High Commissioner for Human Rights. (2004). *Human rights treaty bodies*. Retrieved from <http://www.ohchr.org/en/hrbodies/Pages/HumanRightsBodies.aspx>

Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS. (1998). *HIV/AIDS and human rights: International guidelines*. Paper presented at the Second International Consultation on HIV/AIDS and Human Rights, Geneva, Switzerland.

Otsea, K., Baird, T. L., Billings, D. L., & Taylor, J. E. (1997). *Midwives deliver postabortion care services in Ghana*. Carrboro, NC: Ipas.

Partnership for Maternal, Newborn and Child Health (2009). *Consensus for maternal, newborn and child health*. Geneva, Switzerland: Partnership for Maternal, Newborn & Child Health.

Renner, R. M., Nichols, M. D., Jensen, J. T., Li, H., & Edelman, A. B. (2012). Paracervical block for pain control in first-trimester surgical abortion: a randomized controlled trial. *Obstetrics & Gynecology*, 119(5), 1030-1037.

Starrs, A. (1997). The Safe Motherhood action agenda: priorities for the next decade *Proceedings of the Safe Motherhood Technical Consultation, 18-23 Oct. 1997, Colombo, Sri Lanka*. New York, NY: Inter-Agency Group for Safe Motherhood.

The Partnership for Maternal Newborn & Child Health (PMNCH), World Health Organization (WHO), & Aga Khan University. (2011). *Essential interventions, commodities and guidelines for reproductive, maternal, newborn and child health: A global review of the key interventions related to reproductive, maternal, newborn and child health*. Geneva: World Health Organization .

Turner, K. L., & Page, K. C. (2008). Abortion attitude transformation: A values clarification toolkit for global audiences (pp. 172). Chapel Hill, NC: Ipas.

Turner, K. L., Weiss, E., & Gulati-Partee, G. (2009). *Providers as advocates for safe abortion care: A training manual*. Chapel Hill, NC: Ipas.

UN Women. (2011). *In pursuit of justice: 2011-2012 progress of the world's women*. New York, NY: UN Women.

United Nations. (1994, 5-13 September 1994). *Programme of Action of the United Nations International Conference on Population and Development*. Paper presented at the International Conference on Population and Development, Cairo, Egypt.

United Nations. (1995). *Programme of Action of the Fourth World Conference on Women*. Paper presented at the Fourth World Conference on Women, Beijing, China.

United Nations. (1999). *Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session*

of the General Assembly, Including Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development. (A/S-21/5/Add.1). New York, NY: United Nations.

United Nations Commission on Population and Development. (2012). Report on the forty-fifth session, resolution 27. New York, NY: United Nations.

United Nations Committee on the Rights of the Child. (2003). *General comment No. 4: Adolescent health and development in the context of the Convention on the Rights of the Child.* (CRC/GC/2003/4). New York, NY: United Nations.

United Nations General Assembly. (1966). *The international covenant on economic, social and cultural rights.* New York and Geneva: United Nations General Assembly.

United Nations General Assembly. (1989). *Convention on the rights of the child.* New York and Geneva: United Nations General Assembly.

United Nations General Assembly. (2000). *United National Millennium Declaration.* (55/2). New York, NY: United Nations.

United Nations Human Rights Council. (2011). *Interim report prepared by the Special Rapporteur of the Human Rights Council on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* New York, NY: United Nations.

United Nations Secretary-General. (2010). *Global strategy for women's and children's health.* Geneva: United Nations.

Varkey, S. J., Fonn, S. and Ketlhapile, M. (2001). *Health workers for choice: Working to improve quality of abortion services.* Johannesburg, RSA: Women's Health Project.

World Health Organization. (2005). *WHO Model List of Essential Medicines.* (EML14). Geneva: World Health Organization.

World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems,* (Second Edition ed.). Geneva, Switzerland: World Health Organization.

World Health Organization, John Snow Inc., International Planned Parenthood Federation, PATH, Population Action International, United Nations Population Fund, & World Bank. (2006). *Interagency Guidelines: Interagency List of Essential Medicines for Reproductive Health.* Geneva, Switzerland: World Health Organization.

World Health Organization Executive Board 107th session. (2000). *Making pregnancy safer: Report by the Secretariat.* Geneva, Switzerland: World Health Organization.

World Health Organization (WHO). (2000). *Pregnancy and HIV/AIDS. Fact Sheet No. 250, June 2000.* Geneva, Switzerland: World Health Organization.

Knowledge Test Key

1. False
2. True
3. False
4. True
5. True
6. a, c, d
7. Examples may include (but are not limited to): work to change abortion-related laws and policies; develop or revise clinical standards and guidelines that allow more access to care for all women; conduct or participate in values clarification workshops to reduce stigma and negative attitudes towards women and providers; partner with community and youth groups to organize support for women who need to access abortion-related care and join with legal associations to develop and implement advocacy strategies.

Reproductive Rights Knowledge Test

Circle True or False

1. True or False Human-rights conventions state that governments can decide how many children a woman can have.
2. True or False The principles of universal human rights are codified in international conventions and treaties.
3. True or False The ICPD, also known as the Cairo conference, in 1994 failed to recognize unsafe abortion as a public-health problem.
4. True or False Almost all countries permit abortion in some circumstances.
5. True or False Young people have the right to independent decision making in accordance with their capacities
6. Circle the barriers to accessing abortion-related care:
 - a. Requiring parental consent for young women
 - b. Developing medical protocols that define legal indications of abortion
 - c. Requiring reporting rape cases to the courts prior to taking a pregnancy test
 - d. Requiring three different providers to certify the indication for an abortion
 - e. Women giving informed consent for themselves
7. List two ways providers can overcome barriers to access to abortion-related care and uphold women's rights.

Community Linkages



Purpose:

This module covers the knowledge, skills and attitudes necessary for creating effective linkages with communities to improve the provision of comprehensive abortion care, including postabortion care, and other reproductive-health services.



Prerequisites:

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights to abortion-related care



Objectives:

At the end of this module, participants should be able to:

1. Describe the importance and means of creating linkages with community members
2. Explain the need for building partnerships with community members and leaders to strengthen reproductive health-care knowledge and services
3. Create a Community Map and Profile of reproductive-health services as part of a community assessment
4. Utilize an Action Plan worksheet to address a community health issue
5. Describe programmatic strategies for working with communities



Materials:

- ☐ Community Profile worksheet
- ☐ Action Plan worksheet
- ☐ Community Map example
- ☐ Flipchart-sized version of Action Plan worksheet
- ☐ Knowledge test and test key



Advance preparation:

- ☐ Makes copies of Community Profile and Action Plan worksheets, Community Map example and Knowledge test
- ☐ Create flipchart-sized version of Action Plan worksheet.

Time: 1 hour 30 minutes

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module covers the knowledge, skills and attitudes necessary for creating linkages with communities to improve the provision of comprehensive abortion care and other reproductive-health services for women.

Show slide: *Objectives*

At the end of this module, participants should be able to:

1. Describe the importance and means of creating effective linkages with community members
2. Explain the need for building partnerships and coalitions with community members and leaders to strengthen reproductive health-care knowledge and services
3. Create a Community Map and Profile of reproductive-health services as part of a community assessment
4. Utilize an Action Plan worksheet to address a community health issue.
5. Describe relevant programmatic strategies for working with communities

Say: First we are going to discuss the importance of community involvement and linkages between the health system and the communities they serve.

Divide participants into groups of three. Each group should discuss answers to the following question that you write on a flipchart:

- Why it is important for health-care providers to involve the community in the provision of reproductive-health services?
- The groups have 5 minutes to discuss the question and generate a list of answers. Each group should select a reporter to share with the large group.
- Have each group report on their list without repeating what other groups have said. The list could include:
 - Helps service providers understand the context in which women

and their families live

- Uncovers community attitudes and perceptions related to abortion and high-quality health-care services
 - Determines the extent of community awareness about contraception, unplanned pregnancy, abortion and available health services
 - Helps service providers better understand the unique realities of young women and barriers they often face when accessing sexual and reproductive health services, particularly safe abortion and postabortion care
 - Shapes sensitization and health-education messages regarding unplanned pregnancy, unsafe abortion, the need for safe abortion services and how to identify abortion-related complications
 - Identifies existing barriers to comprehensive abortion services
 - Builds trust between providers and community members
 - Helps health-care providers understand the opportunities and constraints faced when offering comprehensive abortion services in the community
 - Helps identify community opposition to abortion and ways to reduce it
 - Helps identify allies who can promote women's access to reproductive-health services
 - Identifies reasons behind unwanted pregnancy and ways to decrease it
 - Strengthens early identification of abortion complications and ways to facilitate women getting to care more quickly
 - Identifies sources of unsafe abortion services and ways to eradicate them
 - Gets communities working together to change policies to protect women's sexual and reproductive health and rights
 - Can improve positive male involvement in sexual and reproductive health, including abortion-related care
- Summarize the brainstorm lists and add relevant points from above as needed.

Say: Now that we know the importance of such linkages, what are some things that providers and other facility staff can do to build partnerships with community members?

Take a few responses from participants and write them on a flip chart.

Discuss the following slide, noting responses that participants did not mention.

Show slide: *To Create Strong Relationships with Community Members...*

- Provide high-quality, respectful, confidential care
- Inform and consult with community representatives
- Establish ongoing mechanisms for community involvement
- Set up community-based health worker outreach programs

Discuss the following:

- *Provide high-quality, respectful care to all women who seek services and protect women's confidentiality*
- *Inform and consult with community leaders and representatives of different segments of the community, such as different ethnicities and young women*
- *Establish ongoing mechanisms for community involvement in assessments of service delivery, adverse events, recommendations for quality improvements and positive community-provider partnerships, such as community advisory committees that include diverse representatives. When adverse events occur, facilitate discussions to prevent misunderstandings and even potential threats to providers*
- *Establish or strengthen community-based health worker outreach programs to provide locally appropriate information, support and care to community members*

Note that community members can also define perspectives and problems and propose appropriate solutions. Together, providers and community members can improve access to and quality of care.

2. Community Mapping

Say: One thing that is needed to create effective linkages between facilities and communities is an understanding about what services exist, where they are located and how they function together. We're going to reach that understanding through an exercise known as community mapping. We will focus now on learning the process of community mapping; later, you can actually conduct this exercise with your community.

- Explain that mapping the community can serve as an important tool to understand resources and groups within communities, engage the community and conduct any community-level interventions.
- P • Explain that it is helpful to identify institutions that may hinder or assist with the provision of reproductive-health services, especially comprehensive abortion services.
- Stress that an important aspect of working with the community is

defining what you mean by “community.”

- Community can be defined in a variety of ways. It can be the people living in a certain geographical area or a group of people who share similar interests, culture or religion.
- It can also be a group of people who share common political, economic or social interests (like mothers of newborns or youth leaders, for example).

Note to trainer: If you have adequate time, lead a brainstorming session in which people list the various communities to which they belong.

Say: For the purpose of this activity, we will define community as a group of people who share a common geographical location.

Divide participants into small groups of people from the same geographical area.

Note to trainer: You may need to adapt the way you divide participants. Ideally, small groups should consist of people from the same geographic community. If participants are all from the same community, you could divide them into small groups to complete the activity. Alternatively, if participants are from different communities, they could work alone.

- Explain that for this activity, participants will create on a flipchart a Community Map of health services and other institutions that exist in their community.

Show slide: *The Community Map Should Include*

- Hospitals, clinics and health posts, including the following:
 - Reproductive-health services
 - Emergency obstetric services (e.g. blood, surgery)

Hand out the example of the Community Map.

Say: Next to each organization, list what you know about the services offered, the hours of operation, if they offer reduced cost services, and the quality of services as perceived by the community, if you know it.

Show slide: *The Community Map Should Include (cont.)*

- Places where people receive:
 - Information about pregnancy prevention and termination (e.g. clinics, hotlines, community or youth centers, schools)
 - Contraception (e.g. pharmacies)
 - Reproductive-health technologies such as manual vacuum aspiration (MVA) and medical methods
 - Transportation for emergency care

Show slide: *The Community Map Should Include (cont.)*

- Untrained people who provide abortions or abortifacients, if they are known
- Non-health care community organizations that deal with sexual and reproductive health and rights (e.g. women's groups, youth groups)
- Markets, parks and other public gathering places
- Places that young people gather

Conduct Community Map activity.

- Explain how to complete the Community Map.
 - Draw arrows between health-care facilities to indicate any referral linkages.
 - Use one-headed arrows to indicate one-way referrals and two-headed arrows to indicate when organizations refer to one another.
 - Write approximate distances between the clinics, hospitals and other health-care providers.
 - Keep a list of things that are uncertain or need to be researched.
- Hand out markers and flipchart paper and give 25 minutes to complete this activity.
- Walk around the room to provide guidance and answer questions as needed.
- After the time is up, ask for two groups to display their Community Maps. Have each group:
 - Describe the various items on the map.
 - State one new thing they learned about their community through this activity.
- Explain that, when constructing a Community Map, participants should think about how community resources, coalitions and groups might help to reduce or overcome the barriers to accessing reproductive-health services and information. A community advisory group, for example, may be an important ally in participants' efforts.
- Explain that now participants will practice creating what is known as a Community Profile.

Say: Your Community Map provided a visual understanding of the various entities that offer reproductive-health services and information in your community. Now you will develop a Community Profile, which is an important tool to accompany your Community Map. Although this is something we can start in the course, it will have to be completed later when you can get more information about your communities. This will just help us start practicing the process.

- Describe the Community Profile:
 - It helps analyze the social environment—for example, identifies

community leaders and groups supporting or working against comprehensive abortion care—in order to clearly understand who to work with and what barriers or opportunities exist regarding access to care for women of all ages.

— Together the Community Map and Community Profile provide a blueprint or planning tool for initiating work with the community.

- Explain instructions:
 - Work with the same small group to fill in as much information about the community as possible.
 - Place asterisks in places where the answers are unknown or uncertain. These asterisks will serve as reminders to find and fill in that information at a later time.
- Hand out Community Profile worksheets and allow 25 minutes for this activity.
- Walk around the room providing guidance and answering questions.
- After the time is up, ask for two groups that didn't volunteer before to comment on their Community Profile. Have each group:
 - Describe which part of the Community Profile was easiest to complete.
 - Describe which part of the Community Profile was most difficult to complete.
 - State one new thing they learned about their community through this activity.
- Explain that these tools can be used as a point of discussion when engaging the community.
 - For example, elicit feedback from community members and/or leaders about the characterization of the community in the Community Map and Profile.

Note to trainer: If you find that participants need more time to fill in the Profile, assure them that it is okay not to finish it during this time. The important part is to begin the process of thinking about the social environment, constraints and opportunities regarding the provision of safe abortion services. Alternatively, lengthen the time spent on this activity.

Show and discuss slide: *Meet Community Leaders*

Say: The Community Map and Profile give a good picture of the people and institutions that could be engaged in the community. Let's talk now about a community coalition.

Explain that one method for engaging a broad range of community members and leaders at the same time is to create a women's reproductive-health coalition.

- A coalition is a group of people from different organizations and sub-communities who work together toward a common goal.

- An initial task for such a coalition could be to review, add to, reshape and complete the Community Map and Profile.
- The coalition could use the Map and Profile to identify problems and propose solutions, or might decide that a more thorough community assessment is required.

Say: Why would it be useful to gather information about available services and educational efforts in the community, and learn opinions from community members and leaders about unplanned pregnancy and abortion?

- Answers might include:
 - To identify gaps in services and/or service delivery-related barriers to providing high-quality, comprehensive abortion care
 - To develop strategies that increase awareness and education, to do pregnancy-prevention education with community leaders and health workers, and to strengthen comprehensive abortion services

Say: The success of the coalition depends on the participants. Who would be important to include in a women's reproductive-health coalition?

- Answers might include:
 - Community members, especially women who have had experience with abortion, service providers, community leaders from a variety of sectors, including government, education, women's and youth groups, key opinion leaders and young women

For more information on developing effective coalitions and analyzing collective efforts, please see Additional Resources.

Show slide: *Community Action Plans*

Say: Regardless of whether you are forming a coalition or working with just a few people from the community, it is important to create Action Plans. Action Plans document the "who, what, when, where, why and how" for your programmatic strategies and activities.

Show and discuss slide: *Community Advisory Committees*

- 12-20 individuals from community
- Serves as steering committee for project or services
- Should include young people and influential members of difference sectors

Show and discuss slide: *Community Advisory Committee Responsibilities*

- Advocacy
- Information and outreach in the community
- Input and guidance on project or services

Show and discuss slide: *Possible Community Interventions*

- Increase awareness and education
- Ensure rapid transfer of women with abortion-related complications

- Monitor quality of services
- Advocate for improved policies

Show slide: *Case Study*

A hospital administrator and three key reproductive-health providers recently held a community forum to elicit community members' perspectives on abortion. They found out that there is a man posing as a doctor who offers low-cost, unsafe abortion procedures in the southern part of town. One poor woman in the community died as a result of an abortion he performed. She did not know he wasn't a trained doctor.

Brainstorm a few activities or strategies the providers could use to address the issue raised in the case study. List ideas on a flip chart.

- Answers might include:
 - Promote awareness of the safe abortion services available at the hospital.
 - Offer sliding-scale fees based on women's ability to pay and publicize this policy.
 - Educate community members about the dangers of unsafe abortion and the importance of seeking care from trained providers.
 - Consider involving the police.
- Gain consensus on one strategy or activity listed on the flipchart to work on as a large group.
- Fill out a flipchart-sized Action Plan worksheet on the chosen activity or strategy.
- Have participants determine "what, why, with, needs, how and by when." Gain consensus on these points before recording their answers on the Action Plan worksheet on the flipchart.
- If time permits, list all relevant activities/strategies to address the problem in the case study.

3. Summary and test

Ask participants to name key points from this module. Use the objectives as a reference.

Say: What questions do you have about what we discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Thank participants for their participation.

References

- Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: origins, evolution and future directions. *International Family Planning Perspectives*, 29(3), 106-111.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
- Johnston, H. B., Ved, R., Lyall, N., & Agarwal, K. (2001). From community to action: Managing post-abortion complications and their management: A community assessment conducted in rural Uttar Pradesh, India. *PRIME Technical Report*, 23.
- McInerney, T., Baird, T. L., Hyman, A. G., & Huber, A. B. (2001). *Guide to Providing Abortion Care*. Chapel Hill, NC: Ipas.
- Pathfinder International. (2001). Tapping community opinion on postabortion care services. *Pathfinder Technical Guidance Series*, 2.
- Postabortion Care (PAC) Consortium. (2013). Postabortion Care (PAC) Consortium. Retrieved from <http://www.pac-consortium.org/>
- PRIME. (2002). Expanding opportunities for post-abortion care for communities through private nurses/midwives in Kenya. *PAC Clinical Skills Training Curriculum*, Module 11.
- Rogo, K. O., Bohmer, L., & Ombaka, C. (1999). Developing community-based strategies to decrease maternal morbidity and mortality due to unsafe abortion: pre-intervention report. *East African Medical Journal*, 76(11 Suppl), S1-71.
- Turner, K. L., Borjesson, E., Huber, A., & Mulligan, C. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas.
- Varkey, S. J., Fonn, S., & Ketlhapile, M. (2001). *Health workers for choice: Working to improve quality of abortion services*. Johannesburg, South Africa: Women's Health Project, University of Witwatersrand.

Knowledge Test Key

1. a, b, d

2. e

3. False

4. True

5. False

6. True

Community Linkages Knowledge Test

Circle all that apply.

1. It is important for health-care providers to work with communities:

- a. to build trust and understanding
- b. to identify reasons for unwanted pregnancy and unsafe abortion and ways to decrease it
- c. to identify pregnant adolescents in order to inform their parents
- d. to identify sources of unsafe abortion services
- e. none of the above

2. Strategies for linking with communities include:

- a. making a Community Map
- b. developing a Community Profile
- c. establishing a reproductive-health coalition
- d. designing a health campaign
- e. all of the above

Circle True or False

- | | |
|------------------|---|
| 3. True or False | Communities are always defined as the geographic areas in which people live. |
| 4. True or False | A Community Map can help people identify reproductive-health resources and services. |
| 5. True or False | Consulting the top leader of a community is the best way to understand the different viewpoints in the community. |
| 6. True or False | Young people should be a part of community health coalitions. |

Action Plan

Problem statement: _____

Actions						
	1	2	3	4	5	6
WHAT (intended action)						
WHY (purpose)						
WITH (resources available)						
NEED (resources needed)						
HOW (steps to be taken)						
BY WHEN (deadline)						
DATE COMPLETED Notes or follow-up						

Community Profile

Note: Use an asterisk (*) for those things that you do not know or that you need to research further.

1. Name of community:

2. Laws and policies regarding induced abortion and postabortion care:

3. List health facilities/providers that:

- Provide unbiased pregnancy options counseling:

- Offer contraceptive information, counseling and supplies:

- Offer comprehensive abortion care:

(Note beside them whether they are public or private facilities/providers)

4. List opinion leaders in the community:

Opinion leader for...	Supports woman's rights and access to care	Opposes abortion	Neutral or non-committal about abortion	List any involvement in reproductive- and sexual-health issues

5. List government officials:

Government official	Supports woman's rights and access to care	Opposes abortion	Neutral or non-committal about abortion	List any involvement in reproductive- and sexual-health issues

6. List community elders:

Name of elder (e.g. chief, village leader)	Supports woman's rights and access to care	Opposes abortion	Neutral or non-committal about abortion	List any involvement in reproductive- and sexual-health issues

7. List community groups that work on health issues, including sexual and reproductive health and rights:

Name of organization	Supports woman's rights and access to care	Opposes abortion	Neutral or non-committal about abortion	List any involvement in reproductive- and sexual-health issues

8. List local beliefs and attitudes (including myths) regarding reproductive health and abortion:

9. List local beliefs and attitudes (including myths) about providers who perform abortion services:

10. List how the non-health care community organizations on the Community Map influence the provision of reproductive-health services, especially comprehensive abortion care:

Name of organization	Supports provision of abortion-related care	Hinders provision of abortion-related care	How does it support or hinder abortion-related service provision

11. List common barriers to reproductive-health care and abortion care in the community (for example: cost, client age, hours of service, transportation, stigma, partner's/family's opposition)

12. List the incidence of:

- Safe abortion
- Unsafe abortion
- Unplanned pregnancy
- Teen pregnancy

13. List who influences women's decisions regarding pregnancy, including termination of pregnancy:

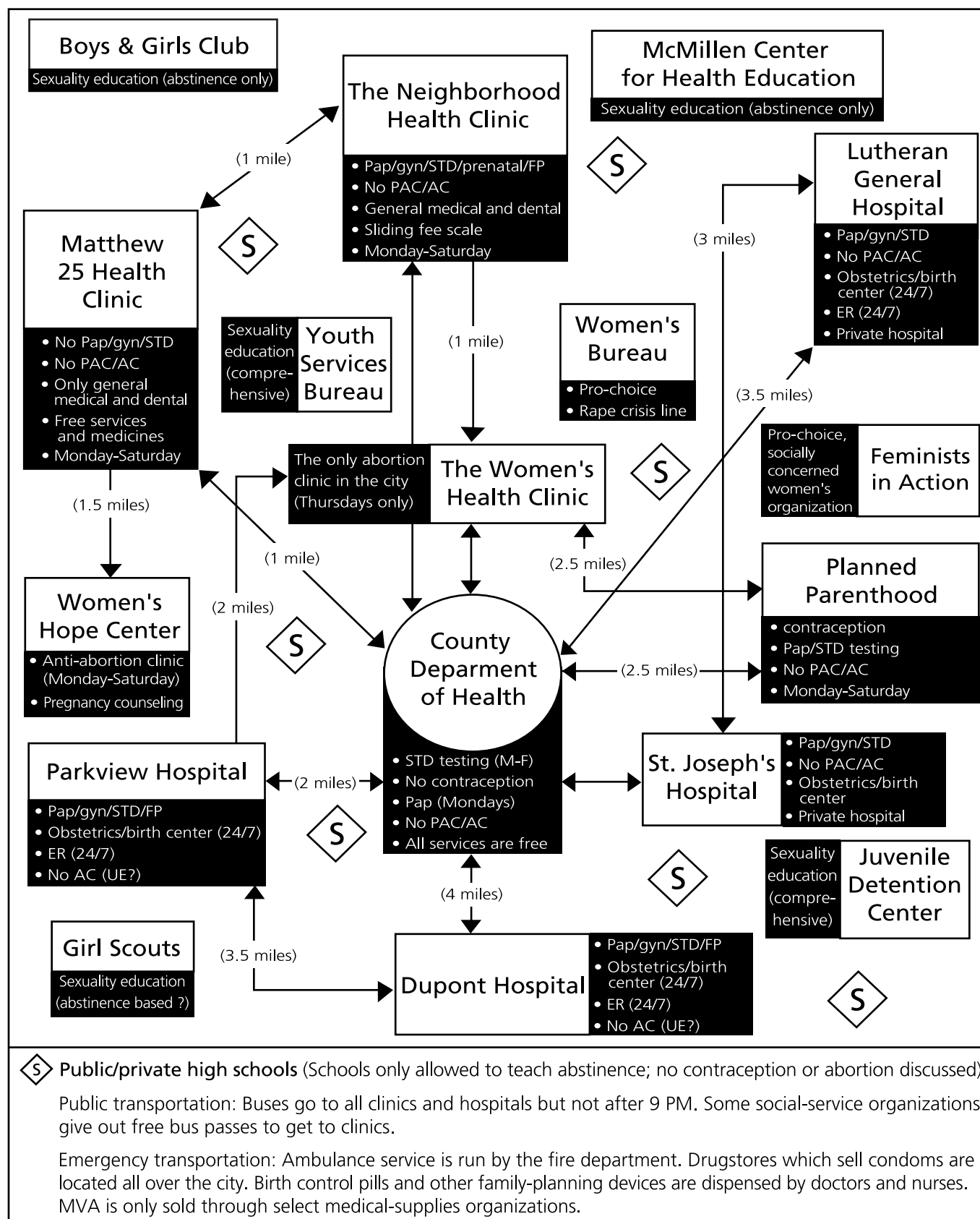
14. Do community members know what services are available and where they are located?

15. Lastly, what are the biggest opportunities and challenges regarding women's access to and utilization of comprehensive abortion care? How about for young women?

Opportunities:

Challenges:

Community Map Example: My City



P Things to research further on the Community Map Example:

Hospitals and clinics

- Do women who go to the private, religious Lutheran and St. Joseph's hospitals get referred to facilities that provide abortion-related care? Do the hospitals perform uterine evacuation under emergency circumstances?
- Are there private providers doing comprehensive abortion care?
- Do the public hospitals (Parkview and Dupont) do uterine evacuation under emergency circumstances?
- There is news that an anti-choice organization bought the building next to the abortion clinic to open up services to deter women from getting abortions. When will this happen?
- What are the community's perceptions regarding the quality of the services at these clinics and hospitals?
- Are there natural healers (homeopaths) that work with women on reproductive health, especially abortion?
- Are young women, including unmarried, welcome? Are they required to have a third party present to consent to an abortion or other SRH service?

Social-service organizations

- How do the Boys and Girls Clubs handle the topic of abortion in their sexuality education? Do they do any direct pregnancy counseling and/or referral?
- How does the Youth Services Bureau handle the topic of abortion in their sexuality education? Do they do any direct pregnancy counseling and/or referral?
- Does the Women's Bureau do any health education or referral of women for pregnancy counseling or abortion?
- Is the Girl Scouts' sexuality education comprehensive or abstinence-based? Do they do any referral for pregnancy counseling?
- Does Planned Parenthood do pregnancy testing and counseling? And do they refer to the Women's Health Clinic (abortion clinic)?
- Are there organizations working to eliminate abortion-related service delivery?
- Do the churches, mosques and synagogues play a role?

Uterine Evacuation Methods



Purpose:

This module describes the safety, efficacy, cost and acceptability of different recommended methods of first-trimester uterine evacuation. It also discusses the importance of transitioning from sharp curettage (SC) to recommended methods of uterine evacuation, specifically vacuum aspiration (VA) and medical methods.



Prerequisites:

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights in the abortion-care setting
- ☐ Describe basic gynecologic anatomy and physiology



Objectives:

By the end of this module, participants should be able to:

1. Describe recommended methods for evacuating the uterus
2. Describe factors in deciding which uterine evacuation method to use
3. Provide information to support transition from SC to VA and medical methods, if needed



Materials:

- ☐ Uterine Evacuation Methods worksheet
- ☐ Transitioning to MVA and Medical Methods worksheet (for optional activity in settings still using SC)
- ☐ Knowledge Test and Test Key



Advance preparation:

- ☐ Contact participants to find out which methods of uterine evacuation are used at their facilities. (This could be done during an overall needs assessment for the training course).
- P

☐ Assess availability of all recommended methods in facilities where

the training will take place and in participants' facilities. Determine which medical methods participants will use in their facilities: mifepristone and misoprostol or misoprostol only. This will need to be specified if they are doing the Transitioning to MVA and Medical Methods Services activity.

- ☐ Prepare flipcharts or duplicate: Uterine Evacuation Methods worksheet and Transitioning to MVA and Medical Methods worksheet.
- ☐ Review the WHO *Safe abortion: Technical and policy guidance for health systems, second edition* and FIGO *Consensus Statement on Uterine Evacuation* that provide evidence that VA and medical methods are recommended over SC.
- ☐ Familiarize yourself with cases in which health-care facilities successfully replaced SC with VA and medical methods to offer as a model for other facilities.
- ☐ Have MVA instruments and pertinent medical methods available to show participants.
- ☐ Make copies of Knowledge Test.

Time: 1 hour (add 20 minutes for optional activity)

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module describes the safety, efficacy, cost and acceptability of different recommended methods of first-trimester uterine evacuation. It also discusses the importance of transitioning from sharp curettage (SC) to recommended methods of uterine evacuation, specifically vacuum aspiration (VA) and medical methods.

Show slide: *Objectives*

By the end of this module, participants should be able to:

1. Describe recommended methods for evacuating the uterus
2. Describe factors in deciding which uterine evacuation method to use
3. Provide information to support transition from SC to VA and medical methods

Say: Let's first begin by looking at the different recommended methods for evacuating the uterus.

Show and discuss slide: *Uterine Evacuation Methods*

- Uterine evacuation removes contents of the uterus.
- Recommended methods for providing first-trimester uterine evacuation:

- Vacuum aspiration
- Medical methods

Show slide: *Obsolete Method: Sharp Curettage*

- WHO: “Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods.”
- International Federation of Gynecology and Obstetrics (FIGO) supports VA and medical methods over SC.
- Health systems should replace sharp curettage with VA and medical methods.
- SC has increased blood loss, pain and procedure time compared to VA.

Say: Determining which method is best requires consideration of several factors. What factors might be considered when deciding which method of uterine evacuation is best?

Answers should reflect the contents of the next slide.

Show and discuss slide: *Which Method Is Best?*

Considerations:

- Safety
- Efficacy
 - Cost
 - Staff skills
 - Available equipment, supplies and drugs
- The woman's clinical condition
 - The woman's personal preference

2. Uterine evacuation methods overview and comparison

Say: This course focuses on first-trimester uterine evacuation, but we wanted to briefly address second-trimester abortion.

P Show and discuss slide: *Second-Trimester Abortion*

WHO recommends:

- dilatation and evacuation (D&E)
- medical abortion

Say: WHO notes that VA can be performed up to 15 weeks LMP if providers have appropriate training and experience and have access to appropri-

ately-sized cannulae. With PAC treatment, products of conception (POC) may be already partially expelled or still in the uterus. For a woman with a uterus that is over 13 weeks in size, options for treatment include uterine evacuation with medications or MVA with or without use of specialized forceps.

Refer participants to *Clinical Updates for Reproductive Health* on the Ipas website and the *Clinician's Guide for Second-Trimester Abortion* in the Additional Resources of the Reference Manual for more information about D&E and medical abortion for second-trimester abortion.

Return participants to a focus on first-trimester abortion and review: *What are the different recommended methods of uterine evacuation in the first trimester?*

- Vacuum aspiration, either manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA)
- Medical methods
- Additionally, expectant management for incomplete abortion

Show participants the Ipas MVA Plus instrument and medications for uterine evacuation.

Tell participants that we will now do an activity in which we compare recommended methods of first-trimester uterine evacuation.

Post flipchart or distribute Uterine Evacuation Methods worksheet.

- Divide participants into small groups.
- Assign one of the methods to each group.
- Ask each group to take 20 minutes to read about their assigned method and complete the row for their method in the Uterine Evacuation Methods worksheet.
- Participants should refer to the information in the Reference Manual. The groups working on medical methods may want to consult both the *Uterine Evacuation Methods* and *Uterine Evacuation with Medical Methods* modules.
- Each group should appoint a reporter to present their responses to the large group.
- Reconvene the large group, refer participants to their Uterine Evacuation Methods worksheet and have each group present the information they found about their method's safety and effectiveness, cost and acceptability to women.
- All participants can fill in information on the worksheet about each method as that group is presenting their responses.
 - Once the group members who researched that method present their information, other participants can then suggest information that they missed.

— Have participants write in any additional answers that arise during the discussion about each method.

- Once all the groups have presented, review the following slides, highlighting information that groups did not present.

Say: Let's start with vacuum aspiration. What is vacuum aspiration, meaning either manual (MVA) or electric vacuum aspiration (EVA)?

- Vacuum aspiration removes the contents of the uterus through a cannula attached to a vacuum source that is either electric or manual.

Vacuum aspiration can be routinely performed up to 13 weeks LMP (or up to 15 weeks LMP if providers have been specially trained and have access to appropriately-sized cannulae)

What is MVA?

- MVA removes the contents of the uterus through a cannula attached to a hand-held device that contains a vacuum that is manually created. The vacuum source is portable and does not need electricity.

Show slide: *Ipas MVA Plus with Ipas EasyGrip Cannulae*

What is EVA?

- EVA is similar to MVA except that the vacuum is created by electricity.

Show slide: *EVA Machine*

Show and discuss slide: *Vacuum Aspiration (MVA or EVA)*

- Extremely safe
- Few complications, especially when performed in the first trimester
- Most studies show success in 98 to 100 percent of cases, including for incomplete abortion
- Less costly when performed on outpatient basis under local anesthesia

Ask: *Why is vacuum aspiration acceptable to women?*

Show and discuss slide: *Acceptability of VA for Women*

- Can remain awake during the procedure
- Don't have to stay overnight if done on an outpatient basis
- MVA is quiet

Ask: *What are the advantages of vacuum aspiration over sharp curettage?*

Show and discuss slide: *Advantages of VA over SC*

- Lower risk of complications
- Less cervical dilatation required

- Can be performed as outpatient procedure
- Decreased need for anesthetic drugs compared to SC

Say: Now let's turn to the pharmacological methods.

P Show slide: *Medical Methods*

Say: Drugs such as mifepristone and misoprostol soften the cervix and stimulate uterine contractions, which causes expulsion of the contents of the uterus. In addition, mifepristone blocks progesterone activity in the uterus, leading to detachment of the pregnancy.

P Show and discuss slide: *Clinical Safety and Effectiveness of Medical Methods for Induced Abortion*

- Combined regimen using mifepristone and misoprostol through thirteen weeks LMP is safe.
- Mifepristone and misoprostol combination is effective in more than 95 percent of cases.
- Misoprostol used alone is safe but less effective (85 percent) and should only be used when mifepristone is not available.

Show and discuss slide: *Clinical Safety and Effectiveness of Medical Methods for PAC*

- Misoprostol for incomplete abortion has average efficacy rates of 91-99 percent.
- For missed abortion, a single dose of misoprostol has 80 percent efficacy.

P Show and discuss slide: *Cost Considerations of Medical Methods*

- Costs depend on the regimen used and re-evacuation, if needed.
- Misoprostol itself is generally inexpensive.
- Mifepristone is not available in all settings and may be costly.

P *Say: Why is medical abortion acceptable to women?*

P Show and discuss slide: *Acceptability of Medical Methods for Women*

- Studies indicate women's satisfaction in a variety of settings, including where resources are limited.
- Misoprostol after mifepristone can be taken at home or other preferred location, and abortion process completed there.
- Some women perceive it as more private and natural than other methods.
- For incomplete abortion, studies indicate women's and providers' high satisfaction.

Say: When we talk with women about how first-trimester uterine evacuation is a safe and effective procedure and complications are very

rare, many women will want to know about the long-term effects. Groups that are against abortion have disseminated a lot of misinformation about its long-term effects in an effort to restrict women's access to abortion.

Show and discuss slide: *Long-Term Safety*

- Safe, induced abortion does not cause future infertility, breast cancer or severe psychological reactions.

Ask participants to briefly summarize the information about uterine evacuation methods' safety, effectiveness, cost and acceptability to women.

Note to trainer: The following is an optional activity that may be used if any participants are working in health-care facilities that are still using sharp curettage. If all participants' facilities are already using VA or medical methods, this activity is not needed.

Say: Because some health-care facilities are still using sharp curettage instead of vacuum aspiration and medical methods, let's talk about how to support facility administrators and staff to make the transition to recommended uterine evacuation methods. Here we focus specifically on medical methods and MVA. Depending on infrastructure and available resources, however, EVA may also be an option.

3. Transitioning to MVA and medical methods (optional activity)

Post flipchart or distribute Transitioning to MVA and Medical Methods worksheet.

- For each consideration, have the large group brainstorm issues they may encounter as they make the transition from SC to MVA and medical methods. Have participants write the transition issues to the right of each consideration in the worksheet.
- There will likely be more than one transition issue under each consideration.
- If an example of a transition issue is needed, mention cost, which is the first consideration listed.
 - A possible issue is that, although MVA services will most likely cost less than SC in the long term, facilities will need to make an initial investment in new instruments, supplies and staff training. Write this in the worksheet under the Transition Issues column.

Have participants brainstorm solutions to each transition issue.

Ask participants to pair up with the person next to them. Assign each pair one of the transition issues named by the large group.

Allow 10 minutes for pairs to list solutions to the issue. Have them write their answers on the worksheet, using the back of the sheet if needed.

- If an example of a solution is needed, discuss cost. A facility could use funds saved from moving from an operating theatre to an outpatient setting to purchase additional supplies and equipment.

Staff may need to advise the facility administrator about longer-term cost savings by transitioning from SC to MVA.

Have participants write this in the Solutions column.

Each pair should discuss their solutions and then share them with the large group. Invite other pairs to offer other solutions. Have them write the solutions in the column.

Tell participants that although making a transition in technology can pose challenges, especially initially, they now have developed some strategies to overcome these challenges.

4. Sustainable supply of MVA and MA

Explain to participants that without the necessary equipment or medicines, they will not be able to provide CAC and PAC services. Maintaining a minimum stock level of MVA and MA will ensure that their supplies are available when they need them.

Show and discuss the slide: Ensuring MVA and MA Are in Full Supply

- Recommended stock levels of MVA are based on average caseload per day and a re-use per aspirator of 25 times
- Recommended stock levels of MA are based on whether the facility uses MA for CAC and/or PAC, average caseload per day, and the MA regimen in the facility
- Recommended stock levels include a minimum amount of needed in stock to provide services for one month plus enough while more supplies are on order, and a maximum amount of reserve stock for 3 months
- Ensure that the facility manager has the recommended supply guidance tools and understands the importance of keeping MVA and MA in full supply

Refer to the MVA calculator (or CD ROM or the printed MVA chart) as the recommended tool for determining MVA supply, and the online (or CD ROM) MA calculator as the recommended tool for determining MA supply.

5. Summary and test

Ask participants to name key points covered in this module. Use the objectives as a reference.

Say: *What questions do you have about anything discussed in this module?*

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Thank the participants for their participation.

References

- Adamchak, S., Bond, K., MacLaren, L., Magnani, R., Nelson, K., & Seltzer, J. (2000). *A guide to monitoring and evaluating adolescent reproductive health programs*. Washington, DC: Focus on Young Adults.
- Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science*, 248(4951), 41-44.
- American Psychological Association Task Force on Mental Health and Abortion. (2008). Report of the APA Task Force on Mental Health and Abortion. Washington DC.
- Andolsek, L., Cheng, M., Hren, M., Ogrinc-Oven, M., Ng, A., Ratnam, S., . . . Tietze, C. (1977). The safety of local anesthesia and outpatient treatment: a controlled study of induced abortion by vacuum aspiration. *Study of Family Planning*, 8(5), 118-124.
- Baird, T. L., & Flinn, S. K. (2001). *Manual vacuum aspiration: Expanding women's access to safe abortion services*. Chapel Hill, NC: Ipas.
- Balogh, S. A. (1983). Vacuum aspiration with the IPAS Modified Gynecologic Syringe. *Contraception*, 27(1), 63-68.
- Beral, V., Bull, D., Doll, R., Peto, R., Reeves, G., & Cancer, C. G. o. H. F. i. B. (2004). Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83,000 women with breast cancer from 16 countries. *Lancet*, 363(9414), 1007-1016. doi: 10.1016/S0140-6736(04)15835-2
- Beri, B. M., & Kupresanin, M. (1971). Vacuum aspiration, using pericervical block, for legal abortion as an outpatient procedure up to the 12th week of pregnancy. *Lancet*, 2(7725), 619-621.
- Billings, D. L., & Benson, J. (2005). Postabortion care in Latin America: policy and service recommendations from a decade of operations research. *Health Policy and Planning*, 20(3), 158-166.
- Bique, C., Usta, M., Debora, B., Chong, E., Westheimer, E., & Winikoff, B. (2007). Comparison of misoprostol and manual vacuum aspiration for the treatment of incomplete abortion. *International journal of gynaecology and obstetrics*, 98(3), 222-226.
- Bird, S. T., Harvey, S. M., Beckman, L. J., Nichols, M. D., Rogers, K., & Blumenthal, P. D. (2003). Similarities in women's perceptions and acceptability of manual vacuum aspiration and electric vacuum aspiration for first trimester abortion. *Contraception*, 67(3), 207-212.
- Bird, S. T., Harvey, S. M., Nichols, M. D., & Edelman, A. (2001). Comparing the acceptability of manual vacuum aspiration and electric vacuum aspiration as methods of early abortion. *Journal of American Medicine Women's Association*, 56(3), 124-126.
- Blumenthal, P. D., & Remsburg, R. E. (1994). A time and cost analysis of the management of incomplete abortion with manual vacuum aspiration. *International Journal of Gynecology and Obstetrics*, 45(3), 261-267.
- Bruce, J. (1990). Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning*, 21(2), 61-91.
- Caceres, G. H., RiañoGamboa, G., Hernández, M. A., & López Escobar, G. (1981). *Hospital management of incomplete abortion: Comparative study of dilation and curettage versus vacuum aspiration*. Bogota, Columbia: Corporacion Centro Regional de Poblacion.
- Carbonell, J. L., Velazco, A., Varela, L., Tanda, R., Sánchez, C., Barambio, S., . . . Marí, J. (2001). Misoprostol for abortion at 9-12 weeks' gestation in adolescents. *The European Journal of Contraception and Reproductive Health Care*, 6(1), 39-45.
- Cates, W., Grimes, D. A., & Schulz, K. F. (2000). Abortion surveillance at CDC: creating public health light out of political heat. *American Journal of Preventive Medicine*, 19(1 Suppl), 12-17.

- Cemicamp., F. W. T. F. a. (1997). *Abortion: A professional responsibility for obstetricians and gynecologists*. Unpublished Workshop Final Report, Campinas, Brazil, March 1997.
- Chen, B. A., & Creinin, M. D. (2007). Contemporary management of early pregnancy failure. *Clinical Obstetrics and Gynecology*, 50(1), 67-88.
- Choobun, T., Khanuengkitkong, S., & Pinjaroen, S. (2012). A comparative study of cost of care and duration of management for first-trimester abortion with manual vacuum aspiration (MVA) and sharp curettage. *Archives of Gynecology and Obstetrics*, 286(5), 1161-1164.
- Clark, S., Blum, J., Blanchard, K., Galvão, L., Fletcher, H., & Winikoff, B. (2002). Misoprostol use in obstetrics and gynecology in Brazil, Jamaica, and the United States. *International Journal of Gynecology & Obstetrics*, 76(1), 65-74.
- Creinin, M. D. (2000). Randomized comparison of efficacy, acceptability and cost of medical versus surgical abortion. *Contraception*, 62(3), 117-124.
- Creinin, M. D., & Burke, A. E. (1996). Methotrexate and misoprostol for early abortion: a multicenter trial. Acceptability. *Contraception*, 54(1), 19-22.
- Dalton, V. K., & Castleman, L. (2002). Manual vacuum aspiration for treatment of early pregnancy loss. *Postgraduate Obstetrics & Gynecology*, 22(19), 1-6.
- Dalton, V. K., Harris, L., Weisman, C. S., Guire, K., Castleman, L., & Lebovic, D. (2006). Patient preferences, satisfaction, and resource use in office evacuation of early pregnancy failure. *Obstetrics & Gynecology*, 108(1), 103-110.
- Dao, B., Blum, J., Thieba, B., Raghavan, S., Ouedraogo, M., Lankoande, J., & Winikoff, B. (2007). Is misoprostol a safe, effective and acceptable alternative to manual vacuum aspiration for postabortion care? Results from a randomised trial in Burkina Faso, West Africa. *British Journal of Obstetrics and Gynecology*, 114(11), 1368-1375.
- Dean, G., Cardenas, L., Darney, P., & Goldberg, A. (2003). Acceptability of manual versus electric aspiration for first trimester abortion: a randomized trial. *Contraception*, 67(3), 201-206.
- Demetroulis, C., Saridogan, E., Kunde, D., & Naftalin, A. A. (2001). A prospective randomized control trial comparing medical and surgical treatment for early pregnancy failure. *Human Reproduction*, 16(2), 365-369.
- Diop, A., Raghavan, S., Rakotovaio, J. P., Comendant, R., Blumenthal, P. D., & Winikoff, B. (2009). Two routes of administration for misoprostol in the treatment of incomplete abortion: a randomized clinical trial. *Contraception*, 79(6), 456-462.
- Do, H., Ng Le Quan, Suong Bui, Thuy Thanh Le and Tri Manh Nguyen. (1998). *Use of double-valve syringe for first-trimester induced abortions at the Hanoi Obstetrics and Gynecology Hospital*. Unpublished.
- Edelman, D. A., Brenner, W. E., & Berger, G. S. (1974). The effectiveness and complications of abortion by dilatation and vacuum aspiration versus dilatation and rigid metal curettage. *American Journal of Obstetricians and Gynecologists*, 119(4), 473-480.
- Edwards, J., & Crenin, M. D. (1997). Surgical abortion for gestations of less than 6 weeks. *Current Problems in Obstetrics, Gynecology and Fertility* (January/February).
- El Kabarity, H., S Abo Louz, A El Etribi, M Yehya and A Ellian. (1985). *Suction abortion versus traditional evacuation in the management of incomplete inevitable abortions*. Unpublished paper presented at the International College of Surgeons, Fifth African Federation, Cairo.
- EngenderHealth. (2003). *COPE® Handbook: A process for improving quality in health services, revised edition*. New York, NY: EngenderHealth.
- EngenderHealth, Ipas, & Reducing Maternal Mortality and Morbidity Project Ghana. (2009). *COPE for*

- comprehensive abortion care services: A toolbook to accompany the COPE® Handbook*. New York, NY: EngenderHealth.
- Federacion Latino Americana de Sociedades de Obstetricia y Ginecologia. (2007). *Uso de misoprostol en obstetricia y ginecologia, segunda edicion* A. Faúndes (Ed.)
- Ferris, L. E., McMain-Klein, M., Colodny, N., Fellows, G. F., & Lamont, J. (1996). Factors associated with immediate abortion complications. *Canadian Medical Association Journal*, 154(11), 1677-1685.
- Forna, F., & Gülmezoglu, A. M. (2001). Surgical procedures to evacuate incomplete abortion. *Cochrane Database SystRev*(1), CD001993.
- Freedman, M. A., Jillson, D. A., Coffin, R. R., & Novick, L. F. (1986). Comparison of complication rates in first trimester abortions performed by physician assistants and physicians. *American Journal of Public Health*, 76(5), 550-554.
- Gabbe, S. G. (2002). *Obstetrics: Normal and problem pregnancies* (Fourth ed.). New York: Churchill Livingstone.
- Gabbe, S. G., Niebyl, J. R., Simpson, J. L., & Annas, G. J. (1996). *Obstetrics: Normal and problem pregnancies* (Third ed.). New York: Churchill Livingstone.
- Garcia-Nunez, J. (1992). *Improving family planning evaluation: A step-by-step guide for managers and evaluators*. West Hartford, CT: Kumarian Press.
- Geyman, J. P., Oliver, L. M., & Sullivan, S. D. (1999). Expectant, medical, or surgical treatment of spontaneous abortion in first trimester of pregnancy? A pooled quantitative literature evaluation. *Journal of the American Board of Family Practice*, 12(1), 55-64.
- Gilles, J. M., Creinin, M. D., Barnhart, K., Westhoff, C., Frederick, M. M., & Zhang, J. (2004). A randomized trial of saline solution-moistened misoprostol versus dry misoprostol for first-trimester pregnancy failure. *American journal of obstetrics and gynecology*, 190 (2), 389-394.
- Goldberg, A. B., Dean, G., Kang, M. S., Youssof, S., & Darney, P. D. (2004). Manual versus electric vacuum aspiration for early first-trimester abortion: a controlled study of complication rates. *Obstetrics and Gynecology*, 103(1), 101-107.
- Goldberg, A. B., Greenberg, M. B., & Darney, P. D. (2001). Misoprostol and pregnancy. *New England Journal of Medicine*, 344(1), 38-47.
- Graziosi, G. C., Mol, B. W., Ankum, W. M., & Bruinse, H. W. (2004). Management of early pregnancy loss. *International journal of gynaecology and obstetrics*, 86(3), 337-346.
- Greenslade, F., Leonard, A. H., Benson, J., Winkler, J., & Henderson, V. (1993). *Manual vacuum aspiration: a summary of clinical & programmatic experience worldwide*. Carrboro, NC: Ipas.
- Grimes, D. A., & Cates, W. (1979). Complications from legally-induced abortion: a review. *Obstetrical and Gynecological Survey*, 34(3), 177-191.
- Grimes, D. A., Schulz, K. F., Cates, W., & Tyler, C. W. (1979). Local versus general anesthesia: which is safer for performing suction curettage abortions? *American Journal of Obstetrics and Gynecology*, 135(8).
- Gynuity Health Projects. (2009). *Misoprostol for treatment of incomplete abortion: An introductory guidebook*. New York, NY: Gynuity Health Projects.
- Hakim-Elahi, E., Tovell, H. M., & Burnhill, M. S. (1990). Complications of first-trimester abortion: a report of 170,000 cases. *Obstetrics & Gynecology*, 76(1), 129-135.
- Hamoda, H., Flett, G. M., Ashok, P. W., & Templeton, A. (2005). Surgical abortion using manual vacuum aspiration under local anaesthesia: a pilot study of feasibility and women's acceptability. *Journal of Family Planning and Reproductive Health Care*, 31(3), 185-188.

- Hart, G., & Macharper, T. (1986). Clinical aspects of induced abortion in South Australia from 1970-1984. *The Australian and New Zealand Journal of Obstetrics and Gynaecology*, 26(3), 219-224.
- Heisterberg, L., & Kringelbach, M. (1987). Early complications after induced first-trimester abortion. *ActaObstetriciaEtGynecologicaScandinavica*, 66(3), 201-204.
- Hemlin, J., & Möller, B. (2001). Manual vacuum aspiration, a safe and effective alternative in early pregnancy termination. *ActaObstetricaetGynecologicaScandinavica*, 80(6), 563-567.
- Hodgson, J. E., & Portmann, K. C. (1974). Complications of 10,453 consecutive first-trimester abortions: a prospective study. *American Journal of Obstetrics and Gynecology*, 120(6), 802-807.
- Hu, D., Grossman, D., Levin, C., Blanchard, K., Adanu, R., & Goldie, S. J. (2010). Cost-effectiveness analysis of unsafe abortion and alternative first-trimester pregnancy termination strategies in Nigeria and Ghana. *African Journal of Reproductive Health*, 14(2), 85-103.
- Huezo, C., & Diaz, S. (1993). Quality of care in family planning: clients' rights and providers' needs. *Advances in Contraception*, 9(2), 129-139.
- International Federation of Gynecology and Obstetrics. (2011). *Consensus statement on uterine evacuation*. London, UK: International Federation of Gynecology and Obstetrics.
- Ipas. (2003). *Factsheets on using the pharmaceutical agents mifepristone and misoprostol for abortion care and other pregnancy-related services*. Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas Nigeria, & Society of Gynaecology and Obstetrics of Nigeria (SOGON). (2010). *Notes from the field: Resource needs and considerations for the introduction of misoprostol into existing PAC services. Results of a study conducted by the Society of Gynaecology and Obstetrics of Nigeria and Ipas* (pp. 1-2). Abuja, Nigeria: Ipas Nigeria.
- Ipas Nigeria, & Society of Gynaecology and Obstetrics of Nigeria (SOGON). (2011). *Offering misoprostol as an alternative to manual vacuum aspiration for treatment of incomplete abortion in Nigeria: Lessons from a multi-site introduction*. Abuja, Nigeria: Ipas.
- Jacot, F. R., Poulin, C., Bilodeau, A. P., Morin, M., Moreau, S., Gendron, F., & Mercier, D. (1993). A five-year experience with second-trimester induced abortions: no increase in complication rate as compared to the first trimester. *American Journal of Obstetrics and Gynecology*, 168(2), 633-637.
- Johnson, B. R., Benson, J., Bradley, J., & Ordonez, A. R. (1993). Costs and resource utilization for the treatment of incomplete abortion in Kenya and Mexico. *Social Science & Medicine*, 36(11), 1443-1453. doi: 10.1016/0277-9536(93)90386-i
- Joint study of the Royal College of General Practitioners and the Royal College of Obstetricians and Gynaecologists. (1985). Induced abortion operations and their early sequelae. *Journal of the Royal College of General Practitioners*, 35(273), 175-180.
- Jowett, M. (2000). Safe Motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness. *Health Policy*, 53(3), 201-228.
- Kaali, S. G., Csákány, G. M., Szigetvári, I., & Barad, D. H. (1990). Updated screening protocol for abortion services. *Obstetrics and Gynecology*, 76(1), 136-138.
- Kaali, S. G., Szigetvari, I. A., & Bartfai, G. S. (1989). The frequency and management of uterine perforations during first-trimester abortions. *American Journal of Obstetrics and Gynecology*, 161(2), 406-408.

- Karki, C., Pokharel, H., Kushwaha, A., Manandhar, D., Bracken, H., & Winikoff, B. (2009). Acceptability and feasibility of medical abortion in Nepal. *International journal of gynaecology and obstetrics*, 106(1), 39-42. doi: 10.1016/j.ijgo.2009.02.007
- King, T. M., Atienza, M. F., & Burkman, R. T. (1980). The incidence of abdominal surgical procedures in a population undergoing abortion. *American Journal of Obstetrics and Gynecology*, 137(5), 530-533.
- King, T. D. N., Abernathy, M., & Hord, C. (1998a). A guide to assessing resource use in the provision of postabortion care: DataPAC Module 3 *DataPAC Core Questionnaire Series*. Carrboro, NC: Ipas.
- King, T. D. N., Abernathy, M., & Hord, C. (1998b). A guide to using the general information questionnaire for postabortion care patients: DataPAC Module 1. *DataPAC Core Questionnaire Series*.
- Kittiwatanakul, W., & Weerakiet, S. (2012). Comparison of efficacy of modified electric vacuum aspiration with sharp curettage for the treatment of incomplete abortion: randomized controlled trial. *Journal of Obstetrics and Gynaecology Research*, 38(4), 681-685. doi: 10.1111/j.1447-0756.2011.01762.x
- Koontz, S. L., Molina de Perez, O., Leon, K., & Foster-Rosales, A. (2003). Treating incomplete abortion in El Salvador: cost savings with manual vacuum aspiration. *Contraception*, 68(5), 345-351.
- Kulier, R., Cheng, L., Fekih, A., Hofmeyr, G. J., & Campana, A. (2001). Surgical methods for first trimester termination of pregnancy. *The Cochrane Database of Systematic Reviews*, Issue 4.
- Kulier, R., Kapp, N., Gulmezoglu, A. M., Hofmeyr, G. J., Cheng, L., & Campana, A. (2011). Medical methods for first trimester abortion. *Cochrane Database of Systematic Reviews*(11), CD002855. doi: 10.1002/14651858.CD002855.pub4
- Laufe, L. E. (1977). The menstrual regulation procedure. *Studies in Family Planning*, 8(10), 253-256.
- Lindell, G., & Flam, F. (1995). Management of uterine perforations in connection with legal abortions. *Acta Obstetrica Et Gynecologica Scandinavica*, 74(5), 373-375.
- Lukman, H. Y., & Pogharian, D. (1996). Management of incomplete abortion with manual vacuum aspiration in comparison to sharp metallic curette in an Ethiopian setting. *East African Medical Journal*, 73(9), 598-603.
- Macisaac, L., & Darney, P. (2000). Early surgical abortion: an alternative to and backup for medical abortion. *American Journal of Obstetrics and Gynecology*, 183(2 Suppl), S76-83.
- Magotti, R. F., Munjinja, P. G., Lema, R. S., & Ngwalle, E. K. (1995). Cost-effectiveness of managing abortions: manual vacuum aspiration (MVA) compared to evacuation by curettage in Tanzania. *East African Medical Journal*, 72(4), 248-251.
- Mahomed, K., Healy, J., & Tandon, S. (1994). A comparison of manual vacuum aspiration (MVA) and sharp curettage in the management of incomplete abortion. *International Journal of Gynecology & Obstetrics*, 46(1), 27-32.
- Mamers, P. M., Lavelle, A. L., Evans, A. J., Bell, S. M., Rusden, J. R., & Healy, D. L. (1997). Women's satisfaction with medical abortion with RU486. *Medical Journal of Australia*, 167(6), 316-317.
- Management Sciences for Health (MSH). (1997). Using evaluation as a management tool. *The Family Planning Manager*, 6(1).
- Marshall, B. R. (1971). Emergency room vacuum curettage for incomplete abortion. *Journal of Reproductive Medicine*, 6(4), 177-178.
- McInerney, T., Baird, T. L., Hyman, A. G., & Huber, A. B. (2001). *Guide to Providing Abortion Care*. Chapel Hill, NC: Ipas.
- Muffley, P. E., Stitely, M. L., & Gherman, R. B. (2002). Early intrauterine pregnancy failure: a randomized trial of medical versus surgical treatment. *American journal of obstetrics and gynecology*, 187(2), 321-325; discussion 325-326.

- Nanda, K., Lopez, L. M., Grimes, D. A., Pelligia, A., & Nanda, G. (2012). Expectant care versus surgical treatment for miscarriage. *Cochrane Database of Systematic Reviews*, 3, CD003518.
- Nathanson, B. N. (1972). Ambulatory abortion: experience with 26,000 cases (July 1, 1970, to August 1, 1971). *New England Journal of Medicine*, 286(8), 403-407. doi: 10.1056/NEJM197202242860805
- Neilson, J. P., Gyte, G. M., Hickey, M., Vazquez, J. C., & Dou, L. (2010). Medical treatments for incomplete miscarriage (less than 24 weeks). *Cochrane Database of Systematic Reviews*, 20(1), CD007223. doi: 10.1002/14651858.CD007223.pub2
- Ngoc, N. T., Blum, J., Westheimer, E., Quan, T. T., & Winikoff, B. (2004). Medical treatment of missed abortion using misoprostol. *International journal of gynaecology and obstetrics*, 87(2), 138-142.
- Ngoc, N. T. N., Winikoff, B., Clark, S., Ellertson, C., Am, K. N., Hieu, D. T., & Elul, B. (1999). Safety, efficacy and acceptability of mifepristone-misoprostol medical abortion in Vietnam. *International Family Planning Perspectives*, 25(1), 10-33.
- Ngoc, T. N., Blum, J., Durocher, J., Quan, T. T., & Winikoff, B. (2005). A randomized controlled study comparing 600 versus 1,200 microg oral misoprostol for medical management of incomplete abortion. *Contraception*, 72(6), 438-442. doi: 10.1016/j.contraception.2005.05.010
- Niinimäki, M., Suhonen, S., Mentula, M., Hemminki, E., Heikinheimo, O., & Gissler, M. (2011). Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. *BMJ*, 342, d2111.
- Otsea, K., Benson, J., Measham, D., Thorley, M., & Lidh, R. (1999). *Monitoring postabortion care: Technical resources for postabortion care* (Vol. 3). Carrboro, NC: Ipas.
- Paul, M. E., Mitchell, C. M., Rogers, A. J., Fox, M. C., & Lackie, E. G. (2002). Early surgical abortion: efficacy and safety. *American Journal of Obstetrics and Gynecology*, 187(2), 407-411.
- Pauleta, J. R., Clode, N., & Graça, L. M. (2009). Expectant management of incomplete abortion in the first trimester. *International Journal of Gynecology and Obstetrics*, 106(1), 35-38.
- Peretz, A., Grunstein, S., Brandes, J. M., & Paldi, E. (1967). Evacuation of the gravid uterus by negative pressure (suction evacuation). *American Journal of Obstetrics & Gynecology*, 98(1), 18-22.
- Phelps, R. H., Schaff, E. A., & Fielding, S. L. (2001). Mifepristone abortion in minors. *Contraception*, 64(6), 339-343.
- Practice, C. o. G. (2009, reaffirmed in 2011). ACOG Committee Opinion No. 434: induced abortion and breast cancer risk. *Obstetrics & Gynecology*, 113(6), 1417-1418. doi: 10.1097/AOG.0b013e3181ac067d
- Reproductive Health Technologies Project, & Gynuity Health Projects. (2003). *Instructions for use: Abortion induction with misoprostol (Cytotec®) in pregnancies up to 9 weeks LMP*. Washington, DC: Reproductive Health Technologies Project and Gynuity Health Projects.
- Royal College of Obstetrics and Gynecology. (2011). *The care of women requesting induced abortion: Evidence-based guideline no. 7*. London, UK: RCOG Press.
- Schulz, K. F., Grimes, D. A., & Cates, W. (1983). Measures to prevent cervical injury during suction curettage abortion. *Lancet*, 1(8335), 1182-1185.
- Schüler, L., Pastuszak, A., Sanseverino, T. V., Orioli, I. M., Brunoni, D., Ashton-Prolla, P., . . . Koren, G. (1999). Pregnancy outcome after exposure to misoprostol in Brazil: a prospective, controlled study. *Reproductive Technology*, 13(2), 147-151.
- Shwekerela, B., Kalumuna, R., Kipingili, R., Mashaka, N., Westheimer, E., Clark, W., & Winikoff, B. (2007). Misoprostol for treatment of incomplete abortion at the regional hospital level: results from Tanzania. *British Journal of Obstetrics and Gynecology*, 114(11), 1363-1367. doi: 10.1111/j.1471-0528.2007.01469.x

- SOGON, I. N. a. (2011A). Offering misoprostol as an alternative to manual vacuum aspiration for treatment of incomplete abortion in Nigeria: Lessons from a multi-site introduction. Abuja, Nigeria.
- Sotiriadis, A., Makrydimas, G., Papatheodorou, S., & Ioannidis, J. P. (2005). Expectant, medical, or surgical management of first-trimester miscarriage: a meta-analysis. *Obstetrics and Gynecology*, 105(5 Pt 1), 1104-1113.
- Stewart, F. H., Weitz, T. A., Wilcox, N., & Tracey, J. (2002). *Abortion provider training manual*. San Francisco, CA: UCSF Center for Reproductive Health Research and Policy.
- Stubblefield, P. G., Carr-Ellis, S., & Borgatta, L. (2004). Methods for induced abortion. *Obstetrics and Gynecology*, 104(1), 174-185. doi: 10.1097/01.AOG.0000130842.21897.53
- Tang, O. S., & Ho, P. C. (2006). The use of misoprostol for early pregnancy failure. *Current Opinion in Obstetrics and Gynecology*, 18(6), 581-586.
- Tang, O. S., Lau, W. N., Ng, E. H., Lee, S. W., & Ho, P. C. (2003). A prospective randomized study to compare the use of repeated doses of vaginal with sublingual misoprostol in the management of first trimester silent miscarriages. *Human Reproduction*, 18(1), 176-181.
- Tang, O. S., Ong, C. Y., Tse, K. Y., Ng, E. H., Lee, S. W., & Ho, P. C. (2006). A randomized trial to compare the use of sublingual misoprostol with or without an additional 1 week course for the management of first trimester silent miscarriage. *Human Reproduction*, 21(1), 189-192.
- Tasnim, N., Mahmud, G., Fatima, S., & Sultana, M. (2011). Manual vacuum aspiration: a safe and cost-effective substitute of electric vacuum aspiration for the surgical management of early pregnancy loss. *Journal of the Pakistan Medical Association*, 61(2), 149-153.
- Thonneau, P., Fougereyrollas, B., Ducot, B., Boubilley, D., Dif, J., Lalande, M., & Soulat, C. (1998). Complications of abortion performed under local anesthesia. *European Journal of Obstetrics, Gynecology, and Reproductive Biology*, 81(1), 59-63.
- Trinder, J., Brocklehurst, P., Porter, R., Read, M., Vyas, S., & Smith, L. (2006). Management of miscarriage: expectant, medical, or surgical? Results of randomised controlled trial (miscarriage treatment (MIST) trial). *BMJ*, 332(7552), 1235-1240.
- Tunçalp, O., Gülmezoglu, A. M., & Souza, J. P. (2010). Surgical procedures for evacuating incomplete miscarriage. *Cochrane Database Systemic Review*(9), CD001993. doi: 10.1002/14651858.CD001993.pub2
- United Nations Children's Fund. (1997). *Guidelines for monitoring the availability and use of obstetric services*. New York, NY: United Nations Children's Fund (UNICEF).
- Velazco, A., Varela, L., Tanda, R., Sánchez, C., Barambio, S., Chami, S., Carbonell, J. L. (2000). Misoprostol for abortion up to 9 weeks' gestation in adolescents. *European Journal of Contraception and Reproductive Health Care*, 5(4), 227-233.
- Velázquez, J. F., Wrooman, E., Cuevas, R. P., Flores, B. O., & Pérez, A. C. (2001). Evaluación de la introducción de aspiración manual endouterina en hospitales del IMSS. *Revista Médica del IMSS*, 39(5), 393-401.
- Warriner, I. K., Meirik, O., Hoffman, M., Morroni, C., Harries, J., My Huong, N. T., Seuc, A. H. (2006). Rates of complication in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: a randomised controlled equivalence trial. *Lancet*, 368(9551), 1965-1972. doi: 10.1016/s0140-6736(06)69742-0
- Weeks, A., Alia, G., Blum, J., Winikoff, B., Ekwaru, P., Durocher, J., & Mirembe, F. (2005). A randomized trial of misoprostol compared with manual vacuum aspiration for incomplete abortion. *Obstetrics and Gynecology*, 106(3), 540-547. doi: 10.1097/01.AOG.0000173799.82687.dc
- Westfall, J. M., O'Brien-Gonzales, A., & Barley, G. (1998). Update on early medical and surgical abortion. *Journal of Women's Health*, 7(8), 991-995.

- Westfall, J. M., Sophocles, A., Burggraf, H., & Ellis, S. (1998). Manual vacuum aspiration for first-trimester abortion. *Archives of family medicine*, 7, 559-562.
- Wieringa-de Waard, M., Bindels, P. J. E., Vos, J., Bonsel, G. J., Stalmeier, P. F. M., & Ankum, W. M. (2004). Patient preferences for expectant management vs. surgical evacuation in first-trimester uncomplicated miscarriage. *Journal of clinical epidemiology*, 57(2), 167-173.
- Winikoff, B., Ellertson, C., Elul, B., & Sivin, I. (1998). Acceptability and feasibility of early pregnancy termination by mifepristone-misoprostol. Results of a large multicenter trial in the United States. Mifepristone Clinical Trials Group. *Archives of Family Medicine*, 7(4), 360-366.
- Winikoff, B., Sivin, I., Coyaji, K. J., Cabezas, E., Xiao, B., Gu, S., . . . Ellertson, C. (1997). Safety, efficacy, and acceptability of medical abortion in China, Cuba, and India: a comparative trial of mifepristone-misoprostol versus surgical abortion. *American Journal of Obstetrics and Gynecology*, 176(2), 431-437.
- World Health Organization. (1994). *Clinical management of abortion complications: a practical guide*. Geneva, Switzerland: World Health Organization (WHO).
- World Health Organization. (2003). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors*. Geneva, Switzerland: World Health Organization (WHO).
- World Health Organization. (2007). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors Integrated management of pregnancy and childbirth (IMPAC)* (Second ed.). Geneva, Switzerland: World Health Organization (WHO).
- World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems*, (Second Edition ed.). Geneva, Switzerland: World Health Organization (WHO).
- Zhang, J., Gilles, J. M., Barnhart, K., Creinin, M. D., Westhoff, C., & Frederick, M. M. (2005). A comparison of medical management with misoprostol and surgical management for early pregnancy failure. *New England Journal of Medicine*, 353(8), 761-769.

Knowledge Test Key

- P**
1. c
 2. b
 3. b
 4. b
 5. d

Uterine Evacuation Methods Knowledge Test

Circle the correct response.

1. Which of the following is not a method of uterine evacuation?
 - a. Medical methods
 - b. Sharp curettage
 - c. Endometrial biopsy
 - d. Vacuum aspiration
2. WHO-recommended methods for uterine evacuation in the first trimester are:
 - a. Dilatation and curettage and vacuum aspiration
 - b. Vacuum aspiration, medical methods and expectant management (for incomplete abortion)
 - c. Sharp curettage and dilatation and curettage
 - d. Dilatation and evacuation, medical methods and expectant management (for incomplete abortion)
3. Which uterine evacuation method has the highest clinical efficacy?
 - a. Mifepristone and misoprostol
 - b. Vacuum aspiration
 - c. Misoprostol only
 - d. Expectant management
4. Use of a certain method of uterine evacuation depends on all of the following except for:
 - a. Staff skills
 - b. Preference of the woman's family members
 - c. Equipment, supplies and drugs available
 - d. The woman's clinical condition
5. In a facility without an anesthetist or reliable electricity, a good solution for providing uterine evacuation services might be to:
 - a. Refer women to the nearest traditional abortion provider.
 - b. Raise funds locally to hire an anesthetist.
 - c. Buy an EVA machine and work with the electric company to bring electricity to the facility.
 - d. Use MVA or medical methods with appropriate pain management.

Uterine Evacuation Methods

Uterine Evacuation Method	Description	Safety and Effectiveness	Cost	Acceptability to Women
Vacuum Aspiration: MVA				
Vacuum Aspiration: EVA				
Medical Abortion with Mifepristone and Misoprostol				
Medical Abortion with Misoprostol Only				
Misoprostol for Incomplete Abortion				
Expectant Management				

Transitioning to MVA and Medical Methods

For induced abortion and/or treatment of incomplete abortion

Manual Vacuum Aspiration (MVA)		
Considerations	Transition Issues	Solutions
Cost		
Safety and Efficacy		
Acceptability to Women, Including Young Women		
Acceptability to Staff: <ul style="list-style-type: none"> • Anesthetists • Doctors • Midlevel providers • Other workers 		
Staff Training		
Other Considerations		
Medical Methods with Mifepristone and Misoprostol or Misoprostol Only (Circle the regimen that will be used in your facility and complete accordingly)		
Cost		
Safety and Efficacy		
Acceptability to Women, Including Young Women		
Acceptability to Staff: <ul style="list-style-type: none"> • Anesthetists • Doctors • Midlevel providers • Other workers 		
Staff Training		
Other Considerations		

Monitoring to Improve Services



Purpose:

This module covers the importance of monitoring abortion-related services to improve quality and ensure they are satisfactory to both clients and health-care workers. It also reviews the general components of a monitoring system.



Prerequisites:

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights in the abortion-care setting



Objectives:

By the end of this module, participants should be able to:

1. Describe monitoring, including adverse event monitoring and reporting, and its importance in improving abortion-related services
2. Identify characteristics of effective monitoring systems
3. Describe indicators, information sources and methods of gathering information
4. Describe the general steps for establishing a monitoring system for abortion-related services



Materials:

- ☐ Monitoring Scenario
- ☐ Monitoring Abortion-Related Services worksheet
- ☐ COPE® for CAC handbook (Can be downloaded at: www.engenderhealth.org/files/pubs/qi/cope-for-abortion-care.pdf)
- ☐ Knowledge Test and Test Key



Advance preparation:

- ☐ Label flipchart: Monitoring.

- ☐ Be familiar with any monitoring practices in the participants' facilities.
- ☐ Be prepared with examples of monitoring for abortion-related services.
- ☐ Make copies of Monitoring Scenario, Monitoring Abortion-Related Services worksheet and Knowledge Test.

Time: 1 hour

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

- This module covers the importance of monitoring abortion-related services to improve quality and ensure they are satisfactory to both clients and health-care workers. It also reviews the general components of a monitoring system.

Show slide: *Objectives*

By the end of this module, participants should be able to:

1. Describe monitoring, including adverse event monitoring and reporting, and its importance in improving abortion-related services
2. Identify characteristics of effective monitoring systems
3. Describe indicators, information sources and methods of information gathering
4. Describe the general steps for establishing a monitoring system for abortion-related services

Say: What do you think of when you hear the word "monitoring"? What words or phrases come into your mind?

- Write responses on the flipchart.
- Ask participants what they notice about the responses.
- Affirm that people may not fully understand or appreciate monitoring.
- Tell the group that, by the end of this module, you hope they will appreciate the importance of monitoring and feel positive about their role in monitoring services to improve them.

Show and discuss slide: *What Is Monitoring?*

- Examining all aspects of care, including client satisfaction
- Tracking services over time to identify strengths and weaknesses
- Using data to provide feedback and make adjustments to improve quality

- An ongoing process

Say: Who can give an example of a monitoring process in which they have been involved?

- Take one or two responses.

Show and discuss slide: *Why Is Monitoring Important?*

- Indicates if services are effective or need improvement
- Provides information that impacts service delivery and policies
- Improves services for clients and workers
- Assesses if changes achieve desired effects
- Keeps abortion-related services operating at a high standard

Say: Monitoring can range from simple and inexpensive to more complex, formalized approaches. A simple approach may be for providers to monitor a few of their own service delivery indicators, while more formalized approaches usually involve assessment and monitoring across a wide range of service delivery components. One of the more formal monitoring approaches is COPE® for Comprehensive Abortion Care (CAC), which is an ongoing quality improvement process and set of tools used by health-care staff to proactively and continuously assess and improve the quality of CAC they provide. There are many other effective approaches as well.

Note to trainer: Have a copy of COPE for CAC handbook on display for participants to review.

Say: Who can give an example of changes they have observed that have resulted from monitoring?

Take one example.

Show and discuss slide: *Effective Monitoring*

- Is integrated into routine work
- Uses simple indicators
- Is participatory and open
- Is conducted ethically
- Is not punitive
- Includes recipients of the services, including young women, in the entire process

Say: Monitoring can be used to reward staff and increase morale. Managers can use creative incentives in monitoring to promote changes in behavior. Monitoring should never be coercive.

Show and discuss slide: *Monitoring Is a Continuous Process*

Say: What information are you currently collecting about your services that could be used for monitoring?

- Take two responses.

Ask participants for examples of how they currently monitor services in their facility.

- Examples may include:
 - Gathering information from log books
 - Reviewing medical records
 - Assessing inventory of supplies and equipment
 - Talking with clients

Say: Compiling and assessing this information helps to determine where services are effective and where they need improvement.

- Point out that monitoring is a critical component of high-quality service delivery.

Show slide: *Adverse Events*

- Complications a woman has during care that are not a result of a disease
- Rare in routine abortion-related care
- Important to monitor because each event offers the opportunity to learn how to improve care

Say: Adverse events monitoring and reporting will be covered further in the Complications module. We will now discuss the basic steps of effective monitoring.

2. Steps of effective monitoring

Show slide: *Monitoring Includes All Health-Care Staff*

Distribute and ask participants to read the Monitoring Scenario about a clinic's monitoring program.

- Ask them to identify the main steps taken to develop the monitoring program.

Say: What main steps did the committee take to establish the monitoring system?

- Planning
- Information gathering
- Analysis
- Action planning

Distribute Monitoring Abortion-Related Services worksheet.

Tell participants that each step of effective monitoring will be discussed.

Tell participants to think about the considerations in the worksheet as each step is discussed:

- People that should be involved
- Specific considerations for participants' facilities
- Potential implementation challenges
- Solutions to challenges

Show and discuss slide: *Planning*

- Monitoring team = staff and recipients of services, including young women
- How team members will be trained
- Aspects of services to be monitored
- Quality standards and indicators to measure them
- Sources of information (service data logbooks and client records)

Show slide: *Planning (cont.)*

- Methods for gathering information (interviews, focus groups, observation and records review)
- Checklists and other tools to guide observations, interviews and records review
- A plan for sharing results with staff and the community, and improving services, if needed
- A timeline for the monitoring process, including activities and persons responsible

In the Monitoring Scenario we read earlier, what planning steps did the clinic director and committee take?

- Responses should include:
 - Formed a committee
 - Appointed a person to collect information
 - Determined information sources
 - Informed staff and clients; invited suggestions

Ask participants to complete the first row of the Monitoring Abortion-Related Services worksheet on the Planning step, specifying who to involve, specific considerations, potential challenges and solutions to challenges in their own settings.

- Ask one participant to explain their responses to the Planning step, and discuss them with the group.

Say: In planning a monitoring system, it is important to consider specific indicators to measure progress.

Show and discuss slide: *Indicators*

- Measurements that help quantify activities and results
- Can help describe the overall quality

Examples:

- Number and type of procedures performed
- Number and type of complications
- Percentage of women desiring contraception who receive methods
- Number of women served by age

Say: It is important to pick indicators that are actually under staff control; otherwise the process can be very demotivating.

Refer participants to the additional indicators listed in Sample indicators for abortion-related services table in the Reference Manual.

Show and discuss slide: *Information Gathering*

- Logbooks, clinical records and supply ledgers, preferably with local analysis
- Periodic observation and client interviews, making sure to seek young women's perspectives
- To measure a change in a specific area of service delivery, use the same indicator over time
- Monitors should always identify themselves, explain what they're doing and ask her permission to continue
- Ensure privacy and confidentiality; never include unique identifying information on data forms

Remind participants that Appendices A and B in the Monitoring to Improve Services module in the Reference Manual provide examples of written consent forms.

Say: In the monitoring scenario, what information-gathering steps did the monitoring committee take?

- Responses should include:
 - Reviewed the clinic logbooks monthly
 - Reviewed a sample of medical charts quarterly
 - Put a suggestion box in the clinic for employees and clients

Say: Another way to gather information is to evaluate performance using checklists. The skills checklists from this curriculum, which can be adapted to reflect local protocols or to emphasize local concerns, can be used by monitoring teams to assess performance on many aspects of abortion-related care.

Note to trainer: Hold up the MVA Skills Checklist from the Uterine Evacuation Procedure With Ipas MVA Plus module or a different checklist from another module as an example.

Say: Can someone give an example of challenges that might be faced when trying to gather information for monitoring purposes?

- Take a few answers. Answers might include:
 - Lack of buy-in by top officials
 - Fear by staff that their jobs might be jeopardized if they voice concerns
 - One key person who won't cooperate
 - Gathering feedback from low-literacy clients

Briefly discuss ideas for countering these challenges.

Ask participants how they currently collect feedback from low-literacy clients. Refer participants to the text box Low Literacy Client Satisfaction Assessment in the Reference Manual.

Show and discuss slide: *Analysis*

- Compile and review findings
- Discuss strengths and weaknesses of services
- Identify problem areas— what factors contributed?
- Develop improvement plans
- Over time, assess progress in improving care

Say: For example, poor-quality counseling services might stem from inadequate training of newly-hired staff and a client-intake process that leaves insufficient time for counseling. The staff review may also identify causes that are more pervasive—for instance, an underlying belief that counseling is not an important part of services. Staff should also seek input from clients and community members to determine the root cause of a problem or issue.

In the Monitoring Scenario, what analysis steps did the monitoring committee take?

- Responses should include:
 - Compiled information from logbook, chart review and suggestion box
 - Discussed what the information meant

- Determined strong and weak aspects of services

Who can name a few people at your own facility that would be important to involve in the analysis step?

- Answers might include:
 - Administrators, including financial managers
 - Heads of nursing
 - Personnel directors
 - Anyone that might have a decisionmaking role in making changes

Show and discuss slide: *Action Planning*

- Community members, including young women, should be part of action planning
- Start with problems that are relatively easy to fix, given available resources
- Discuss a range of approaches before selecting one
- Draft written plan including timeline
- Specify who is responsible for each step

Show and discuss slide: *Action Planning (cont.)*

- Discuss plan with staff and community members who may help implement
- Present findings and proposed solutions to staff, get feedback
- Share positive findings and improvements with staff and community, when appropriate
- Staff who have helped improve services should be recognized

Show and discuss slide: *Possible Solutions*

- On-the-job training
- Reorganization of services
- Changes to hours of operation
- Changes to supplies procurement
- Strengthened referral systems

Say: In the Monitoring Scenario we read earlier, the monitoring committee made a plan to improve the weaker aspects of services, communicated these plans to the staff and clients, and asked for feedback about how well the improvement plan was working.

Invite participants to use the Monitoring Abortion-Related Services worksheet as a starting place for implementing or improving a monitoring

system at their facilities.

3. Summary and test

Ask participants to name key points from this module. Use the objectives as a reference.

Say: What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Thank participants for their participation.

References

- Adamchak, S., Bond, K., MacLaren, L., Magnani, R., Nelson, K., & Seltzer, J. (2000). *A guide to monitoring and evaluating adolescent reproductive health programs*. Washington, DC: Focus on Young Adults.
- Bruce, J. (1990). Fundamental elements of the quality of care: a simple framework. *Studies in Family Planning*, 21(2), 61-91.
- EngenderHealth. (2003). *COPE® Handbook: A process for improving quality in health services, revised edition*. New York, NY: EngenderHealth.
- EngenderHealth, Ipas, & Reducing Maternal Mortality and Morbidity Project Ghana. (2009). *COPE for comprehensive abortion care services: A toolbook to accompany the COPE® Handbook*. New York, NY: EngenderHealth.
- Garcia-Nunez, J. (1992). *Improving family planning evaluation: A step-by-step guide for managers and evaluators*. West Hartford, CT: Kumarian Press.
- Healy, J., Otsea, K., & Benson, J. (2006). Counting abortions so that abortion counts: Indicators for monitoring the availability and use of abortion care services. *International Journal of Gynecology & Obstetrics*, 95(2), 209-220. doi: 10.1016/j.ijgo.2006.08.002
- Huezo, C., & Diaz, S. (1993). Quality of care in family planning: clients' rights and providers' needs. *Advances in Contraception*, 9(2), 129-139.
- Ipas. (2006). *Safe Abortion Care (SAC) Toolkit*. Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.
- King, T. D. N., Abernathy, M., & Hord, C. (1998a). A guide to assessing resource use in the provision of postabortion care: DataPAC Module 3 *DataPAC Core Questionnaire Series*. Carrboro, NC: Ipas.
- King, T. D. N., Abernathy, M., & Hord, C. (1998b). A guide to using the general information questionnaire for postabortion care patients: DataPAC Module 1. *DataPAC Core Questionnaire Series*.
- Leonard, A. H., & Winkler, J. (1991). A quality of care framework for abortion care. *Advances in Abortion Care*, 1(1).
- Management Sciences for Health. (1997). Using evaluation as a management tool. *The Family Planning Manager*, 6(1).
- McInerney, T., Baird, T. L., Hyman, A. G., & Huber, A. B. (2001). *Guide to Providing Abortion Care*. Retrieved from <https://venus.ipas.org/library/Fulltext/GuidetoProviding.pdf>
- Otsea, K., Benson, J., Measham, D., Thorley, M., & Lidh, R. (1999). *Monitoring postabortion care Technical resources for postabortion care* (Vol. 3). Carrboro, NC: Ipas.
- United Nations Children's Fund (1997). *Guidelines for monitoring the availability and use of obstetric services*. New York, NY: United Nations Children's Fund.

Knowledge Test Key

1. False
2. True
3. True
4. False
5. True
6. b, a, d, c

Monitoring to Improve Services Knowledge Test

Circle True or False.

1. True or False Monitoring is a random tracking of services conducted occasionally.
2. True or False Monitoring does not need to be expensive or complex.
3. True or False It is possible to use existing sources of information for monitoring.
4. True or False To measure a change in a specific area of service delivery, use different indicators over time.
5. True or False An example of an indicator is the number and type of abortion complications.
6. Put the steps of monitoring in correct order:
 - a. Information gathering
 - b. Planning
 - c. Action planning
 - d. Analysis

Monitoring Scenario

A clinic director decided to put a monitoring system in place. She gathered a committee of clinicians, nurses, administrators and community and youth leaders to lead the process and decide how to monitor their abortion-related services. The committee asked the director to appoint a staff person to review logbooks monthly and medical charts quarterly and to put a suggestion box in the clinic for employees and clients. They informed staff and clients about the plan and invited them to share their suggestions. At the end of the first quarter, the staff person compiled information from the logbook and medical-chart review and from the suggestion box. The committee discussed what the information meant. They identified strengths and made a plan to improve any weaknesses. They communicated these plans to all staff and clients and asked them to give feedback about how well the plan was working.

Monitoring Abortion-Related Services

Steps	People to Involve	Specific Considerations for Your Site	Potential Challenges	Solutions to Challenges
1. Planning				
2. Information Gathering				
3. Analysis				
4. Action Planning				

Informed Consent, Information and Counseling



Purpose:

This module covers essential information women need; voluntary, informed consent and counseling for abortion-related care; and how providers can interact and communicate with women in a respectful, effective manner. It also includes instructions on making appropriate referrals and information on counseling women with special considerations.



Prerequisites:

Participants should already be able to:

- ☐ **P** Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ **P** Describe a woman's rights in the abortion-related care setting



Objectives:

By the end of this module, participants should be able to:

1. Identify the essential information women need about their pregnancy and procedure options
2. Describe the basic elements of abortion-related counseling, including pregnancy options, procedure options, voluntary, informed consent and women's feelings
3. Examine how providers' values, attitudes and empathy impact counseling
4. Discuss provider biases toward women seeking abortion-related care and the importance of separating personal beliefs from professional responsibilities
5. Describe effective communication and counseling techniques
6. Describe how providers should make referrals to other services



Materials:

- ☐ Counseling Skills checklist, two per participant
- ☐ Tape and signs for Four Corners activity
- ☐ Four Corners worksheets (Part A and B), one set for each participant

- ☐ Counseling Referral worksheets
- ☐ Counseling Role Play Scenarios, one per group
- ☐ Counseling Skills Improvement worksheet
- ☐ Knowledge Test and Test Key



Advance preparation:

- ☐ Make copies of checklist, worksheets, scenarios and knowledge test.
- ☐ Post “Strongly Agree,” “Agree,” “Disagree” and “Strongly Disagree” signs around the room at eye level.
- ☐ Select or adapt appropriate role plays for Techniques for Effective Counseling activity.
- ☐ Obtain video(s) in local language, if available, that address counseling for additional module activities.

Time: 3 hours, 30 minutes

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module covers essential information women need, voluntary informed consent and counseling for abortion-related care and how providers can interact and communicate with women in a respectful, effective manner. It also includes instructions on making appropriate referrals and information on counseling women with special considerations.

Show slide: *Objectives*

By the end of this module, participants should be able to:

1. Identify the essential information women need about their pregnancy and procedure options
2. Describe the basic elements of abortion-related counseling, including pregnancy options, procedure options, voluntary, informed consent and women's feelings
3. Examine how providers' values, attitudes and empathy impact counseling
4. Discuss provider biases towards women seeking abortion-related care and the importance of separating personal beliefs from professional responsibilities
5. Describe effective communication and counseling techniques
6. Describe how providers should make referrals to other services

Discuss how, when a woman comes in for abortion-related care, her experience is both physical and emotional.

- Health-care providers should be prepared to offer effective and compassionate interaction, communication, emotional support and, if desired, counseling that focus on the woman's needs.
- Each woman has unique circumstances surrounding her unwanted pregnancy, and she may be experiencing a range of emotions.
- The woman and provider may have different values, social circumstances and cultures, and speak different languages, which can create barriers to understanding. It is the provider's responsibility to recognize and positively address these differences to achieve empathy and understanding.

Discuss how, because many facilities do not have full-time counseling positions, existing staff members can be trained to provide basic abortion-related counseling.

- In cases where clinicians also provide counseling, they must remain mindful that client-counselor dynamics may differ from client-clinician relations.
- Whether or not they have formal counseling responsibilities, clinicians should possess counseling knowledge, an affirming, nonjudgmental attitude and caring and supportive behaviors.

Distribute one Counseling Skills checklist to each participant.

- Acknowledge that participants may or may not already be performing abortion-related counseling in their facilities. Ask participants to assess their current counseling performance with women seeking abortion-related care, or with their health-care clients in general, by checking "yes" if they routinely perform each skill during every counseling session and "no" if they do not.
 - Encourage them to be as honest as possible.
 - Explain that they will not have to share their responses with others.

Once they have finished completing the checklist, ask them to reflect on their responses, which skills they are currently performing well, which they need to improve and how they might improve them.

- Explain that they will work with their completed checklist later in the module.

Show and discuss slide: *How Counseling Can Improve Comprehensive Abortion Care*

- Supports women in exploring their feelings, decisions and coping
- Affirms women's ability to make informed decisions
- Identifies women's special needs

- Improves woman-provider relationships
- Facilitates a more comfortable, less painful procedure
- Creates greater satisfaction

Say: Now that we understand how counseling can improve comprehensive abortion care for both women and providers, let's make sure we know what counseling is and is not.

Post two flipchart papers, one saying "*Counseling Is*" and one saying "*Counseling Isn't*."

Explain to participants that you will read the following phrases one at a time and ask them to state whether they think it belongs in the "*Counseling Is*" or "*Counseling Isn't*" category. Record their answers on the flipchart.

- Giving advice
- Soliciting the woman's thoughts and feelings
- Strictly providing information
- Accepting the woman's perceptions and feelings
- Respecting privacy and confidentiality
- Voluntary
- Focusing on the woman's needs and concerns
- Influencing the woman's attitudes, beliefs and behaviors
- Communicating effectively
- Supporting the woman's decisions

When you have finished the list and participants have given their opinions as to which category each phrase belongs in, show the following slides.

Show and discuss slide: *Counseling Is*

- Soliciting the woman's thoughts and feelings
- Accepting the woman's perceptions and feelings
- Respecting confidentiality
- Voluntary
- Focused on the woman's needs
- Communicating effectively
- Supporting the woman's decisions

Show and discuss slide: *Counseling Isn't*

- Strictly providing information

- Giving advice
- Influencing the woman's attitudes and behaviors

Show and discuss slide: *Definition of Counseling*

- A structured interaction in which a person voluntarily receives emotional support and guidance from a trained person in an environment that is conducive to openly sharing thoughts, feelings and perceptions.

Say: Some women do not routinely access health care. Counseling provides an important opportunity for providers to determine each woman's physical and emotional health needs and address them or make referrals to appropriate services.

Information should be provided to all women. However, it is the woman's choice whether or not to undergo a discussion of her feelings, decisions and situation with the provider.

Show and discuss slide: *Woman-Centered Counseling*

- Structured completely around each woman's unique emotional and physical state, needs and concerns
- No pre-determined script or list of items to be covered and checked off
- Needs are determined by asking open-ended questions
- Woman's needs and responses guide the counseling

Say: Now that we have discussed counseling in general, we will talk about counseling for abortion-related care.

2. Elements of woman-centered, comprehensive abortion care counseling

Say: Woman-centered counseling should be offered to women seeking abortion-related care. But who can provide counseling? And where and how should it take place?

Let's start with the question "Who can provide abortion-related counseling?"

Take several responses.

Show and discuss slide: *Who Can Provide Counseling?*

- Staff members and clinicians with appropriate training and experience

Say: There may not always be a separate counseling room. What are important considerations when determining possible places where counseling might be provided?

Take several responses.

- It is important that the location has auditory and visual privacy and that it is accessible and comfortable for women seeking abortion-related care.

Say: When do you think counseling should take place?

Show and discuss slide: *When Should Counseling Take Place?*

- Before, during and after the procedure
- During a formal counseling session at some point in the visit

Say: What three topics should be offered to the woman for discussion before a uterine evacuation?

Show and discuss slide: *Topics for Discussion Before a Uterine Evacuation*

1. Pregnancy options
2. Procedure options
3. Voluntary, informed consent

Say: Providers should answer any questions the woman has about pregnancy and procedure options and provide the information necessary for her to give voluntary, informed consent. Pregnancy options counseling should not be required or serve as a barrier to receiving abortion-related care, as women have usually carefully considered their options and decisions prior to seeking care. Pregnancy options counseling is not necessary for postabortion care. Ideally, contraceptive counseling and information on available methods should also be provided before the uterine evacuation. It is advisable to discuss contraception together with uterine evacuation options because there may be implications for whether and how certain contraceptive methods are provided.

What do you think voluntary, informed consent means?

Take a few answers. Responses should include:

- Full information on options
- Benefits, risks and alternatives to the procedures discussed
- Free decisionmaking without pressure or coercion

Explain and discuss:

- Voluntary, informed consent should be confirmed by counselors before beginning care or administering any medications.
- Each woman should be given as much time as needed to make her decisions.

Say: What circumstances might limit a woman's ability to give true voluntary, informed consent?

Take a few answers. Responses should include:

- She is under pressure from her partner or family members.
- She has difficulty communicating due to language or disability.
- She has experienced a traumatic event.
- She is in need of emergency care.

Show and discuss slide: *Primary Roles in Abortion-Related Counseling*

- Allow the woman to explore her feelings and affirm them
- Elicit circumstances surrounding the pregnancy that are relevant to her clinical care
- Help the woman clarify her thoughts and decisions about her pregnancy, abortion-related needs and future sexual and reproductive health
- Ensure that the woman receives appropriate answers to her questions and concerns, in language she understands
- Provide referrals to additional services, if necessary
- Help the woman determine who she might go to for social support, if she needs it

Show and discuss slide: *Abortion-Related Care Counseling Challenges*

- Lack of adequate time
- Woman's conflicting feelings and emotional state
- Different cultures, languages
- Provider overwork or "burn out"

Note to trainer: You might include a brief discussion about provider "burn out," which is a common issue when providers are dealing with challenging service delivery circumstances. Participants can share ideas about how to address this problem and, if possible, prevent it.

Show and discuss slide: *Provide Privacy*

Say: What are some ways to ensure a woman's privacy while she is receiving abortion-related care?

Show and discuss slide: *Ensure Privacy*

- Provide counseling where no one else can see or hear (visual and auditory privacy)
- Have others participate only with the woman's permission.

Show and discuss slide: *Ask if She Would Like Her Partner to Be With Her*

Say: What challenges might this picture illustrate?

- Answers might include:
 - The woman might be reluctant to tell the man not to participate even though she doesn't want him there.
 - An angry or hostile partner can pose safety issues for staff and the woman.
 - He might not be her partner but a brother or friend.

Show and discuss slide: *Ensure Confidentiality*

- Inform her that all information is confidential.
- Assure her that information will not be released without her authorization.

Say: Just as privacy and confidentiality are important, there are essential attitudes that providers offering abortion-related counseling should possess to provide high-quality counseling.

Introduce the Four Corners activity.

- Inform participants that this is an activity where they will be speaking from their personal point of view, as well as defending others' views. Encourage participants to respond honestly to get the most out of the activity.

Say: Often, our beliefs about abortion are so engrained that we are not fully aware of them until we are confronted with situations that cause them to rise to the surface or challenge them. This activity helps us identify our own beliefs about abortion as well as understand the issues from other points of view.

Note to trainer: You can adapt the worksheet statements to make them more relevant to participants' settings. If you are training on postabortion care only, you can adapt the statements to specifically address PAC issues.

- Hand each participant a Four Corners worksheet Part A. Instruct them not to write their names on either of their worksheets. Ask them to complete the worksheet and then turn the sheet over.
- Hand each participant a Four Corners worksheet Part B. Ask them to complete the worksheet and then turn the sheet over. If they are a man, instruct them to respond as if they were a woman in that situation.
- Ask participants to turn worksheets A and B face up and place them next to each other. Tell them that Part A asks about their beliefs for women in general, and Part B asks about their beliefs concerning themselves. Ask participants to compare their answers on A versus B.
- Ask the following discussion questions:
 - *What similarities or differences do you see in the beliefs you hold for women in general versus yourself?*
 - *If there are differences, why do you think that is?*

- Take a few comments for a brief discussion. Point out that differences between responses on worksheets A and B can sometimes indicate a double standard. Some people believe that women in general should not be allowed to freely access abortion services, but they should be able to access abortion services if they or a family member need them. Gently encourage participants to consider whether they maintain a double standard for themselves versus women in general and ask them to reflect on this more deeply. Stress the negative impact such double standards can have on the accessibility of abortion services, social stigma on abortion and laws and policies on abortion.
- Ask participants to stand in a circle and crumple their Part A worksheets into a ball and throw them into the middle of the circle. Randomly toss a “ball” back to each participant. Explain that for the remainder of the activity, they will represent the responses on the worksheet they have in their hands. If they got their own worksheet, they should act as though someone else completed it.
- Point out the four signs placed around the room. Tell them they will be discussing a select number of statements from Part A, one at a time.

Note to trainer: This activity will be too long if you try to discuss all, or even most, of the statements. Three statements are normally enough to gain the desired effect from the activity. If participants want to see how the group responded to all of the statements, you can have them move to the four corners for each statement and see how the responses are distributed, but then only discuss a select number of them. Select the statements that will elicit the most important discussion for that audience and setting. You can select the statements in advance or after you have seen how participants responded and where the greatest differences in opinion are.

- Read the first statement out loud. Ask participants to move to the sign that corresponds to the response circled on the worksheet they are holding. Remind participants that they are representing the responses on their worksheets, even if they conflict with their personal beliefs.
- Invite participants to look around the room and note the opinions held by the group. There may be different-sized groups in the four corners, and sometimes all four corners may not be occupied. You can then ask some people to move to another group if the four are not evenly distributed.
- Ask the group under each sign to discuss for two minutes the strongest rationale for why people might hold that opinion.
 - Encourage them to come up with more meaningful reasons that are based on underlying, core values.
 - The Strongly Agree or Strongly Disagree groups should make sure they can differentiate between merely Agree or Disagree and Strongly Agree or Strongly Disagree.
 - Ask each group to appoint a spokesperson to present why people might hold that opinion. Ask the spokespeople to speak convincingly, as though they hold the belief themselves. For example. “I strongly disagree with this statement because ... ”

- Start with the spokesperson under Strongly Agree and proceed in order to Strongly Disagree.
 - Remind participants that the designated spokespeople may or may not personally agree with the opinions they are presenting.
 - Do not allow other groups to comment at this time.
- Read the next statement, and ask participants to move to the sign that corresponds to the response circled on their worksheet. Invite participants to note the opinions held by the group. Redistribute some people if groups are not evenly distributed. Ask groups to select someone who has not yet spoken to be their spokesperson. Reverse the order of the groups' presentations.
- Continue in the same manner for the remaining statement(s).
- Have participants return to their seats. Discuss the activity by asking a few of the following questions:
 - What was it like to represent beliefs about abortion that were different from your own?
 - What was it like to hear your beliefs represented by others?
 - What rationale for certain beliefs caused you to think differently?
 - What are your general impressions about the beliefs held by the people in this room (but not by any particular individual)?
 - What is your sense of the underlying, core values that inform these beliefs?
 - How do our beliefs about abortion affect societal stigma or acceptance of abortion?
 - What relevance do the beliefs discussed in this activity have for abortion care in our setting or country?
 - Were any of the arguments/rationales presented by the small groups based on women's internationally recognized right to reproductive health care, including safe abortion? If not, what does this say about our understanding of women's right to abortion services?
 - How might our beliefs about abortion affect our provision of abortion-related services?
 - What can we do to ensure that we maintain a professional standard of high-quality abortion care regardless of our personal beliefs?

Note to trainer: When asking the questions about women's rights, you may want to include some information about international agreements or treaties on health and human rights that include the right to safe abortion and whether these treaties were signed or ratified by the country (or countries) represented in your workshop.

Health-care providers or workers may need help with the last question.

Suggestions may include: attend more trainings on how to provide compassionate, nonjudgmental abortion care; ask co-workers for feedback and make improvements accordingly; institute an anonymous client/patient satisfaction evaluation system and make improvements based on feedback; and consider transferring to another clinical specialty if personal beliefs prevent provision or referral to high-quality abortion care.

Say: What questions or comments do you have about the Four Corners activity?

What are some biases that health-care workers may have toward women seeking abortion-related care?

- Health-care workers may have biases against women who:
 - Terminate their pregnancies
 - Have had multiple abortions
 - Have had difficulty using contraception consistently or do not use contraception even though they do not want to become pregnant
 - Have become pregnant while living with HIV
 - Have multiple sexual partners
 - Are young
 - Have been sexually assaulted
 - Are of a different race, religion or sexual orientation
 - Have had an unsafe or illegal abortion

Paraphrase the following points:

- Women of all ages are entitled to high-quality abortion-related care.
- Health-care workers should separate their personal attitudes and biases from their professional responsibilities.
- Negative biases affect women's trust in providers and reduce the likelihood that they will seek care from them.

Refer participants to Ipas's *Abortion attitude transformation: A values clarification toolkit for global audiences* for more on values, attitudes and professional responsibilities.

Say: Empathy is an important component of high-quality, abortion-related care. Empathy is the ability to understand another person's feelings from their point of view and to communicate this understanding to the person. Empathy does not mean feeling sorry for the person.

Show slide: *The Empathetic Provider*

- Listens actively
- Is genuine

- Seeks to understand the woman's feelings from her viewpoint
- Shows caring
- Responds honestly
- Is friendly and helpful

Say: Women are entitled to empathetic abortion-related counseling and services. Now we will explore techniques for effective counseling.

3. Techniques and plans for effective counseling

Ask participants to take five minutes to read the section of the Reference Manual on effective communication.

Ask participants to think of a time when they were having a serious, private conversation, and they did not feel that the other person was listening carefully to them.

- What about the person's verbal and nonverbal communication made you feel that they were not listening well?
 - For each participant's response, encourage them to provide a brief, specific example.
- Answers may include:
 - Made assumptions about me and what I was trying to say
 - Focused on their own concerns rather than mine
 - Indicated their lack of interest through nonverbal cues (yawning, acting distracted)
 - Asked only closed-ended questions
 - Did not maintain eye contact
 - Interrupted or spoke over me
 - Misunderstood my words
 - Did not pay attention to my nonverbal cues
 - Did not check back to make sure that I understood
 - Allowed interruptions (telephone calls, people interrupting)

Ask participants to think of a time when they were having a serious, private conversation, and they felt that the other person was actively listening to them.

- What about the person's verbal and nonverbal communication made you feel that they were actively listening?
 - For each participant's response, encourage them to provide a brief, specific example.
- Answers may include:

- Stayed attentive
- Focused on my needs
- Used nonverbal cues to convey interest (faced me, leaned slightly forward, nodded head, used appropriate physical contact)
- Asked open-ended questions
- Used encouraging words ("yes," "go on," "tell me more")
- Paid close attention while listening for the underlying meaning
- Observed my nonverbal cues
- Followed up with appropriate feedback to encourage me to explore my feelings

Show slide: *Active Listening*

- Is more than just hearing
- Uses multiple senses to gather information, convey understanding and encourage communication
- Avoids dismissive phrases

Say: *What is an example of a dismissive phrase?*

- Answers may include "don't worry," "you'll feel better soon" and "everything will be fine." These are responses that can feel like the listener is dismissing the seriousness of the person's concerns.

Show slide: *Verbal Communication*

- Talking and active listening with encouraging phrases
- Using open-ended questions to encourage more communication
- Reflecting understanding of feelings

Ask participants to give an example of each.

Show slide: *Nonverbal Communication*

- Body gestures
- Facial expressions

Ask participants to give an example of each.

Show slide: *Effective Communication*

- Stay attentive.
- Use nonverbal cues to convey concern.
- Ask open-ended questions.
- Use encouraging words.

Show slide: *Effective Communication (cont.)*

- Pay close attention to the woman's spoken words.
- Observe her nonverbal cues.
- Help her explore her feelings.
- Use medical language in a manner she understands.

Show slide: *Communicate Effectively*

Emphasize that this is a brief overview of effective communication techniques. It is similar to the GATHER technique that many people may be familiar with. See Additional Training Resources for more information.

- Encourage participants to review the Reference Manual for greater detail.

Say: Women may experience many different emotions while receiving abortion-related care. A provider should never make assumptions or judgments about how a woman may feel.

- Ask participants what feelings women may have about their pregnancy.
 - Possible feelings may include: joy, hope, uncertainty, fear, sadness, disappointment, guilt, desperation, relief or other feelings.
- Ask participants what feelings women may have about having an abortion.
 - Like with pregnancy, possible feelings may include: joy, hope, uncertainty, fear, sadness, disappointment, guilt, desperation, relief or other feelings. Women may experience any number of different feelings. There is no correct way for women to feel about pregnancy and abortion. Providers should affirm and support women's feelings.

Say: Now we will discuss some of the contents of abortion-related counseling.

When a woman requests an abortion, she has usually already considered her options and made her decision. However, if the woman asks for more information about her options, the provider can review this with her.

Show slide: *Options*

- Continue the pregnancy to term
 - Parent
 - Release the child for adoption
- Terminate the pregnancy

Explain that once the woman has firmly decided, without coercion, to terminate the pregnancy, the provider can discuss the following information.

P Show slide: *Information Surrounding Decision to Terminate*

- Confidentiality of care
- Length of pregnancy
- Uterine evacuation methods available
- Pain medications available
- Any other tests that may be done
- If applicable, fetal anomalies or other medical indications detected
- Permission to treat a complication if necessary

Show slide: *Obtain Informed Consent*

Explain that for the purpose of informed consent, providers should always review the woman's medical condition and her options, including the benefits, risks and alternatives of each.

Show slide: *Procedure Choice*

- Differences between methods
- What will be done during and after the procedure
- What she is likely to experience
- How long it will take
- Which pain management options she can choose
- Expected effects, side effects, risks and potential complications
- Aftercare and follow up, if needed

Refer participants to the Uterine Evacuation Methods module of the Reference Manual for more details on vacuum aspiration and medical methods. There is a chart comparing the methods that can be reviewed with women during counseling.

Say: When a woman's counseling needs exceed the resources of the provider or facility, the provider should refer the woman to additional counseling or other services.

Ask participants the following questions and record answers on a flipchart.

- What are some examples of when a provider might need to make a referral for other services?
- What are some ways to determine referral needs and resources?
- What are some ways to develop a referral protocol and system?

Refer to the Reference Manual for more information on making referrals.

Show slide: *Provide Referrals*

Hand out one Counseling Referral worksheet to each participant.

- Instruct participants to complete the worksheets when they return to their facilities.
- Tell them they can use these worksheets to develop counseling referral protocols.

Show slide: *Closing a Counseling Session*

- Summarize key concepts.
- Ask the woman for any additional questions.
- Ensure that the woman understands important clinical and other information.
- Provide written instructions or referrals.

Show slide: *Considerations for Postabortion Care*

- Counseling and informed consent may need to be deferred until after the woman is stabilized and able to comprehend and communicate.
- As with all abortion-related care, women have a right to privacy and confidentiality.
- Providers should be able to respond to questions about safe, legal abortion and where women can access such services.
- Providers should consider that this may have been a wanted pregnancy.

In what situations should counseling and informed consent be deferred?

- Answers should include:
 - In cases of shock or other life-threatening conditions, a complete clinical assessment and voluntary, informed consent may be deferred until after the woman is stabilized.
 - If a woman is in extreme pain or emotional distress, counseling should be offered when she is stable and able to comprehend and communicate.

Say: In a legally restrictive environment, women who have self-induced or obtained a clandestine abortion may be particularly fearful that information will be reported to authorities. Providers should inform the woman that medical and personal information will not be released without her voluntary authorization, except when it is specifically legally required. Providers are not usually required to report abortions to authorities.

You will now have an opportunity to practice techniques for counseling women seeking abortion-related care through the following role plays.

Divide participants into groups of three.

- Give each group a copy of the Counseling Role Play scenarios and a

Counseling Skills checklist.

- Ask participants to review the Counseling Skills checklist before beginning.
- Assign a scenario to each group.

P If training in postabortion care only, trainers will need to select appropriate Counseling Role Play scenarios.

- In each group, one person will play the role of the woman, another will play the role of the provider offering counseling and the third will be the observer.
 - The provider and the woman will role play for 15 minutes, while the observer evaluates the role play using the Counseling Skills checklist.
 - At the end of the role play, within each small group, the provider will give feedback on counseling skills they felt they performed well and areas for improvement. The woman and then the observer will then use the checklist to give feedback to the provider.

After 20 minutes, re-assemble participants into one large group and choose the three most-skilled participants to demonstrate their role play for the whole group. Process the activity with the following questions:

- What were the key counseling issues in the scenarios?
- What counseling skills did the provider perform well?
- What are some challenges of providing effective abortion-related counseling?

Explain that participants will now complete Counseling Skills Improvement Plans.

- Instruct participants to take out the counseling self-assessment that they conducted on their Counseling Skills checklists at the beginning of the module.
 - Give each participant a Counseling Skills Improvement worksheet.
- For each area of counseling skills on the worksheet, ask them to identify the desired skills and practices, improvements needed and plans for improvement.
- Allow 10 minutes for participants to complete the worksheets. Ask them to follow up with these improvement plans once they are back at their facilities.

4. Summary and test

Ask participants for key points covered in this module. Use the objectives as a guide.

What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Thank the participants for their participation.

References

American College of Obstetricians and Gynecologists. (2008). *Female genital cutting: Clinical management of circumcised women, second edition*. Washington, DC: American College of Obstetricians and Gynecologists (ACOG).

Baker, A., & Beresford, T. (2009). Informed consent, patient education, and counseling. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes & P. G. Stubblefield (Eds.), *A clinician's guide to medical and surgical abortion*. New York, NY: Churchill Livingstone.

Cameron, S. T., & Glasier, A. (2012). Identifying women in need of further discussion about the decision to have an abortion and eventual outcome. *Contraception*.

Caralis, P. V., & Musialowski, R. (1997). Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *South African Medical Journal*, 90(11), 1075-1080.

Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: Origins, evolution and future directions. *International Family Planning Perspectives*, 29(3), 106-111.

De Bruyn, M. (2003). *Violence, pregnancy and abortion: Issues of women's rights and public health, second edition*. Chapel Hill, NC: Ipas.

EngenderHealth. (1999). *Counseling the postabortion patient: Training for service providers*. New York, NY: EngenderHealth.

Family Health International. (2003). *Reproductive health of young adults: Contraception, pregnancy and sexually transmitted diseases*. Research Triangle Park, NC: Family Health International.

Gallo, M. F., & Nghia, N. C. (2007). Real life is different: A qualitative study of why women delay abortion until the second trimester in Vietnam. *Social Science & Medicine*, 64(9), 1812-1822. doi: 10.1016/j.socscimed.2007.02.005

Gardner, R., & Blackburn, R. (1997). People who move: new reproductive health focus. *Population Reports, Series J*(45), 1-27.

Hall, J. A., Roter, D. L., & Katz, N. R. (1988). Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care*, 26(7), 657-675.

Harries, J., Orner, P., Gabriel, M., & Mitchell, E. (2007). Delays in seeking an abortion until the second trimester: A qualitative study in South Africa. *Reproductive Health*, 4, 7.

- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Johns Hopkins School of Public Health. (1999). Pullout guide: What health care providers can do about domestic violence. *Population Reports, Series L*(11).
- Kulier, R., Kapp, N., Gulmezoglu, A. M., Hofmeyr, G. J., Cheng, L., & Campana, A. (2011). Medical methods for first trimester abortion. *Cochrane Database of Systematic Reviews*(11), CD002855. doi: 10.1002/14651858.CD002855.pub4
- Lansdown, G., & UNICEF. Innocenti Research Centre. (2005). *The evolving capacities of the child*. Florence, Italy: Save the Children: UNICEF.
- McIntyre, J. (1999). *HIV in pregnancy: A review*. Geneva, Switzerland: UNAIDS.
- Paul, M., Grimes, D. A., Lichtenberg, E. S., Borgatta, L., & Stubblefield, P. G. (1999). *A clinician's guide to medical and surgical abortion*. New York, NY: Churchill Livingstone.
- Paul, M. E., Mitchell, C. M., Rogers, A. J., Fox, M. C., & Lackie, E. G. (2002). Early surgical abortion: efficacy and safety. *American Journal of Obstetrics and Gynecology*, 187(2), 407-411.
- Policar, M. S., Pollack, A. E., Nicholas, C., & Dudley, S. (Eds.). (1999). *Principles of abortion care: A curriculum for physician assistants and advanced practice nurses*. Washington, DC: National Abortion Federation.
- PRIME. (1997). *Reproductive health training for primary providers: A sourcebook for curriculum development*. Chapel Hill, NC: INTRAH.
- Rowlands, S. (2008). The decision to opt for abortion. *Journal of Family Planning and Reproductive Health Care*, 34(3), 175-180. doi: 10.1783/147118908784734765
- Royal College of Obstetricians and Gynaecologists. (2004). The care of women requesting induced abortion. *Evidence-based Clinical Guideline*, (No. 7).
- Stewart, F. H., Wells, E. S., Flin, S. K., & Weitz, T. A. (2001). *Early medical abortion: Issues for practice*. Retrieved from <http://bixbycenter.ucsf.edu/publications/files/EMAR.pdf>
- Turner, K. L., Borjesson, E., Huber, A., & Mulligan, C. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas.
- Turner, K. L., & Page, K. C. (2008). *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas.
- United Nations Children's Fund. (2000). Domestic violence against women and girls. *Innocenti Digest*, 6.
- United Nations High Commissioner for Refugees. (1995). *Sexual violence against refugees*. Geneva, Switzerland: United Nations High Commissioner for Refugees.
- Winkler, J., & Gringle, R. E. (1999). *Postabortion family planning: A two-day training curriculum guide for improving counseling and services*. Chapel Hill, NC: Ipas.
- World Health Organization (WHO). (1997). *Post-abortion family planning: A practical guide for programme managers*. Geneva, Switzerland: World Health Organization (WHO).
- World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems* (Second ed.). Geneva, Switzerland: World Health Organization (WHO).
- World Health Organization (WHO). (2013). *Mother-to-child transmission of HIV*. Retrieved from <http://www.who.int/hiv/topics/mtct/en/>

World Health Organization (WHO), & UNAIDS. (2007). *Guidance on provider-initiated HIV testing and counselling in health facilities* Retrieved from <http://www.who.int/hiv/pub/vct/pitc/en/index.html>

Knowledge Test Key

1. False
2. False
3. True
4. False
5. False
6. True
7. b
8. c
9. a
10. d

Counseling - Knowledge Test

Circle True or False.

1. True or False Counseling means providing information to a woman.
2. True or False Providers designated as counselors do not need to be trained in counseling techniques as long as they are sensitive.
3. True or False When possible, counseling should take place before any clinical procedure.
4. True or False Informed decisionmaking occurs before the provider has explained procedure options.
5. True or False Empathy is feeling sorry for a woman.
6. True or False No one else should participate in counseling without the woman's prior permission, including other health-care staff.

7. What is the primary role of the abortion-related care counselor?

- a. To convince the woman about the correct option for unwanted pregnancy.
- b. To help her clarify her feelings, thoughts, questions and decisions and provide support.
- c. To ensure she will never have another abortion.
- d. To give advice about what the counselor would do in her situation.

8. Circle the example below that demonstrates an open-ended question:

- a. Do you understand that all information discussed here is private?
- b. Are there any concerns you have about your care?
- c. How do you feel about the topics we've covered today?
- d. Would you like for me to talk to you during the procedure?

9. A provider should do all of the following when closing a counseling session except:

- a. Repeat all of the information covered during the session.
- b. Ask the woman if she has any additional questions.
- c. Ensure the woman understands the information given.
- d. Provide written or pictorial information or referrals, if appropriate.

10. How might a health-care provider's judgmental attitudes affect a woman?
- a. Decrease the likelihood that the woman will listen to recommendations.
 - b. Reduce her satisfaction with her care.
 - c. Lower the chances that she will seek care from a provider in the future.
 - d. All of the above.

Counseling Skills Checklist

Instructions for self-assessment: Check “yes” or “no” as to whether you routinely demonstrate each skill during your counseling sessions, and write comments.

Instructions for observation: Silently observe and evaluate the counseling session. Do not interact verbally or nonverbally with the woman or the counselor during an observation. Check “yes” or “no” as to whether the provider demonstrated each skill during the counseling session, and write comments. Offer your evaluation and comments to the provider in private after the conclusion of the session.

	Skills	Yes	No	Comments
P	Pregnancy Options			
P	Discusses pregnancy options with woman, if she desires it			
	Voluntary, Informed Consent			
	Provides full information on options			
	Discusses benefits, risks, alternatives and what to expect with each procedure			
	Explores consequences of not receiving abortion-related care			
	Explains details of procedure once method is determined			
	Ensures the woman has understood the information			
	Ensures the woman has given consent without pressure or coercion			
	Obtains consent before the uterine evacuation, unless the woman is in need of emergency care			
	Procedure Options			
	Explains pregnancy and medical information, medical eligibility, available methods and pain management in clear, simple language			
	Encourages her questions and ensures that she understands the information provided			
	Avoids inserting own preferences into discussion			
	Obtains permission to treat the woman in the unlikely event of a complication or emergency			
	Discusses return to fertility post procedure, contraceptive options and when they can be given			
	Counseling			
	Counsels privately where no one else can see or hear			
	Assures her of confidentiality			
	Asks the woman in private whether she wants to invite anyone else in			
	Structures counseling around each woman's needs and concerns			
	Considers woman's individual circumstances, including emotional and physical state, medical condition, cultural and religious background and comprehension			

Demonstrates empathy			
Separates personal values and beliefs from those of the woman			
Provides referrals to additional services if necessary			
Effective Verbal and Non-Verbal Communication			
Faces or sits beside woman without physical barriers between them			
Leans forward slightly and makes appropriate eye contact			
Asks open-ended questions without judgment or assumptions			
Answers the woman's questions fully, using simple language			
Makes appropriate sounds, facial expressions and gestures			
Listens actively by being attentive and focusing on the woman			
Reflects understanding of woman's feelings and concerns			
Confirms that understanding of what woman has said is correct			
Takes into account special considerations			
Referrals			
Refers to other available health services that are needed			
Makes referrals to services that are accessible and appropriate			
Closing a Counseling Session			
Asks woman to summarize key information discussed			
Solicits additional questions			
Ensures the woman understands information and instructions			
Provides written or pictorial information or referrals, if appropriate			
Documents services and referrals in logbook			

P Four Corners, Part A

Instructions

Please read the following statements and circle the answers that best reflect your personal beliefs. Please be honest and do not write your name on this sheet.

SA = Strongly Agree A = Agree D = Disagree SD = Strongly Disagree

1. Abortion services should be available to every woman who wants them.	SA	A	D	SD
2. Women who have an abortion are ending a life.	SA	A	D	SD
3. A woman should be able to have an abortion even if her husband or partner wants her to continue the pregnancy.	SA	A	D	SD
4. Liberal abortion laws lead to more irresponsible sexual behavior.	SA	A	D	SD
5. Young, unmarried girls should be allowed to have an abortion if they want one.	SA	A	D	SD
6. Clinicians who specialize in ob-gyn have a responsibility to perform abortions.	SA	A	D	SD
7. Minors should be required to get their parents' consent in order to have an abortion.	SA	A	D	SD
8. Pregnant women who have HIV/AIDS should be counseled to terminate their pregnancy, even if it is wanted.	SA	A	D	SD
9. Most women do not seriously consider the consequences before having an abortion.	SA	A	D	SD
10. Women should be able to have a second-trimester abortion if they need one.	SA	A	D	SD
11. Women who have second-trimester abortions are indecisive.	SA	A	D	SD
12. Women who have multiple abortions should be encouraged to undergo sterilization.	SA	A	D	SD

Four Corners, Part B

Instructions

Please read the following statements and circle the answers that best reflect your personal beliefs. Please be honest and do not write your name on this sheet. If you are a man, respond as though you were a woman in this situation.

SA = Strongly Agree A = Agree D = Disagree SD = Strongly Disagree

1. Abortion services should be available to me if I want them.	SA	A	D	SD
2. If I had an abortion, I would be ending a life.	SA	A	D	SD
3. I should be able to have an abortion even if my husband or partner wants me to continue the pregnancy.	SA	A	D	SD
4. Liberal abortion laws will lead to me behaving in a more sexually irresponsible way.	SA	A	D	SD
5. If I was young and unmarried, I should be allowed to have an abortion if I wanted one.	SA	A	D	SD
6. If I was a clinician specializing in ob-gyn, I would have a responsibility to perform abortions.	SA	A	D	SD
7. If I was a minor, I should be required to get my parents' consent in order to have an abortion.	SA	A	D	SD
8. If I was pregnant and had HIV/AIDS, I should be counseled to terminate my pregnancy, even if it was wanted.	SA	A	D	SD
9. I would not seriously consider the consequences before having an abortion.	SA	A	D	SD
10. I should be able to have a second-trimester abortion if I need one.	SA	A	D	SD
11. If I had an abortion in the second trimester, it would be because I was being indecisive.	SA	A	D	SD
12. If I had multiple abortions, I should be encouraged to undergo sterilization.	SA	A	D	SD

Counseling Referral

Topic	When to Refer	Where to Refer (agency and staff contact information)
Contraceptive services		
STIs/HIV		
Cervical and other cancers		
Violence		
Mental health		
Substance abuse		
Life skills (employment, finances)		
Chronic reproductive health problems		
Infertility		

P Counseling Role Play Scenarios

Scenario 1

Maria is a 28-year-old woman. She has had two deliveries and three abortions. You are not sure if the previous abortion was spontaneous or induced. Her two children are alive and well. She tells you she doesn't want another baby until next year. She is worried that because of the three abortions, she may never be able to get pregnant again.

Scenario 2

Gita is a 40-year-old woman with six children. She is pregnant and doesn't want another child. She has bruises and burn marks on her chest, back and thighs. Her family does not know she is at your clinic. She is very concerned about getting home soon to complete her chores before her husband returns. Her husband is proud of their large family and wants more children.

Scenario 3

Leila is a 25-year-old woman living with HIV who was treated for a miscarriage. She tells you that this is the third time she has lost a pregnancy in the last five years. Leila's husband is very angry that she has not given him a son yet. He has threatened to send her back to her family if she doesn't have a child soon. Leila is afraid to tell her husband that she is HIV-positive.

Scenario 4

Marianna is a 16-year-old woman who had an MVA abortion last year. She is pregnant again and she tells you she doesn't want to continue the pregnancy. She wants an abortion, but is afraid of having another MVA. She says that she was using the pill when she got pregnant. Her boyfriend, who is a year older, came with her to the clinic for the abortion and is concerned about her health.

Scenario 5

Karen is a 30-year-old commercial sex worker. Her customers refuse to wear condoms and she can't afford contraception. She has had four abortions and doesn't want to go through another one. She lives with another woman who comes with her to the clinic.

Scenario 6

Rebecca is a 21-year-old woman with Down's Syndrome who comes to the clinic with her guardian. She is pregnant from her boyfriend who lives in the same group home. Her guardian says she needs an abortion because she cannot care for a child. Rebecca is not sure exactly how she got pregnant, but is afraid her boyfriend is going to be in trouble somehow for this.

Scenario 7

May is a 14-year-old, unmarried girl who is a refugee in your country. She was raped in the refugee camp and became pregnant. She does not want to continue the pregnancy. Her family doesn't know about the rape or the pregnancy. She can't ask her family for support because they will disown her if they find out she was raped. May wonders if the clinic can help her.

Scenario 8

Grace is a 33-year-old woman who experienced complications from female genital cutting as a pre-adolescent. Because of this, she is very sensitive about her genitals and has avoided being examined by a provider. Now she is at the clinic with symptoms of a miscarriage. She is very apprehensive about anyone examining her vagina.

Counseling Skills Improvement Plan

Instructions: For each area of counseling skills, identify the desired skills and practices, improvements needed and plans for improvement.

P

Skill	Desired Skills and Practices	Improvements Needed	Plans for Improvement
Pregnancy Options			
Voluntary, Informed Consent			
Procedure Options			
Counseling in Abortion-Related Care Setting			
Privacy and Confidentiality			
Values and Empathy			
Active Listening			
Open-ended Questions and Reflecting Feelings			
Non-Verbal Communication			
Referral			
Closing Counseling Session			
Special Considerations			

Contraceptive Services



Purpose

This module discusses why contraceptive counseling and method provision are critical components of comprehensive abortion care. It covers the knowledge, attitudes and skills a provider needs to provide high-quality contraceptive services to women seeking abortion-related care.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights in the abortion-related care setting
- ☐ Demonstrate an understanding of human reproduction
- ☐ Present information about locally available, modern contraceptive methods and their benefits, risks, alternatives, eligibility criteria, use, mechanisms of action and potential side effects
- ☐ Provide or refer women for contraceptive methods
- ☐ Demonstrate effective sexual- and reproductive-health counseling skills



Objectives

By the end of this module, participants should be able to:

1. Identify goals of postabortion contraceptive counseling and method provision
2. Identify several service delivery models
3. Explain long-acting, reversible contraception (LARC) and emergency contraception (EC) and the importance of offering them as options
4. Understand partner involvement in the contraceptive counseling process
5. Describe effective contraceptive counseling techniques
6. Identify women's, including young women's, medical eligibility for contraceptive methods following abortion-related care

7. Identify situations indicating the need for specialized counseling, services and referrals, including for young women



Materials

- ☐ Models of Service Delivery worksheet
- ☐ Contraceptive Counseling Skills checklist
- ☐ Counseling Attitudes Skit script
- ☐ Helping the Woman Choose a Method Skit scripts
- ☐ Role Play Scenarios
- ☐ Contraceptive Method Information worksheet
- ☐ Knowledge Test and Test Key
- ☐ Sample contraceptive methods, including EC, if available
- ☐ Educational materials on contraceptive methods, if available
- ☐ HU/CCP and WHO's *Family planning: A global handbook for providers*, if available (see CD-ROM)



Advance preparation

- ☐ Assess local contraceptive methods and educational materials that are locally available and have them on hand for participants' use in activities.
- ☐ Make copies of worksheets, scripts, scenarios, checklist and knowledge test.
- ☐ Be familiar with local policies about contraception for women of any age.
- ☐ To increase knowledge and facilitate more discussion on LARC methods, especially for young women, see PowerPoint presentation on the curriculum CD-ROM.

Time: 3 hours

1. Introduction

- [P]** Greet the participants. Introduce yourself and the module.
- [P]** Show slide: *Purpose*

This module discusses why contraceptive counseling and method provision are critical components of comprehensive abortion care. It covers the knowledge, attitudes and skills a provider needs to provide high-quality contraceptive services to women seeking abortion-related care.

Show slide: *Objectives*

By the end of the module, participants should be able to:

1. Identify goals of postabortion contraceptive counseling and method provision
2. Identify various service delivery models
3. Explain long-acting, reversible contraception (LARC) and emergency contraception (EC) and the importance of offering them as options
4. Understand partner involvement in the contraceptive counseling process
5. Describe effective contraceptive counseling
6. Identify women's, including young women's, medical eligibility for contraceptive methods following abortion-related care
7. Identify situations indicating the need for specialized, services and referrals, including for young women

Say: International organizations, including the World Health Organization, have recognized that access to contraceptive services constitutes a basic human right and is fundamental to reproductive and sexual health.

Explain that in the International Planned Parenthood Federation's (IPPF) Charter on Sexual and Reproductive Rights, there are two rights that relate to contraception.

Show slide: *Contraception: A Basic Human Right*

The IPPF Charter on Sexual and Reproductive Rights includes:

- The right to decide whether or not to marry and to found and plan a family
- The right to decide whether or when to have children

Say: Lack of access to contraceptive methods hampers women's ability to enjoy these rights.

Explain that you are going to read a story to illustrate an important point.

Ava and her boyfriend are students who also work long hours to pay their tuition. They are very serious about each other but their families do not want them to marry until they finish school and begin their careers. They tried to get contraception at the local health center but were turned away by the nurse who told them that unmarried people should not have sexual relations. They tried at another health center with the same result. Discouraged, they resorted to the withdrawal method. Shortly thereafter, Ava became pregnant. She did not want to have a baby then because she would not be allowed to finish school. She went to a local private provider and had an early medical abortion. The provider did not provide any counseling. When she asked the provider about contraception, he told her to go to a pharmacy or the public health center. Remembering her earlier experiences, she did neither. Six months later, she became pregnant again. She sought another abortion.

Say: What points does this story make about contraceptive services?

It shows the cycle of unwanted pregnancy and multiple abortions. It also shows that judgmental provider attitudes towards women's, especially young women's, sexuality can have dramatic effects on contraceptive access and use and possible subsequent unwanted pregnancy.

Show and discuss slide: *Contraceptive Need*

- Each year, approximately 208 million pregnancies occur worldwide.
- About 41 percent of these are unintended.
- About 21 percent of all pregnancies end in elective, induced abortion.
- Contraceptive availability and use can significantly decrease the rate of abortion.

Say: Offering on-site contraceptive counseling and method provision in the unit where abortion-related care is provided as an integrated part of abortion-related services can improve contraceptive acceptance and help break the cycle of multiple unwanted pregnancies.

All women receiving abortion-related care, regardless of their age, marital status or number of children, should be offered contraceptive services.

Show and discuss slide: *Avoid Assumptions*

- Women seek abortion-related care for many different reasons.
- Providers should not make assumptions about women's reasons for having an abortion or needing postabortion care, whether the pregnancy was wanted, and their desires for future pregnancies.
- Some women want to be pregnant but are terminating this pregnancy for medical or other reasons.
- Women who have had a spontaneous abortion may want to get pregnant again right away.

Show and discuss slide: *Return to Fertility*

How soon after a uterine evacuation can ovulation take place?

Say: Ovulation can take place within 2 weeks after a vacuum aspiration abortion or incomplete abortion, and as early as 8 days after medical abortion with mifepristone and misoprostol. Contraception should be provided immediately to women who want to prevent pregnancy.

A common factor among women receiving abortion-related care is that they are at a critical juncture in their lives and can benefit from compassionate counseling about contraception.

Show and discuss slide: *The Goals of Postabortion Contraceptive Counseling*

- To assist a woman in deciding if she wants to prevent pregnancy in the short or long term, as well as sexually transmitted infections, and help her choose an appropriate method.

An effective provider of contraceptive services focuses on a woman's personal needs, reproductive desires and clinical condition.

Show and discuss slide: *Contraceptive Use*

- Promotes women's health
- Allows women to improve their lives
- Reduces maternal mortality and morbidity

Say: How does contraceptive use promote women's health and rights?

Answers include:

- Allows spacing between pregnancies, which benefits women and couples and their children
- Allows women to be in control of their reproductive health including the number and timing of children
- Helps women avoid unwanted pregnancies and prevents unnecessary exposure to potential risks during pregnancy and delivery

Say: How does contraceptive use reduce maternal mortality and morbidity?

- Contraception helps women avoid unwanted pregnancy and the related risks and potentially unsafe abortion.

2. Components of high-quality contraceptive services

Show and discuss slide: *Service-Delivery Models*

- Counseling offered and methods provided in the unit by staff providing abortion-related care
- Staff from contraceptive services unit provide counseling and methods in unit where abortion-related care is provided
- Counseling offered in unit where abortion-related care is provided and referral for methods
- Women go to another unit or facility for counseling and methods
- Community-based contraceptive counseling and method provision by trained individuals such as village health workers or staff of community-based organizations

Say: Which of these models best facilitates women's access to postabortion contraceptive counseling and methods?

Show and discuss slide: *Preferred Service-Delivery Model*

- Counseling and method provision in the unit is ideal
- Interim methods when methods of choice are not available
- Different cadres of staff can provide contraceptive services

Discuss how counseling offered and method dispensed at the unit where abortion-related care is provided reduces barriers to access and can help ensure that a woman receives a contraceptive methods before leaving the facility. Note that different cadres of staff can and should be trained to provide contraceptive services.

Explain that contraceptive counseling can be offered at various times.

Show and discuss slide: *Timing of Contraceptive Counseling*

- Ideally, before or immediately after the uterine evacuation procedure
- At a follow-up visit, if scheduled

Say: Before uterine evacuation is the recommended timing, when possible depending on woman's condition.

Show and discuss slide: *Discussing Contraception and Procedure Together*

- Discuss contraceptive and uterine evacuation options at same time
- UE method has implications for whether and how certain contraceptive methods can be provided
- Discuss the importance of providing information on contraceptive options along with information on the uterine evacuation methods and procedure. For example, for women who want an IUD, a vacuum aspiration procedure would allow her to have the IUD inserted immediately, ensuring that she can leave the facility with her method of choice. However, women who choose medical abortion and desire an IUD must return to a provider to have it inserted. Women who choose an implant can have it inserted immediately, whether they have a vacuum aspiration procedure or medical abortion.

Distribute Models of Service Delivery worksheet.

- Have participants form groups with colleagues from the same facility, if possible.
- If all participants are from the same facility, have them complete this worksheet as a large group.
- Ask participants to take five minutes to fill out the worksheet.
- Have them come back to large group to share ideas about improving contraceptive services in their facilities.
- Instruct them to follow up with the appropriate personnel when return to their facilities to implement the suggested improvements.

Say: There are key messages every woman receiving abortion-related care should know before leaving the facility.

Show and discuss slide: *Key Messages on Postabortion Contraception*

- A woman can become pregnant again very quickly after a uterine evacuation (within 2 weeks, and as early as 8 days after medical

abortion with mifepristone and misoprostol)

- In general, all methods can be used immediately
- Where to go for contraceptive services, including emergency contraception (EC)

Show and discuss slide: *"We've Failed Her Twice"*

"If a woman comes to a hospital with an incomplete abortion, we've already failed once to help her avoid an unwanted or a mistimed pregnancy. If she leaves the facility without having any means of preventing another pregnancy in the future that may not be wanted, we've failed her twice." – Cynthia Steele Verme, Postabortion Care (PAC) Consortium

- Remind participants that many women receiving abortion-related services have terminated unwanted pregnancies that resulted from contraceptive failure or from failure to use the method consistently or correctly.

Say: When providing contraceptive counseling with a woman who has just had an abortion or treatment of an incomplete abortion, the first step is to ask her whether and when she wants to become pregnant again and if she desires contraceptive counseling and methods.

Ask participants to pair up with the person next to them. Instruct them to discuss the following questions for five minutes and list their responses:

- What are all the reasons for contraceptive failure?
- In what ways does the health system fail women by not providing contraceptives after a uterine evacuation?

Ask participants to list all the reasons for contraceptive failure.

- No method is 100 percent effective.
- The woman and her partner may not remember to consistently take or use the method.
- The woman may not be able to afford contraceptives on a regular basis
- The woman may stop use due to side effects or misunderstandings about effects on fertility or health.
- The woman's partner, family members, religious leaders or influential people may pressure her not to use contraception.
- The woman may have had non-consensual sex.
- The woman may have concerns about being stigmatized due to cultural attitudes that equate contraceptive use with promiscuity.

Say: In what ways does the health system fail women by not providing contraceptives after a uterine evacuation?

- Provider does not adequately explain methods.

- National policies limit access to contraception for certain women, such as young or unmarried women.
- Contraceptive methods are too expensive.
- Clinics do not reliably stock women's preferred methods.
- Contraceptive service locations and times are not convenient.
- Contraceptive service protocols limit re-supply, for example, dispensing only a one-month supply at a time.

Ask participants to give examples of policies that limit contraceptive use and access.

- One example: a policy that requires women to be married or of a certain age to receive contraception. Another example: A protocol that mandates dispensing only one month's supply of pills at a time or that requires medical tests or examinations that are more than is necessary for the method, such as a pelvic exam for pills.

Emphasize that a woman's ability to use contraception successfully may not always be in her control. It's important not to blame her for not preventing an unwanted pregnancy.

Say: How can blame potentially lead to further unwanted pregnancies?

- A woman who is made to feel guilty when she seeks abortion-related care may be reluctant to seek services in the future, including contraception.

Tell participants to:

- Empathetically help each woman assess her own situation and consider which method might help her prevent a future unwanted pregnancy
- Discuss possible solutions to challenges she may have using contraception
- Assist women to make a decision based on full information about a variety of methods

Say: Now we're going to discuss privacy, confidentiality and informed choice during contraceptive counseling.

Show and discuss slide: *Privacy, Confidentiality and Informed Choice*

- Privacy and confidentiality are essential in the abortion-related care setting.
- The woman should be counseled in an area where no one else can see and hear to ensure confidentiality.
- Providers should follow professional protocols that protect confidentiality.

Show slide: *Provide Privacy*

Say: Presenting the woman with information about many contraceptive methods and assisting her to choose a method will increase the potential for success. What are some factors that might influence the woman's informed choice?

- Answers:

- Partner, mother-in-law or other person encouraging her to use a particular method
- Provider's recommendation
- Provider giving information about some contraceptive methods but not others
- Policies restricting or promoting certain contraceptive methods

Emphasize:

- Women of all ages have the right to make a free, informed choice about the method they will use.
- Women should never feel required to accept contraception or a specific method.

Show and discuss slide: *Informed Choice Means*

- Choosing a method voluntarily, without coercion or pressure
- Choosing from a wide range of methods
- Understanding the benefits and risks of each method
- Informed consent is obtained prior to method provision
- Informed consent is particularly important for permanent methods such as sterilization

Show slide: *Ask if She Would Like Her Partner to Be With Her*

Say: Now we're going to discuss the involvement of partners.

Discuss with participants:

- The woman should be asked privately whether or not she wants her partner included in contraceptive counseling.
- If a woman does not want her partner involved, she should be counseled and given the method privately and no information from the visit should be shared with her partner.

Say: What are the benefits of including partners in contraceptive counseling?

- Answers include:
 - It sometimes increases the effectiveness of the counseling and the partner's support of the woman's contraceptive use.

- Male partners' support of contraception is a strong predictor of the woman's contraceptive use.
- Counseling male partners can increase their awareness and use of male methods, such as vasectomy and male condoms.

Say: What might be the repercussions of a partner discovering a woman's use of contraception?

- In the counseling session, discuss the possible repercussions of contraceptive use.
- If the woman's partner does not approve but she still wants to use contraception, help her select a method that does not require her partner's knowledge, such as an injectable, implant or IUD.
- Discuss possible consequences, such as violence, that may occur if the woman's partner learns of her contraceptive use.
- Help the woman think of how she will protect herself in such an event and provide referrals for further help.

3. Effective contraceptive counseling

Say: Provider attitude is a critical factor in providing high-quality contraceptive counseling.

Tell participants that, in this next activity, two participants will perform skits demonstrating different attitudes held by a contraceptive provider.

- Ask for two volunteers.
- Give each volunteer a copy of the Counseling Attitudes Skit script.
- Have volunteers perform Skit 1.
 - Ask participants to describe judgmental provider attitudes.
- Have volunteers perform Skit 2.
 - Ask participants to describe supportive provider attitudes.

Say: Now we'll discuss effective contraceptive counseling using the GATHER technique. A provider who counsels effectively does more than describe the various contraceptive methods available.

Show and discuss slide: *Effective Contraceptive Counseling*

1. Greet and establish rapport
2. Ask the woman
3. Tell the woman about the characteristics of available methods
4. Help the woman choose her method
5. Explain how the method works
6. Return for follow-up care and refer to other resources

Say: How do you establish good rapport with a client?

- Answers include:
 - Greet her in a friendly way.
 - Speak directly to her, using appropriate body language.
 - Demonstrate interest and concern.
 - Assure her of confidentiality.
 - Ask if she would like her partner present.

Tell participants to:

- Ask the woman if she feels it is a good time to discuss contraception.
- If she does not, determine a time that would be more appropriate.

Show and discuss slide: *Ask the Woman*

About her needs – use open-ended questions

- If she was using contraception
 - If yes, ask her to explain what didn't work well for her.
- Whether she desires to delay or prevent future pregnancy
- Consider her clinical condition and personal situation

Show and discuss slide: *Ask if She Desires to Delay Pregnancy*

- Some women may not want to delay pregnancy now, but want to hear future options.
- Many women desire contraception to prevent or delay another pregnancy.
- Even women who say they do not plan to have sex again now might need information for the future.

Show and discuss slide: *Explain Human Reproduction if Necessary*

- Explain how contraception prevents pregnancy.
- Discuss contraception in terms of the woman's monthly cycle.
- Explain in terms she understands.
- Dispel myths about how the methods work.

Tell participants that some women who seek abortion-related care may not fully understand basic information on how they became pregnant or how contraception prevents pregnancy. This may be particularly true for young women.

Show and discuss slide: *Consider the Woman's Individual Situation*

- Clinical condition

- Personal situation

Refer participants to Appendix A: Individual Factors and Counseling Recommendations and Rationales in the Reference Manual for more information.

Say: You can begin with a discussion on partner or family issues:

- Ask the woman gently about issues concerning her partner or family, such as: violence, whether her partner is willing to use condoms, influential family members' (such as mother-in-law's) views on contraception, myths and lack of knowledge about contraception.

Show and discuss slide: *Tell Characteristics of Methods*

- Determine which methods are available and accessible to her and for which she is medically eligible
- Explain characteristics, side effects and effectiveness
- Direct her to accessible places to obtain them
- If possible, show actual methods and use educational tools, pamphlets, pictures or anatomical models

Show and discuss slide: *Help Her Choose a Method*

- Do not choose a method for the woman; help her make her own choice.
- Support the woman in selecting the method that best suits her and her partner.
- Discuss potential barriers to successful use of contraception and ways to overcome them.
- Explore resupply issues, such as where to find in her community.
- If the woman is unsure about her contraceptive needs, offer interim contraception, such as condoms, pills and EC, and make a referral for future services.

Show slide: *Helping the Woman Choose a Method Skit*

Tell participants the next activity will be brief skits about helping women choose a method.

- Give two volunteers each a copy of the Helping the Woman Choose a Method Skit script.
- One volunteer will act as the provider and the other will play the woman.
- Have them perform each of the four skits in a row.
- At the end of each skit, ask participants to state how well the provider helped the woman choose a method.
- Ensure participants cover all the responses listed in the script.

- Explain that the intention was to show how providers need to facilitate women's own decision-making process rather than imposing their own biases and preferences on the woman. The last one showed the most positive interaction.

Show and discuss slide: *Explain How the Method Works*

- Ensure she understands how the method works
- Help her develop a plan for continued use
- Also explain how to obtain and correctly use EC

Show and discuss slide: *Return for Follow-Up Care and Refer to Other Resources*

- Encourage her to return if she has any concerns or problems with her method.
- Counseling may reveal issues for which she needs additional assistance.
- Refer her to other resources as needed.
- Have a resource list available.

Say: *Why might the woman need referrals to other contraceptive resources?*

Answers include:

- This facility may not be able to offer her preferred method.
- Women may need to resupply at another location.
- Some women will have to wait to begin using their preferred method or will choose to delay making a decision and seek services elsewhere.

4. Medical eligibility for contraceptive use after uterine evacuation

Say: *Now we will discuss medical eligibility for contraceptive use after a uterine evacuation.*

Show and discuss slide: *Medical Eligibility for Methods*

- If no severe complications, all modern methods can be used immediately following a uterine evacuation, including by young women
- Screen for any medical precautions for particular methods
- All methods require adequate counseling and informed consent

Say: *Long-acting reversible contraceptives (LARC) have many advantages and should be offered as an option for women of all ages.*

Show and discuss slide: *Long-Acting Reversible Contraceptives (LARC)*

- LARC includes IUDs and implants

- For both young and adult women, LARC are more effective and have higher satisfaction than pills
- LARC also often have longer continuation than pills or injectables

Show and discuss slide: *Advantages of LARC: Effectiveness*

Perfect use is defined as consistent and correct use, typical use is defined as the way the method is used in actual practice, on average. Point out and discuss the difference in perfect and typical use, and how much closer these are for IUDs and implants. Note that the IUDs in this data were copper-Ts.

Show and discuss slide: *Advantages of LARC: Satisfaction*

Point out and discuss the differences in satisfaction between methods. Note that 12 month continuation of LARC was 86 percent, compared to 55 percent for non-LARC, and that women under 21 also had high continuation rates of LARC.

Show and discuss slide: *Integrating LARC into Abortion-Related Services*

- Offering LARC enhances women's access to effective contraception.
- Women of all ages should be offered LARC as an option.
- Providers should insert women's chosen method as soon as possible.

Discuss specific considerations for health-care managers and providers who are integrating LARC into abortion-related services to enhance women's access to effective contraception. During counseling, all women, regardless of age or marital status, should receive information on LARC methods and, if chosen, have their method inserted as soon as possible. Many providers incorrectly believe that LARC are not appropriate for young women and thus do not offer them as options. Women of all ages receiving abortion-related care deserve the most effective contraceptive methods that meet their needs.

Tell participants to open to Appendix B: Guidelines for Selection of Contraception by Method in the Reference Manual for more information about medical eligibility.

- Fertility-awareness methods are not recommended until a normal menstrual pattern returns.
- Abstinence from intercourse is recommended until any complications are resolved and the chosen contraceptive method has become effective.
- If a woman has contraindications to using her desired method, such as using an IUD immediately after a septic abortion, she should be offered an interim method until she can safely use her chosen method.

Explain that there are guidelines for contraceptive methods in certain clinical situations.

Remind participants that young women, like older women, are able to

use all contraceptive methods. Also note that eligibility for contraceptive methods after postabortion care is the same as after induced abortion.

- Ask participants to take two to three minutes to read over Section 8.0, Medical Eligibility for Contraceptive Use After a Uterine Evacuation, in the Reference Manual.

Say: Let's now look at what methods can be used after uterine evacuation.

Show and discuss slide: *Uncomplicated Uterine Evacuation Using Medical Methods*

- Medical eligibility after a uterine evacuation by medical methods is not different from that of other first-trimester methods.
- Most hormonal methods can be used immediately with misoprostol
- Delay IUS/IUS or sterilization until reasonably sure woman is no longer pregnant

Show and discuss slide: *Uncomplicated Vacuum Aspiration*

- All modern contraceptive methods can be used immediately

Show and discuss slide: *Vacuum Aspiration With Complications: Infection*

- IUD/IUS, sterilization appropriate when infection has been resolved
- Avoid intercourse until the infection has been resolved

Show and discuss slide: *Vacuum Aspiration With Complications: Genital Injury*

- Spermicides, female barrier methods may be restricted
- Provider must decide whether her condition rules out a particular method

Show and discuss slide: *Vacuum Aspiration With Complications: Excessive Blood Loss*

- Delay sterilization if the woman is too anemic

Tell participants that we will be researching and discussing less widely-used or newer contraceptive technologies. Be sure to consider emergency contraception and long-acting reversible methods.

Divide the participants into small groups and assign each group a different method to research and report on. Ask them to use the Contraceptive Method Information worksheet to guide their investigation.

- Groups can use the Contraceptive Services module in the Reference Manual and any additional resources provided by the trainer.
- If possible, have the methods available for participants to handle.
- Questions for the groups to consider and report back on for each method:
 - When can it be started after a uterine evacuation? Is it the same for vacuum aspiration and medical methods?

- What are the demographics of the current users for your setting?
- What are the advantages of it for all women that may not be widely known? For young women?
- What are barriers to its use (availability, providers' and women's familiarity, myths?) How do we address these?

Show and discuss slide: *Supply EC Pills*

Say: Why is it particularly important to offer EC in advance?

- Answers include:
 - Can be used as a back-up method in case of contraceptive failure (for example, condom breakage).
 - Can be used after unprotected sex or when sex is non-consensual.

Refer participants to Section 9.0 of the Reference Manual for more information and references about timing and dosages of EC pills and timing of IUD insertion.

Say: Now we will discuss special contraceptive-counseling considerations.

Explain that there are certain specialized considerations providers should keep in mind when providing contraceptive counseling. Ask participants to review the information provided in Appendix C: Special Contraceptive Counseling Considerations on how providers can meet the specific contraceptives needs for women in these circumstances.

Ask a participant to read aloud the following short case studies.

- Discuss each one at a time.

Show slide: *Case Study 1: Violence*

- A 22-year-old married mother of one discloses that she is frequently beaten by her husband. The last beating occurred while she was pregnant, and she came to the facility with a lot of vaginal bleeding and cramping. She is afraid to discuss contraception for child spacing with her husband.

Say: What are the special contraceptive-counseling considerations for this woman?

- Ensure that responses include:
 - If the woman cannot control the circumstances of her sexual activity, advise her about methods that do not require partner participation such as injectables, implants, IUDs and EC.
 - If the violence is a result of her contraceptive use, she may consider a method that cannot be detected by others such as an IUD, implant or injectable.
 - Advise her on how to access and use EC.
 - It may be beneficial to provide EC pills in advance.
 - Offer referrals for women experiencing violence.

Show slide: *Case Study 2: HIV*

- A 28-year-old mother of two comes into the clinic extremely sick and learns that she is HIV-positive. Her only sexual partner has been her husband. She wants to prevent another pregnancy until she receives treatment for HIV and is feeling better.

Say: What are special contraceptive-counseling considerations for this woman?

- Be sure that responses include:
 - Ensure that she has correct information on HIV and how to care for her health and slow the effects of the disease.
 - Discuss how contraception may interact with medications for HIV and which methods may be better for her.
 - Oral contraceptive pills can interact with some antiretroviral drugs with a resulting decrease in the effectiveness of her contraception.
 - DMPA may be used with antiretrovirals without reduced efficacy.
 - Women who are stable on antiretrovirals may be eligible for an intrauterine device.
 - Women who are on antiretroviral medications with oral contraception should be encouraged to use condoms to prevent HIV transmission and compensate for any reduced effectiveness of her contraception.

Show and discuss slide: *Condoms for Both Females and Males*

Say: What does dual-method use mean?

Answer: Using male or female condoms to prevent STI/HIV with another contraceptive method to prevent pregnancy, or using condoms to prevent both pregnancy and disease, with EC as a back-up method.

Show slide: *Case Study 3: Young Women*

- A 16-year-old woman is sexually active with her boyfriend. They use withdrawal because she doesn't feel comfortable asking him to use condoms. She wants to use something more effective but is afraid her family might be upset if they see her taking birth control pills. She has tried to get injectables in the past but has been denied by a nurse at the health center because she isn't married.

Say: What are special contraceptive-counseling considerations for this woman?

- Ensure that responses include:
 - Learn what her privacy needs are and barriers she may face in using different contraceptive methods to help her identify the most appropriate option for her.
 - Some young women may want to become pregnant immediately and not require contraception – as with all women, ask what her immediate and longer-term reproductive plan is.

- Include basic information on her menstrual cycle, fertility, and how pregnancy occurs and is prevented, if needed.
- Fully explain how any contraceptive she is interested in works, including efficacy, potential side effects, and long-term clinical implications of any side effects, to allay fears about contraceptives causing illness or future permanent infertility.
- Offer for her to leave the facility with at least one dose of EC, in addition to her contraceptive method of choice.
- Clinical eligibility guidelines are the same as for adult women.
- Young women are more likely to experience regret after sterilization.
- Methods that don't require a daily regimen may be more effective for some young women, and LARC such as IUDs and implants have been found to be more effective and have higher satisfaction for young women than pills in preventing future pregnancies.
- An IUD would have particular benefits for her because it would not be obvious to her family (no scar).
- For all LARC there are no resupply concerns and there is no chance of improper use on her part.

Show slide: *Case Study 4: A Woman Who Is Finished With Childbearing*

A 36-year-old woman with five children does not want to have any more children. Her husband refuses to wear condoms. She has used injectables in the past and did not like the change in her bleeding pattern.

Contraceptive considerations:

To limit births, women may use any form of contraception for which they are eligible. Long-acting contraception has an excellent combination of long duration, high efficacy and high satisfaction. For this woman, a copper IUD may be a good choice because it will not cause irregular bleeding or amenorrhea and has a duration of action of 10-12 years. IUD is as effective as sterilization without the need to undergo a surgical procedure. It is reversible if the woman's life circumstances change. Permanent methods including tubal sterilization or vasectomy may also be offered if the woman is sure about her decision to not have more children.

5. Skills practice

Say: Now we will integrate all the sections of this module and practice postabortion contraceptive counseling skills, being sure to cover all six Essential Steps for Contraceptive Counseling (GATHER).

Divide participants into groups of three.

- Give each group one copy of the Role Play scenarios and three copies of the Contraceptive Counseling Skills Checklist.
- Ask groups to decide who will first play the roles of provider, woman and observer. Switch until everyone has played all three roles.

- They should review the checklist so they are clear about the performance expectations for the provider.
- Ask participants to refer to Section 7.0 of the Reference Manual for the Essential Steps for Contraceptive Counseling.
- Ask the participant playing the woman to review and select one of the scenarios.
- The groups will spend 10 minutes doing each role play.
 - Advise the provider to move quickly through each element so they have enough time.
 - The observer will silently watch the interaction and complete the checklist based on the skills demonstrated by the provider.
 - For two minutes, the groups will quickly debrief the role play.
 - The provider will share his or her experience of the role play, the woman will give feedback, and the observer will share observations and comments.
 - Repeat this process until each participant has played each role.

Bring the group back together. Ask participants the following questions:

- What were key counseling issues that you discussed?
- How comfortable did you feel during the role plays?
- How did the woman respond to your counseling?
- What were some skills the providers performed well? What counseling skills could be improved?
- What are some challenges of providing effective counseling to women with special considerations?
- How could you gain additional skills before performing contraceptive counseling with actual clients?

6. Summary and test

Ask participants for key points covered in this module. Use the objectives as a guide.

What questions do you have about anything discussed during this module?

Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Thank the participants for their participation.

References

- Abdel-Tawah, N., Huntington, D., Hassan, E. O., Youssef, H., & Nawar, L. (1999). Effects of husband involvement on postabortion patients' recovery and use of contraception in Egypt. In D. Huntington & N. J. Peterson (Eds.), *Postabortion care: Lessons from operations research*. New York, NY: The Population Council.
- Alan Guttmacher Institute (AGI). (1999). *Sharing responsibility: women, society & abortion worldwide*: The Alan Guttmacher Institute.
- Bednarek, P. H., Creinin, M. D., Reeves, M. F., Cwiak, C., Espey, E., & Jensen, J. T. (2011). Immediate versus delayed IUD insertion after uterine aspiration. *New England Journal of Medicine*, 364(23), 2208-2217.
- Benson, J., Leonard, A. H., Winkler, J., Wolf, M., & McLaurin, K. E. (1992). Meeting women's needs for post-abortion family planning: Framing the questions. *Issues in Abortion Care*, 2.
- Betstadt, S. J., Turok, D. K., Kapp, N., Feng, K. T., & Borgatta, L. (2011). Intrauterine device insertion after medical abortion. *Contraception*, 83(6), 517-521. doi: 10.1016/j.contraception.2010.10.006
- Billings, D. L., Crane, B. B., Benson, J., Solo, J., & Feters, T. (2007). Scaling-up a public health innovation: A comparative study of post-abortion care in Bolivia and Mexico. *Social Science & Medicine*, 64(11), 2210-2222.
- Bongaarts, J., & Westoff, C. F. (2000). The potential role of contraception in reducing abortion. *Studies in Family Planning*, 31(3), 193-202.
- Boyd, E. F., & Holmstrom, E. G. (1972). Ovulation following therapeutic abortion. *American Journal of Obstetrics and Gynecology*, 113(4), 469-473.
- Center for Reproductive Rights (CRR). (2008). *Bringing rights to bear anew: 2008 update*. Retrieved from <http://reproductiverights.org/en/press-room/bringing-rights-to-bear-anew-2008-update>
- Centers for Disease Control and Prevention (CDC). (2001). Appendix B: Management of occupational blood exposures. *Morbidity and mortality weekly report*, 50(RR11), 45-46.
- Cheng, L., Che, Y., & Gülmezoglu, A. M. (2012). Methods of emergency contraception. *Cochrane Summaries*.
- Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: origins, evolution and future directions. *International Family Planning Perspectives*, 29(3), 106-111.
- Curtis, C., Huber, D., & Moss-Knight, T. (2010). Postabortion family planning: addressing the cycle of repeat unintended pregnancy and abortion. *International Perspectives on Sexual and Reproductive Health*, 36(1), 44-48.
- Curtis, K. M., Mohllajee, A. P., & Peterson, H. B. (2006). Regret following female sterilization at a young age: a systematic review. *Contraception*, 73(2), 205-210.
- Dinerman, L. M., Wilson, M. D., Duggan, A. K., & Joffe, A. (1995). Outcomes of adolescents using levonorgestrel implants vs oral contraceptives or other contraceptive methods. *Archives of Pediatrics and Adolescent Medicine*, 149(9), 967-972.
- Diouf, K., & Nour, N. (2013). Female genital cutting and HIV transmission: is there an association? *American Journal of Reproductive Immunology*, 69 Suppl 1, 45-50.
- Family Health International (FHI). (2000). Contraception after pregnancy. *Contraceptive Technology Update Series, October 2000*.
- Ferreira, A. L., Souza, A. I., Lima, R. A., & Braga, C. (2010). Choices on contraceptive methods in post-abortion family planning clinic in the northeast Brazil. *Reproductive Health*, 7(5).

- Huntington, D., Hassan, E. O., Attallah, N., Toubia, N., Naguib, M., & Nawar, L. (1995). Improving the medical care and counseling of postabortion patients in Egypt. *Studies in Family Planning*, 26(6), 350-362.
- International Consortium for Emergency Contraception (ICEC). (2012). *Emergency Contraceptive Pills: Medical and Service Delivery Guidelines* (3rd ed.). New York, NY: ICEC.
- International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), International Council of Nurses (ICN), & United States Agency for International Development (USAID). (2009). *Family planning: A key component of post abortion care. Consensus statement*. Retrieved from http://transition.usaid.gov/our_work/global_health/pop/techareas/pac/fp_component.pdf
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Johnson, B. R., Ndhlovu, S., Farr, S. L., & Chipato, T. (2002). Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception. *Studies in Family Planning*, 33(2), 195-202.
- Leonard, A. H., & Ladipo, O. A. (1994). Postabortion family planning: Factors in individual choice of contraceptive methods. *Advances in Abortion Care*, 4(2).
- Mason, K., & Pilyman, L. (1992). Not for women only: Child spacing clubs for Malawian men. *AVSC News*, 30(4).
- McDougall, J., Feters, T., Clark, K. A., & Rathavy, T. (2009). Determinants of Contraceptive Acceptance Among Cambodian Abortion Patients. *Studies in Family Planning*, 40(2), 123-132.
- Peipert, J. F., Zhao, Q., Allsworth, J. E., Petrosky, E., Madden, T., Eisenberg, D., & Secura, G. (2011). Continuation and satisfaction of reversible contraception. *Obstetrics & Gynecology*, 117(5), 1105-1113.
- Ratten, G. J. (1972). Resumption of ovulation after incomplete abortion. *The Australian and New Zealand Journal of Obstetrics and Gynaecology*, 12(4), 217-219.
- Roberts, H., Silva, M., & Xu, S. (2010). Post abortion contraception and its effect on repeat abortions in Auckland, New Zealand. *Contraception*, 82(3), 260-265.
- Rosenstock, J. R., Peipert, J. F., Madden, T., Zhao, Q., & Secura, G. M. (2012). Continuation of reversible contraception in teenagers and young women. *Obstetrics & Gynecology*, 120(6), 1298-1305.
- Ross, J. A., Rich, M., & Molzan, J. P. (1989). *Management strategies for family planning programs*. New York, NY: Columbia University.
- Salter, C., Johnston, H. B., & Hengen, N. (1997). Care for postabortion complications: Saving women's lives. *Population Reports, Series L*(10).
- Scholes, D., LaCroix, A. Z., Ichikawa, L. E., Barlow, W. E., & Ott, S. M. (2005). Change in bone mineral density among adolescent women using and discontinuing depot medroxyprogesterone acetate contraception. *Archives of Pediatrics and Adolescent Medicine*, 159(2), 139-144.
- Schreiber, C. A., Sober, S., Ratcliffe, S., & Creinin, M. D. (2011). Ovulation resumption after medical abortion with mifepristone and misoprostol. *Contraception*, 84(3), 230-233. doi: 10.1016/j.contraception.2011.01.013
- Sedgh, G., Singh, S., Shah, I. H., Ahman, E., Henshaw, S. K., & Bankole, A. (2012). Induced abortion:

incidence and trends worldwide from 1995 to 2008. *Lancet*, 379(9816), 625-632. doi: 10.1016/S0140-6736(11)61786-8

Solo, J., Billings, D. L., Aloo-Obunga, C., Ominde, A., & Makumi, M. (1999). Creating linkages between incomplete abortion treatment and family planning services in Kenya. *Studies in Family Planning*, 30(1), 17-27.

Stanek, A. M., Bednarek, P. H., Nichols, M. D., Jensen, J. T., & Edelman, A. B. (2009). Barriers associated with the failure to return for intrauterine device insertion following first-trimester abortion. *Contraception*, 79(3), 216-220. doi: 10.1016/j.contraception.2008.09.003

Stevens-Simon, C., Kelly, L., & Kulick, R. (2001). A village would be nice but...it takes a long-acting contraceptive to prevent repeat adolescent pregnancies. *American Journal of Preventive Medicine*, 21(1), 60-65.

Task Force on Postovulatory Methods of Fertility Regulation (TFPMFR). (1998). Randomised controlled trial of levonorgestrel versus the Yuzpe regimen of combined oral contraceptives for emergency contraception. Task Force on Postovulatory Methods of Fertility Regulation. *Lancet*, 352(9126), 428-433.

Templeman, C. L., Cook, V., Goldsmith, L. J., Powell, J., & Hertweck, S. P. (2000). Postpartum contraceptive use among adolescent mothers. *Obstetrics and Gynecology*, 95(5), 770-776.

Tolaymat, L. L., & Kaunitz, A. M. (2007). Long-acting contraceptives in adolescents. *Current Opinion in Obstetrics and Gynecology*, 19(5), 453-460.

Tripney, J., Schucan, B. K., Kwan, I., & Kavanagh, J. (2010). *The impact of post-abortion care family planning counselling and services in low-income countries: a systematic review of the evidence (Technical report)*. London, England: University of London.

Trussell, J. (2009). Choosing a Contraceptive: Efficacy, Safety and Personal Considerations. In R. A. Hatcher, J. Trussell, A. L. Nelson, W. Cates Jr., F. H. Stewart & D. Kowal (Eds.), *Contraceptive Technology* (19 ed.). New York, NY: Ardent Media.

Turner, K. L., Borjesson, E., Huber, A., & Mulligan, C. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas.

Upadhyay, U. D., & Robey, B. (1999). Why family planning matters. *Population Reports, Series J* (49).

Winner, B., Peipert, J. F., Zhao, Q., Buckel, C., Madden, T., Allsworth, J. E., & Secura, G. M. (2012). Effectiveness of long-acting reversible contraception. *New England Journal of Medicine*, 366(21), 1998-2007.

Wolf, M., & Benson, J. (1994). Meeting women's needs for post-abortion family planning. Report of a Belagio Technical Working Group. *International Journal of Gynecology & Obstetrics*, 45 Suppl, S1-33.

World Health Organization (WHO). (1997). *Post-abortion family planning: A practical guide for programme managers*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2008). *Selected practice recommendations for contraceptive use, update to second edition*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2009). *Medical eligibility criteria for contraceptive use* (pp. 1 online resource (121 p.)). Retrieved from http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf

World Health Organization. (2010a). *Adolescent job aid: A handy desk reference tool for primary level health workers*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2010b). *Medical eligibility criteria for contraceptive use* (4th ed.). Geneva, Switzerland: World Health Organization (WHO).

World Health Organization. (2012). *Emergency contraception*. Geneva, Switzerland: World Health Organization.

Knowledge Test Key

1. True
2. False
3. False
4. True
5. False
6. b
7. d
8. b
9. c
10. c

Contraceptive Services - Knowledge Test

Circle the correct response.

1. True or False Two ways that health systems may fail women are that facilities do not offer a full range of contraceptive options and providers do not adequately explain how to use and get resupplies of methods.
2. True or False Free and informed choice means that a woman chooses a method voluntarily, unless her partner insists that she use a different method.
3. True or False All women receiving abortion-related care should be made to use contraception immediately afterwards.
4. True or False Including partners in contraceptive counseling may increase their awareness and use of male contraceptive methods.
5. True or False Young women are not eligible for IUDs because of their increased risk for STIs.
6. Contraception is critical to women's health for all of the following reasons except:
 - a. It reduces maternal mortality and morbidity by helping women avoid unwanted pregnancy and the possibility of an unsafe abortion that can end in injury or death.
 - b. It permits partners to decide whether and how many children a woman should have.
 - c. It allows women to space births.
 - d. It gives women the freedom to improve their quality of life and pursue an education and career.
7. Which of the following is not one of the key messages all women requesting abortion-related care should receive?
 - a. She could become pregnant again within two weeks, and as early as eight days after medical abortion with mifepristone and misoprostol.
 - b. Safe methods to prevent or delay pregnancy are available.
 - c. Where and how she can obtain contraceptive services and methods.
 - d. There are very few contraceptive methods that can be used after a uterine evacuation.
8. Postabortion contraceptive services are more likely to be effective if:
 - a. The women using them are already married.
 - b. Women choose the method themselves based on their needs and informed choice.
 - c. The women already have children.
 - d. Providers are using contraceptive methods themselves.

9. A woman choosing a fertility awareness-based method should be informed that she will need to use another contraceptive method:
- a. For two weeks
 - b. For one year
 - c. Until her normal menses returns
 - d. Forever, because this method doesn't work
10. Which of the following methods would not be appropriate for a woman immediately after a septic abortion?
- a. Injectables
 - b. Pills
 - c. Intrauterine device
 - d. Patches

Models of Service Delivery

Instructions: For each question, think about the situation in your facility. Fill in the answers across each row.

Question	Current Practice at Health-Care Facility	What to Change	What Is Needed to Make the Change
Where is contraceptive counseling and method provision offered for women receiving abortion-related services?			
When do postabortion contraceptive services take place?			
Who provides contraceptive services to abortion clients?			

Contraceptive Counseling Skills Checklist

Instructions for observer: Silently observe and evaluate the counseling session. Do not interact with the woman or provider. Check “yes” or “no,” depending on whether the provider demonstrated the skill during the counseling session, and write comments. Offer your evaluation and comments to the provider at the end of the session.

Skill	Yes	No	Comments
Establishes Rapport			
Greets clients in a friendly way, demonstrating interest and concern			
Assures privacy and confidentiality			
Asks for permission prior to including others in session			
Assesses Woman's Needs			
Asks open-ended questions about woman's circumstances and needs			
Without judgment, explores factors that led to the need for an abortion			
If she was using contraception, assesses reasons for failure of method		(continued on pages 314-315)	
Explains Human Reproduction (if necessary)			
Determines Desire to Delay or Prevent Pregnancy			
Explores woman's current desire to delay or prevent pregnancy			
Provides information on the health benefits of child spacing			
Assesses Woman's Individual Situation			
Assesses woman's clinical and personal situation			
Discusses potential barriers to successful use of contraception and ways to resolve them			

(continued on pages 144-145)

Contraceptive Counseling Skills Checklist

Skill (continued)	Yes	No	Comments
Explains Characteristics of Available and Effective Methods			
Discusses any contraindications and methods for which she is medically eligible			
Offers a full range of methods available at the facility and where the woman will seek re-supply			
Discusses when contraceptives can be provided in relation to her uterine evacuation method and process			
Explains, in order from most to least effective, her eligible methods' effectiveness, characteristics, use and side effects			
If she will need re-supplies, explains where she can access them			
Shows actual methods and uses educational tools, pamphlets, pictures or anatomical models			
Helps the Woman Choose Her Method			
Supports the woman in selecting the most effective method for her situation			
Ensures informed choice of method			
Ensures Understanding of Chosen Methods			
Ensures woman fully understands the method she has chosen			
Helps her plan for continued use, ensuring she knows where and when to resupply or change her method if necessary			
Provides chosen method or interim method if chosen method is not available			
Provides EC and instructions for use as a back-up method, if available			

Contraceptive Counseling Skills Checklist

Skill (continued)	Yes	No	Comments
Refers to Other Resources As Needed			
Manages special needs			
Has resource lists available to make referrals			
If unable to offer specialized counseling or services or meet woman's needs, makes referrals to appropriate services			

Counseling Attitudes Skit

Instructions: One participant plays the role of the provider while the other plays the role of the woman. The woman is lying in a bed and there are other women in the room.

Skit 1: Provider with Judgmental Attitude:

Provider: [Looks at chart; does not look at woman; speaks loudly enough that other women can easily hear.]

So, I see in your chart you had an abortion. This was the second one this year. Are you still bleeding? Do you need some contraception?

Woman: [Looks around at other women, embarrassed.] *I am still bleeding a little, but I do need pills.*

Provider: [In a commanding voice.] *You need an IUD so you don't get pregnant and into trouble again. Can you come back in two weeks?*

Woman: [Intimidated.] *I guess so.*

Skit 2: Provider with Supportive Attitude

Provider: [Looks at chart before approaching woman; draws a curtain between woman and other women for privacy and speaks softly.] *Hello.* [Reaches out to shake her hand; calls her by name.] *I am a contraceptive provider. Would you like to talk about ways to prevent pregnancy?*

Woman: [Looks at provider; shakes her hand.] *Hello. Thank you, yes, I would.*

Provider: *Your chart says you had a uterine evacuation. How are you feeling now?*

Woman: *Tired and still bleeding a little, but otherwise fine.*

Provider: *Would you like to get pregnant again soon or would you like to prevent pregnancy for now?*

Woman: *I do not want to become pregnant again for at least a few years.*

Provider: *Well, you did not have any complications, so there are many methods of contraception that may work for you. I'll need to ask you some personal questions so that you can determine which method will most suit your needs.*

Woman: *Okay, go ahead please.*

Helping the Woman Choose a Method Skit

Instructions: One participant plays the provider and another participant plays the woman. At the end of each skit, participants will state how well the provider helped the woman choose a method. Trainers should ensure that participants give correct responses as written after each skit.

Skit One

Provider: [Busy and distracted.] *You have four children already, and this is your second abortion. You need to get sterilized so you won't get pregnant again.*

Woman: [Intimidated.] *Okay, I will, if that's what you think is best.*

Correct responses: The provider did not find out what the woman's contraceptive preferences are, and she made the decision for her. This is especially damaging because sterilization is a permanent method. This is an extremely bad example of contraceptive counseling.

Skit Two

Provider: [Disinterested.] *Well, we have these two methods in the clinic today.* [Lays out two methods.] *You can pick the one you want.*

Woman: *I'll take this one because my sister uses it.* [Picks up one of the methods.]

Correct responses: The provider was not interested. She showed the woman only two methods, and she did not offer information about each method. She did not find out what the woman's particular needs are or probe to determine if the method she chose would work for her.

Skit Three

Woman: *You've described several methods, but I can't decide between condoms or injectables.*

Provider: *Injectables will provide protection over a longer period of time. You should probably choose those.*

Correct responses: The provider described a range of methods, which is positive. However, the provider did not ask why the woman was having trouble deciding between the two methods, which might have helped the woman determine which method would work better.

Skit Four

Woman: *You've shown and described several methods, but now I can't decide between the condoms or the injectables.*

Provider: *Tell me more about why you can't decide.*

Woman: *I know I can get condoms in my village, but I'm not sure where to get injectables. I don't think my husband will want to wear condoms, though.*

Provider: *The clinic in your village now has both injectables and condoms. Injectables are an effective means for you to prevent pregnancy, but they do not protect against sexually transmitted infections (STIs), including HIV. If your husband will wear condoms, they will provide protection against both pregnancy and STIs. You can take injectables yourself to keep from getting pregnant, but you may want to consider using both instead of choosing only one.*

Correct responses: The provider is interested and actively helping the woman make her decision by asking her to explain the reasons for her indecision. The provider gave information about resupply and the benefits and drawbacks of each method for pregnancy versus STI prevention.

Role Play Scenarios

Case 1

A 16-year-old woman with good overall health was given a uterine evacuation with MVA with no complications. She does not want to get pregnant again. She does not trust methods with hormones and is interested in the IUD. She does not want her parents to know that she is using contraceptives. She may be having sex with older men in exchange for tuition assistance.

Case 2

A 27-year-old woman who had a uterine evacuation with medical methods is back. She was given condoms to use until she selected a longer-term method, but she says she hasn't had intercourse during that time because she was still bleeding. She is still having light spotting, but says she wants to start using a contraceptive because she thinks she'll have sex with her partner soon and doesn't want to become pregnant again right away.

Case 3

A 39-year-old woman with four children came to your facility seeking a uterine evacuation with medical methods. She and her husband decided before she came that she should get a tubal ligation. She came to this facility for abortion-related care because she heard that you also perform female sterilization. She lives very far from the facility and does not know when she will be able to return.

Case 4

34-year-old woman was given a uterine evacuation with MVA followed by repair to a minor cervical laceration that occurred during the procedure. She wants to take the pill. She smokes and has high blood pressure. Both her father and older sister had a stroke while in their 30s. She has three children and says she doesn't want any more.

Contraceptive Method Information

1. Name of method:
2. When can it be started after a uterine evacuation with VA?
3. When can it be started after a uterine evacuation with medical methods?
4. Do you currently provide counseling and provision of this method in your practice?
5. In your setting, what are the characteristics of a typical user of this method?
6. What advantages of this method may not be widely known? What are specific advantages for young women, if any?
7. What are barriers to its use? (availability, providers' and women's familiarity, myths) How do we address these?

Infection Prevention



Purpose

This module discusses the knowledge and attitudes health-care workers must have to successfully prevent infection to themselves, clients, coworkers and communities when providing abortion-related care.



Prerequisites

Participants should already be able to:

- Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- Describe a woman's rights in the abortion-related care setting
- Explain the need for infection prevention in a health-care setting
- Generally describe germ theory and aseptic technique



Objectives

By the end of this module, participants should be able to:

1. Explain how infection can be transmitted in the abortion-related care setting
2. Identify the essential elements of infection prevention, including standard precautions
3. Explain proper procedures for managing occupational exposure to blood and body fluids



Materials

- ☐ Infection Prevention Skills checklist and Action Plan worksheet
- ☐ Making Personal Protective Barriers from Locally Available Materials (optional)
- ☐ Set of personal protective barriers: face protection (mask and eyewear or face shield), arm protection (gown or lab coat) and gloves
- ☐ Sample of face shield made from locally available materials (optional)
- ☐ Hypodermic syringe with cap
- ☐ Samples of acceptable sharps containers (such as empty, well-sealed shipping box) and unacceptable (such as drink cans or bottles)

☐ Knowledge Test and Test Key



Advance preparation

- ☐ Determine the availability at participants' facilities of supplies needed to implement infection-prevention techniques.
- ☐ Adapt training activities, if necessary, according to participants' workplace roles and the uterine evacuation methods used at their facilities.
- ☐ Assess local resources for making face shields and proper sharps containers.
- ☐ Create a sample face shield as shown in drawing in Section 3.2 of the Reference Manual. (optional)
- ☐ Make copies of Infection Prevention Skills Checklist, Action Plan worksheet and Knowledge Test.

Note to Trainer: At the end of this module, there are instructions that can be covered in settings where making personal protective barriers from locally available materials would be appropriate.

Time: 1 hour, 30 minutes

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

- This module discusses how health-care workers can prevent infection to themselves, clients, coworkers and communities when providing abortion-related care.

Show slide: *Objectives*

- By the end of this module, participants should be able to:
 1. Explain infection transmission routes in the abortion-related care setting
 2. Identify essential elements of infection prevention, including standard precautions
 3. Explain procedures for managing occupational exposure to blood and body fluids

Explain to participants that they will complete an infection prevention self-assessment using the Infection Prevention Skills Checklist and Action Plan worksheet.

- Hand out the worksheet and give several minutes to complete the second column of the worksheet, which is entitled "Do you?"
- Ask what the group learned about their current infection prevention practices.

— Take one to two brief responses.

- Inform participants that they will complete the rest of the worksheet later in the module.

Say: Now we will discuss why it is critical to protect our clients, ourselves, our coworkers and our communities against blood-borne pathogens.

Show and discuss slide: *Why Protect Against Blood-Borne Pathogens?*

- They can cause incurable infections such as HIV, HBV, HCV and Ebola.
- Transmission is through blood, secretions, excretions and certain other body fluids, which are common in health facilities.

Show and discuss slide: *How Do Blood-Borne Diseases Spread?*

- Infectious agents are transmitted by:
 - Cuts or openings in skin
 - Contact with mucous membranes

Show slide: *Most Common Blood-Borne Transmission*

- Injuries from contaminated sharp instruments, such as needle sticks
- Contact with blood on non-intact skin or mucous membranes

Say: What is the one body fluid not considered infectious?

- Sweat

Show and discuss slide: *Who Has Blood-Borne Diseases?*

- It is not always possible to tell who is infected, as some diseases have no noticeable signs or symptoms.
- Precautions should be taken with every person.
- Avoid making assumptions based on behaviors or appearances.

Explain that any person could have blood-borne diseases, and neither they nor the health-care workers may realize it.

- Health-care workers may mistakenly assume that some clients are likely to be uninfected, such as older women, babies or healthy-looking people.
- Tests cannot always detect whether or not a person is currently infected.
- All clients and colleagues must be treated with the same precautions at all times.

Say: Think back to your self-assessment. Choose one of the infection-prevention techniques you do not currently practice and reflect on the worst possible outcome of not practicing it.

- Allow participants time to reflect.

Say: What are some possible worst-case outcomes?

- Take one to two brief responses.
- Answers might include:
 - Acquiring an incurable disease such as HIV
 - Contaminating a community water supply

Say: These sobering reflections give us plenty of reason to consistently practice infection prevention.

Remind participants that they can refer to the Reference Manual for more details about infection prevention for abortion-related services.

2. Elements of infection prevention

Using the same precautions for all patients is called “standard precautions,” formerly called “universal precautions.”

Show and discuss slide: *Standard Precautions*

- Proper handling of blood and body fluids
- Use of appropriate prevention techniques
- Followed with all clients and workers
- No reason to treat individuals with known diseases differently

Show slide: *Essential Elements of Infection Prevention*

- Handwashing
- Personal protective barriers
- Proper handling of sharp items
- Proper instrument processing
- Aseptic technique
- Environmental cleanliness
- Proper infectious-waste disposal

Say: Now we are going to talk about these infection-prevention elements one at a time. The first one is handwashing.

Hands are a common route for infection transmission. Handwashing is an important, but often neglected, way to prevent infection.

Show slide: *When Should We Wash Our Hands?*

- Before and after each client contact
- After contact with potentially contaminated items, even if wearing gloves
- Many times a day

Show slide: *How Should We Wash Our Hands?*

- Use soap and clean water for each person
- Use flowing water, not standing pools of water
- A brush may be used to clean hands thoroughly
- Use a clean or individual towel

Say: *What is a “standing pool of water” compared to “flowing water?”*

- Answer: A standing pool of water is a basin or other container of water which does not have flowing water and into which everyone dips their hands. When running water is not available by faucet, spigot or pump, one person can pour fresh water from a container, enabling another person to wash.

Say: *Why is this not a good infection-prevention practice?*

- Answer: Because contamination can spread to everyone who washes their hands in that water. Microorganisms can thrive in a container of water used by multiple people.

Show slide: *Handwashing*

Say: *According to studies of handwashing behavior, when head doctors and other clinic leaders wash their hands regularly, other health-care workers tend to do the same.*

Ask participants to think about the handwashing practices of lead clinicians in their own facilities.

- Do these leaders set a good example of handwashing behaviors?
- If they do not, how could they be convinced to do so?

Say: *Now we'll talk about personal protective barriers, which are used as protection against exposure to infection.*

Put on personal protective barriers—face protection (mask and eyewear or a face shield), arm protection (gown or lab coat), and gloves. Wear them while you discuss the next few points.

Show and discuss slide: *When to Wear Personal Protective Barriers*

- Barriers must be worn whenever there is the possibility of contact with blood or body fluids.

Note to Trainer: For the following slides, you may want to indicate on your own body what areas might be exposed to blood and demonstrate the personal protective barriers and where and how they should be used.

Show slide: *Personal Protective Barriers for Performing MVA*

Say: *When a health-care provider is performing an MVA, what areas of their body might be exposed to blood?*

- Eyes, face, mouth, arms, hands

Say: What personal protective barriers should the provider wear during an MVA procedure?

- Face protection (shield or mask and eyewear), arm covering (gown or lab coat) and hand protection (gloves).

Say: Is it necessary to wear all these barriers whenever doing anything in the clinic?

- No, only when contact with blood is possible, such as by accidental splashing.

Say: What barriers should a person wear when cleaning instruments, even if the instruments have been soaked in a chlorine solution?

- Face shield or eye and mouth protection, gloves, gown or lab coat

Say: Sometimes people think that it looks inappropriate for an MVA provider to be wearing a mask if they are not working in an operating theatre. Why should a provider always wear mouth covering, such as a surgical mask, when performing MVA?

- A surgical mask is to protect the provider, not the client, from infection.

Say: Another barrier to use is gloves.

Show and discuss slide: *When Should We Wear Gloves?*

- Wear gloves when contact with body fluids is likely.
- Change gloves between clients, after contact with a potentially contaminated item, before touching sterile instruments, and between rectal and vaginal examinations.
- Remove gloves and wash hands immediately following a procedure.

Say: Next we will talk about how to safely handle sharp items.

Handling sharp items is a common way that workers get exposed to blood and body fluids. It is often responsible for disease transmission.

Ask participants to name some sharp items in the clinic.

- Answers may include: blades, glass, hypodermic needles, tenaculae, suture needles, and scissors

Say: Handling needles or other sharp items in certain ways can result in injuries and infection. Who has been stuck or cut while providing clinical services?

- Have one person briefly say how they were stuck or cut and how it affected their infection-prevention practices afterwards.

Show and discuss slide: *How Can We Prevent Injuries From Sharp Items?*

- Do not carry hypodermic needles.
- Set aside a specific area for keeping sharps during procedures.
- Announce the passage and presence of sharps to avoid accidentally sticking others.

- Dispose of needles and syringes immediately, in puncture resistant containers, without recapping, removing, cutting or bending them.
- If syringes must be recapped, use the "scoop method."

Say: Who can propose other ways to prevent injuries from sharp items?

Show slide: *Scoop Method*

- If syringes must be recapped during a procedure:
 - Scoop cap onto needle without touching cap or needle
 - Pull cap onto needle by holding cap near base
 - Never put fingers on tip of cap while pushing cap onto needle

Ask a volunteer to come to the front and demonstrate the scoop method.

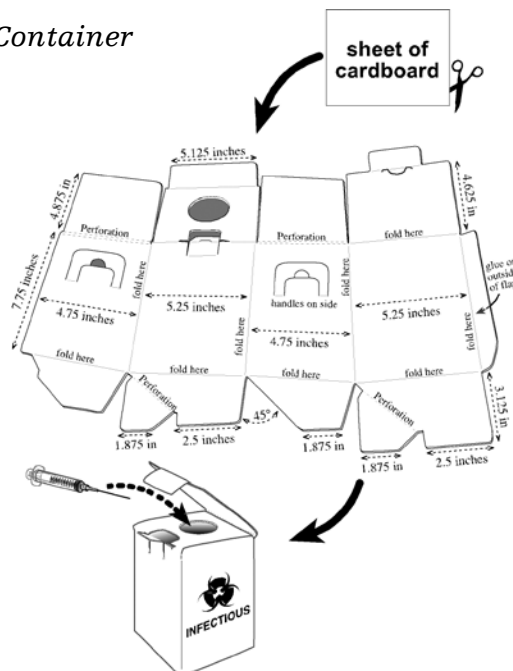
- Emphasize that the last step is to pull the cap over the needle, not to push it from the top of the cap, as the needle can easily pierce through the cap and into the fingertip.
- Recapping needles is only to be done when necessary during a procedure and never before disposing of a needle.

Show and discuss slide: *Safe Needle Disposal*

- Immediately drop needles into sharps container.
- Do not recap, remove, cut or bend needles.
- Place sharps containers everywhere that needles are used.

Say: A sharps container is a container that securely contains the syringe with the needle still attached. The container should not allow the syringe to puncture anything or be easily removed. Sharps containers vary in appearance.

Show slide: *Sharps Container*



Say: What sharps containers are you using locally?

- For every example, ask if it meets the criteria for safe disposal.
- Criteria:
 - Container is secure, cannot be punctured, prevents items from being easily removed, allows syringe to be dropped in immediately with the needle still attached.
- If the item does not meet the criteria, then it is not appropriate for use in clinics.
 - For example, drink cans do not allow syringes to be dropped in immediately with needles still attached.

Say: Now we will discuss a few scenarios to apply our knowledge.

Read the following scenarios and, for each one, ask participants whether or not it presents a good solution for proper sharps disposal.

Show slide and read: *Sharps Containers Scenario 1*

Say: As a way to reduce costs, a clinic decides to put one large container at the centrally located nurses' station. Workers bring their sharps there from all over the clinic.

Good solution?

Correct response: No. Containers should be located every place needles are used, because carrying needles causes accidental injuries.

Show slide and read: *Sharps Containers Scenario 2*

Say: Another clinic thought a technological solution would help, so they bought a needle cutter that automatically breaks needles before disposal.

Good solution?

Correct response: No. Needles should not be broken, cut or bent before disposal. Breaking, bending or manipulating needles in any way—even with a machine—causes injuries.

Show slide and read: *Sharps Containers Scenario 3*

Say: One clinic used large, metal cooking-oil containers into which many needles and syringes can easily be dropped. The containers, which can be securely closed when full, were placed everywhere that needles are used.

Good solution?

Correct response: Yes. Staff don't have to carry the needles anywhere for disposal and the containers are secure, cannot be punctured, prevent items from being easily removed and allow syringes to be dropped in immediately with needles still attached.

Show slide and read: *Sharps Containers Scenario 4*

Say: At one clinic, workers had to take the needle off the syringe and insert both separately into a small drink can.

Good solution?

Correct response: No. Needles should not be handled before disposal, even to detach. A drink can is not an appropriate sharps container. It does not provide enough room for the syringe to be dropped in immediately with the needle still attached.

Summarize content on proper sharps handling by emphasizing how they reduce the risks of injury to providers, clients, coworkers and the community around the clinic.

Say: We have been talking about standard precautions which protect workers and clients. Now we will discuss "aseptic technique," which protects clients against infection after procedures.

Show and discuss slide: *Aseptic Technique for Uterine Evacuation Includes*

- Antiseptic preparation
- No-touch technique
- Proper processing and handling of instruments

Show and discuss slide: *Antiseptic Preparation*

- Use antiseptic to clean the cervical os and, if desired, the vaginal walls
- Resident vaginal flora can be introduced when inserting the cannula into the uterus, causing infection
- Ask about any allergic reactions to antiseptics.

Show slide: *Cervical Preparation*

Show and discuss slide: *No-Touch Technique*

- Always handle instruments by the end that does not come into contact with the woman
- No instrument contact with a contaminated surface before insertion through the woman's cervix
- The tenaculum, cannula or dilator tips should not touch providers' gloves, woman's vaginal walls or unsterile parts of the instrument area

Say: Instrument processing and aseptic handling of MVA instruments are discussed in the Uterine Evacuation Procedure with Ipas MVA Plus module.

Now let's talk about environmental cleanliness. A clinic and everything in it should be kept clean and dry at all times to stop the spread of infection.

Show slide: *Environmental Cleanliness*

- Everything in the clinic should be clean and dry
- Use 0.5 percent chlorine solution for cleaning

Show and discuss slide: *When Should the Clinic Be Cleaned?*

- At the beginning of each session
- Between clients as needed
- At the end of each day

Say: Properly disposing of infectious waste is also critical to maintaining environmental cleanliness.

Show slide: *Infectious Waste*

- All disposable material that has come in contact with body fluids
- Proper waste disposal protects the community

Say: When infectious waste makes its way from a clinic into the community, what dangers does this pose?

- Answers include: Accidental needle sticks and exposure to infected blood and other body fluids in solid waste or water sources.

Show and discuss slide: *Safe Infectious-Waste Disposal*

- Secured; not in an open pile
- Ideally, incinerated
- Buried and protected by a fence, away from water source
- Liquid waste buried or poured down a drain

Say: Liquid waste can include, for example, products of conception (POC) and fluids from an MVA procedure or uterine evacuation with medical methods. In such cases, the waste should be poured down a drain or buried, as with other liquid infectious waste.

How do you currently dispose of infectious waste at your facilities?

- Have a few participants respond.
- Identify those who are properly disposing of waste.

Say: Ensuring that infectious waste is properly handled may be a complicated administrative decision, but there are some locally available solutions.

- Ask the participants to open to Section 3.7 of the Reference Manual, where there is an illustration of an incinerator that might be used at their facilities.

Say: Now we'll discuss accidental exposure. In spite of our best efforts, workers are sometimes accidentally exposed to blood and body fluids. This is one reason why it is important for facilities to develop protocols for accidental exposure, widely disseminate the protocols to staff, and monitor the program periodically.

Show and discuss slide: *If Exposed*

- If exposure caused bleeding, allow to bleed briefly
- Immediately flush with clean water
- Wash wound and skin thoroughly; flush mucous membranes
- If water isn't available, use antiseptic solution
- Determine type of fluid and exposure
- Give post-exposure prophylaxis if available

Show and discuss slide: *If Exposed (cont.)*

- Consult an infectious-disease specialist
- Record exposure and action taken
- Offer voluntary, confidential HIV, HBV and HCV counseling and testing
- Evaluate acute illnesses that develop

Inform participants about more resources on management of exposure – see Additional Resources in Reference Manual.

Explain that preventing injuries is always best, especially if post-exposure resources are not locally available.

Explain to participants that they are now going to work in groups to create an Action Plan that demonstrates their commitment to improving infection-prevention practices at their clinic facilities.

- Have participants divide into groups of three to four, preferably by facility.
- Ask them to take out the Infection Prevention Skills Checklist and Action Plan worksheet.
- Have participants take 15 minutes to fill out the remaining columns as a group.
- Where they answered “yes” in the “Do you?” column, they do not need to do anything further.
- Where they answered “no,” they should fill in the next column, “Could you?”
 - In other words, could they implement this technique once they return to their facilities?
- If they could, they should indicate this.
- If they could not, they should indicate in the “Why not?” column the obstacles to implementing that technique.
 - These may include personnel and material shortages, administrative policies, etc.

- In the final column, they should indicate how they plan to solve this problem and overcome the obstacles identified.

This is your Action Plan for implementing proper infection-prevention practices at your facility. What remaining questions do you have about infection prevention for abortion-related services?

- Answer questions.

3. Summary and test

Ask participants for key points covered in this module. Use the objectives as a reference.

Say: What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.

Thank the participants for their participation.

References

- Achilles, S. L., & Reeves, M. F. (2011). Prevention of infection after induced abortion: release date October 2010: SFP guideline 20102. *Contraception*, 83(4), 295-309. doi: 10.1016/j.contraception.2010.11.006
- Association of Operating Room Nurses. (2010). Aseptic technique [Video]. Denver, CO: Association of Operating Room Nurses.
- Association of Operating Room Nurses. (2012). *Perioperative standards and practices for inpatient and ambulatory settings*. Denver, CO: Association of Operating Room Nurses.
- Centers for Disease Control and Prevention. (2001). Appendix B: Management of occupational blood exposures. *Morbidity and mortality weekly report*, 50(RR11), 45-46.
- EngenderHealth. (2000). *Infection prevention: A reference booklet for healthcare providers, 2nd edition*. Retrieved from <http://www.engenderhealth.org/pubs/quality/infection-prevention.php>
- Gruendemann, B. J., & Mangum, S. S. (2001). *Infection prevention in surgical settings*. Philadelphia, PA: W. B. Saunders Company.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Lankford, M. G., Zembower, T. R., Trick, W. E., Hacek, D. M., Noskin, G. A., & Peterson, L. R. (2003). Influence of role models and hospital design on hand hygiene of healthcare workers. *Emerging Infectious Diseases*, 9(2), 217-223. doi: 10.3201/eid0902.020249
- Siegel, J. D., Rhinehart, E., Jackson, M., & Chiarello, L. (2007). *Guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings*. Retrieved from <http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>
- Tietjen, L., Bossemeyer, D., & MacIntosh, N. (2003). *Infection prevention: Guidelines for healthcare facilities with limited resources*. Baltimore, MD: JHPIEGO.
- World Health Organization. (2003). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors*. Geneva, Switzerland: World Health Organization (WHO).
- World Health Organization. (2007). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors Integrated management of pregnancy and childbirth (IMPAC)* (Second ed.). Geneva: World Health Organization.
- World Health Organization (2012). *Safe abortion: Technical and policy guidance for health systems* (Second ed.). Geneva, Switzerland: World Health Organization (WHO).

Knowledge Test Key

1. b
2. a
3. c
4. b
5. d

Infection Prevention Knowledge Test

Circle the correct response.

1. How are blood-borne diseases commonly spread in clinics?
 - a. Contact with infected bed linens
 - b. Injuries from sharp instruments, such as needle sticks
 - c. Contact with blood on workers' gowns or lab coats
 - d. Splashes of blood on intact skin

2. Which of these is not an essential element of infection prevention?
 - a. Breaking needles before disposal
 - b. Environmental cleanliness
 - c. Handwashing
 - d. Personal protective barriers

3. Which of the following is not a proper procedure for managing occupational exposure to blood and body fluids?
 - a. Immediately flush area with clean water.
 - b. If exposure caused bleeding wound, allow to bleed briefly.
 - c. Prevent the employee from working until HIV status is known.
 - d. Give post-exposure prophylaxis when available.

4. Which statement best describes safe infectious-waste disposal?
 - a. Infectious waste should be collected and disposed of into an open pile.
 - b. Solid infectious waste should be incinerated in a secure area.
 - c. Solid infectious waste should be buried, but only near a water source.
 - d. Liquid waste should be poured down a well or into nearby standing water.

5. One way to demonstrate your commitment to implementing infection-prevention protocols is to:
 - a. Treat all clients the same, except those that are known to have HIV.
 - b. Insist that all workers share a basin to wash hands.
 - c. Wear a face shield at all times, regardless of the procedure being performed.
 - d. Lead by example and consistently practice standard precautions.

Infection Prevention Skills Checklist and Action Plan Worksheet

Instructions: Read each statement. In the second and third columns, respond with Y (yes) if you always do or could do this technique or N (no) if you do not do or could not do this in your clinic. If you respond no, list the obstacles to performing this technique, then list your plans to begin consistently performing this technique.

	Do you?	Could you?	Why not? (List obstacle)	Plan to implement practice
Standard Precautions I treat all clients the same with my infection-prevention practices.				
I regard all client and staff blood, body fluids, secretions and excretions and wet body surfaces (except sweat) as possibly contaminated, regardless of any diagnosed disease.				
Handwashing I always wash my hands before and after contact with a client.				
I wash my hands with fresh, flowing water.				
I always wash my hands when they are contaminated with a client's blood or body fluid, whether or not disease has been diagnosed.				
Personal Protective Barriers I wear gloves, face protection and a gown when there is a risk of my hands, face or arms being contaminated with the blood or body fluid of a client or staff.				
Handling of Sharps I cautiously avoid injury from used needles.				
I immediately dispose of used needles in a sharps container.				
I dispose of needles without bending or cutting them. I dispose of used needles without putting the needle caps back on.				

Making Personal Protective Barriers from Locally Available Materials (optional)

Face shield

Ask participants to open the Reference Manual to the illustration in Section 3.2 of how to make a face shield. Pass a sample face shield around for participants to inspect.

Tell the group that this is a very simple face shield which can be made from locally available materials. It can be washed and reused.

Sharps containers

Show participants some versions of suitable, locally made sharps containers: for example, a well-sealed empty shipping box.

- Describe how to make them.
- Ask participants to open the Reference Manual to Appendix A: Sharps Container to see a pattern for making a sharps container.

Clinical Assessment



Purpose

This module describes how to conduct a complete clinical assessment before a uterine evacuation and address preexisting conditions and special client considerations.



Note to trainers: If training on postabortion care only, the slides for this module are in a different order. Please refer to the postabortion care PowerPoint presentation on the CD-ROM.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights in the abortion-related care setting
- ☐ Demonstrate standard precautions and aseptic technique
- ☐ Perform a general physical examination, including a pelvic exam and assessment of uterine size and abnormalities



Objectives

By the end of this module, participants should be able to:

1. Describe how to conduct a clinical assessment before uterine evacuation for comprehensive abortion care, including postabortion care
2. Address preexisting conditions relevant to abortion-related care
3. Address special client considerations



Materials

- ☐ Clinical Assessment Skills Checklist
- ☐ Clinical Assessment For Postabortion Care Skills Checklist
- ☐ Role Play Scenarios handout and key
- ☐ A marker for each participant
- ☐ Knowledge Test and Test Key



Advance preparation

- ☐ Select or adapt appropriate Role Play Scenarios for these training participants.
- ☐ Make copies of Role Play handout, Clinical Assessment Skills Checklist and Knowledge Test.
- ☐ Identify local protocols for assessing women seeking abortion-related services and discuss these along with Ipas recommendations.
- ☐ Become familiar with the level of abortion-related care that can be provided at participants' facilities, to inform discussion.
- ☐ Label three flipchart pages: 1) Client History, 2) Physical Exam and 3) Collection of Specimens and Ordering of Any Lab Tests, only if needed

Time: 2 hours

1. Introduction

Welcome the participants. Introduce yourself and the module.

Show slide: *Purpose*

- This module describes how to conduct a complete clinical assessment before a uterine evacuation and address preexisting conditions and special client considerations.

Show slide: *Objectives*

- By the end of this module, participants should be able to:
 1. Describe how to conduct a clinical assessment before uterine evacuation for comprehensive abortion care, including postabortion care
 2. Address preexisting conditions relevant to abortion-related care
 3. Address special client considerations

Say: When a woman presents for abortion-related care, it is essential to assess her health and condition immediately. Why perform this rapid, initial assessment?

- It allows the provider to quickly and properly evaluate the woman's health and identify and treat any life-threatening complications.
- It is important to evaluate the woman's emotional state and circumstances.
- A woman presenting for postabortion care may need emergency treatment of complications, including shock.
- Open, supportive communication and a gentle, reassuring manner help ensure that the provider obtains the relevant information needed to offer the best possible care for the woman.

Say: More information on clinical assessment for postabortion care will be covered later in the module.

When we say that an assessment must be conducted in “private,” what exactly do we mean?

- The assessment must be conducted in a place where the woman and provider cannot be seen or heard by others (visual and auditory privacy).

Say: A clinical assessment can generally be organized into three main components.

Show slide: *Components of a Complete Clinical Assessment*

- Client history
- Physical examination, including pelvic and bimanual exam
- Collection of specimens and ordering of any lab tests, only if needed

2. Completing a client history

Say: You already have the knowledge and skills for performing a general physical examination. We will now review that process and make it relevant for abortion-related services.

Post three flipchart pages around the room, each labeled with one of the three components of a clinical assessment:

1. Client History,
 2. Physical Exam and
 3. Collection of Specimens and Ordering of Any Lab Tests, only if needed
- Give each participant a marker.
 - Tell participants to walk around to all three pieces of paper, listing on each the information that providers should obtain during each component of a clinical assessment for abortion-related care.
 - After 10 minutes, explain that correct responses will be discussed by reviewing the Clinical Assessment Skills Checklist.

Hand out the Clinical Assessment Skills Checklist.

- Tell participants to follow along with the checklist during the discussion.

Discuss correct answers and identify incorrect information. Guidelines given in this module are consistent with World Health Organization (WHO) guidelines for abortion-related care. Local guidelines may vary. In this discussion, please distinguish any differences between WHO and local guidelines.

Say: The first component of a clinical assessment is the client history. What information should be collected during this component?

- Refer to the flipchart page labeled “Client History.”
- Discuss whether or not each comment written by participants is needed during a clinical assessment for abortion-related care.
- Correct and explain any comments written by participants that are not relevant.
- Let participants know if local protocols vary from WHO guidelines.
- Ensure all points on the slides below have been listed on the flipchart.

Say: What do you think are the first steps in assessing a woman who is seeking abortion-related care?

- The first step is to determine if she is pregnant. If she is, determine the length of the pregnancy.

Say: How can it be determined that she is pregnant?

- Ask her for the date of her last menstrual period (LMP). A pregnancy test may also be performed, if available.

Say: How can we determine the length of a pregnancy?

- Ask her for the date of her LMP, and a bimanual exam should also be performed.

Say: What are some common signs and symptoms of pregnancy?

- Breast enlargement and soreness, nausea, vomiting, fatigue, appetite changes, increased frequency of urination.

Review key information that should be collected when conducting the client history during a clinical assessment for abortion care. Refer participants to Section 2.0: Client History in the Reference Manual.

Show slide: *Client History*

- First day of LMP
- Signs and symptoms of pregnancy
- Any pregnancy tests or ultrasounds and their results
- Any bleeding or spotting during the pregnancy
- Known drug allergies
- Obstetric and gynecological history

Say: What do we mean by “obstetric and gynecological history”?

- Live births, miscarriages, abortions, contraceptive use history, ectopic pregnancies, menstrual history, fibroids, infections or recent abortion-related care.

Show slide: *Client History (cont.)*

- Sexual history
- Medications such as misoprostol or herbal remedies
- HIV status and presence of sexually transmitted infection
- Surgical history
- Physical or cognitive disabilities or mental illness
- Known health conditions

Explain that some clinically-important conditions can be found by conducting a client history.

- Give participants about three minutes to read the box describing health conditions relevant to abortion-related care in Section 2.0 of the Reference Manual.
- Discuss conditions that might require a referral to a facility that can address them.

Say: What if you determine that the woman has used the medication misoprostol in an attempt to terminate the pregnancy herself?

- No specialized treatment is indicated. If she has used a recommended medical abortion regimen, she may not need additional procedures, depending on the time passed since taking the medications. Some women may present with significant bleeding that needs further treatment. Women with an ongoing pregnancy should be counseled about the very rare risk of birth defects if they choose to continue the pregnancy. Cervical dilatation may not be needed during an MVA procedure.
 - If the pregnancy is greater than 12 weeks, be alert to possible heavy bleeding, which may be stopped by vacuum aspiration.
- P**
- Refer participants to the Uterine Evacuation With Medical Methods module for more information on misoprostol.

3. Conducting a physical examination

Say: Before going into the details of a physical examination, let's discuss the importance of accurately estimating the length of a pregnancy.

Show and discuss slide: *Gestational Age*

- Misestimation is uncommon in abortion-related care.
- Use LMP in combination with bimanual exam.
- For VA, significant underestimation can result in increased risks and complications.
- For medical methods, underestimation is unlikely to be clinically important.

Say: The last point is true because medical methods' efficacy and safety decrease only gradually as gestational age increases.

Show and discuss slide: *Estimate Uterine Size Accurately*

- Bimanual pelvic exam
- Last menstrual period (LMP)
- Other signs of pregnancy

Say: In postabortion care, uterine size, not gestational age, determines eligibility, and the uterus may be smaller than the LMP indicates.

Show and discuss slide: *Use Both Estimation Methods*

Bimanual exam + LMP → Gestational age

Say: Studies show that the combination of estimation methods results in accurate estimates of gestational age. Although these are usually sufficient, ultrasound may be useful for confirmation when gestational age is unclear based on history and exam.

Ask participants to consider the potential adverse effects of underestimating the length of pregnancy for each method of uterine evacuation, medical methods and VA, referring to the box in Section 2.0 of the Reference Manual as a resource.

Explain that the physical exam should begin with a general health assessment.

Show and discuss slide: *General Health*

- Check and record vital signs
- Note weakness, lethargy, anemia, malnourishment
- Check her abdomen for masses, tenderness

Say: The next step is to perform a pelvic examination. Many women are apprehensive about a pelvic exam. How can providers help the woman feel more relaxed?

- Answers include: Reassure her, tell her in advance what to expect, ask if she would like to have a support person with her. This is especially important if this is the woman's first pelvic exam, which is most likely in young or nulliparous women.
- Have participants turn to examples of verbal reassurance in the Uterine Evacuation Procedure With Ipas MVA Plus module in the Reference Manual.
- Ask participant(s) to read the examples aloud and compare them to the group responses.

Show slide: *Pelvic Exam*

- Ask the woman to empty her bladder.

- Help her move into lithotomy position.
- Attend to any special physical needs.
- Ensure her privacy is protected.
- Conduct both a speculum and a bimanual exam.

Say: Why ask the woman to empty her bladder?

- A full bladder can make it difficult to assess the uterus and can mask findings.

Say: What does “ensuring her privacy is protected” mean? How do we achieve this?

- Keep her perineum covered by a sheet, towel or piece of clothing at all times, except when actually doing the procedure.

Show slide: *Lithotomy Position*

Say: Can you point out the ways in which this slide illustrates the proper way to treat a woman in lithotomy position?

- Her privacy is protected. She is supported emotionally and physically. She appears comfortable.

Say: Before inserting the speculum, inspect the external genitalia, vaginal canal and cervix. Note any ulcers or signs of sexually transmitted infections (STIs) on the external genitalia.

Show slide: *Speculum Exam*

- Gently insert appropriate-sized speculum.
- Check for bleeding, discharge, pus, lesions.

Explain what should be done if possible infection is detected.

- Take samples for culture, if possible.
- Women with signs and symptoms of a reproductive tract infection should be treated immediately and the procedure can be performed without delay.
- If a woman is screened for STIs, the uterine evacuation can be provided before results are returned. If positive, she may be treated after the uterine evacuation.

Say: The bimanual exam can be conducted before or after the speculum exam, depending on provider preference.

Show and discuss slide: *Bimanual Exam*

- Assess size, consistency and position of uterus and adnexa.
- It may be her first bimanual exam, especially if she is young. If so, treat her with extra care and gentleness.

- Compare the size of the uterus with history of amenorrhea.

Show slide: *Perform Bimanual Exam*

Say: If the uterus is found to be smaller than expected, what might be the reason?

- The woman is not pregnant, estimation of length of pregnancy was inaccurate, ectopic pregnancy, spontaneous abortion, molar pregnancy, normal variation between women, incomplete or missed abortion.

Say: Now let's consider the opposite situation: If the uterus is larger than expected, what are the possible explanations?

- Inaccurate estimation of length of pregnancy, multiple pregnancies, uterine anomalies such as fibroids or bicornate uterus, molar pregnancy, normal variation.

Say: What situations or conditions might make it difficult to assess the size of the uterus?

- Fibroids; retroversion of the uterus; obesity; full bladder; the woman not relaxing her abdomen

Show slide: *Uncertain About Uterine Size?*

- Ask another provider to check.
- Use ultrasound.

Say: Why is it important to determine the position of the uterus before a VA procedure?

- Answer: A uterus tilted forward, backward or to one side may increase the risk of perforation.

Say: Let's return to the flipcharts to see if we included all the necessary actions the provider must take when conducting a physical examination.

- Refer to the flipchart page labeled "Physical Exam."
- Discuss whether or not each comment written by the participants is needed during an assessment for abortion-related care. Correct and explain any comments written by participants that are not relevant.
- Let participants know if local protocols vary from WHO guidelines.

Turn to the last flipchart page, "Collection of Specimens and Ordering of Lab Tests"

- Correct and explain any comments written by participants about laboratory tests that are not relevant.
- Let participants know if local protocols vary from WHO guidelines.
- Ensure all points on the next slide have been listed on the flipchart.

Show and discuss slide: *Lab Tests*

- No routine labs required
- History and exam usually sufficient
- If there is doubt the woman is pregnant, use pregnancy test or ultrasound, but abortion can proceed
- Hemoglobin, hematocrit optional, perhaps helpful where anemia is prevalent
- Rh iso-immunization only according to local protocol

Say: This concludes our discussion about the abortion-relevant information that needs to be collected during a clinical assessment.

Solicit and respond to questions.

4. Special considerations during clinical assessment

Say: We have discussed the three components of a clinical assessment for abortion-related care: client history, physical examination and laboratory tests. Now we will consider some additional issues.

Divide the participants into three groups.

- Refer participants to Sections 5.0, 6.0 and 7.0 of the Reference Manual.
- Assign one of these sections to each group.
- Tell the groups to select a “reporter” from their group before they begin.
- Ask each group to read and summarize their assigned section.
- They should select the four or five most important points in the section.
- They can make notes on a piece of paper.
- Each group will report back to the larger group.

After 10 minutes, ask the group assigned to Section 5.0: Ultrasound Exam and Ectopic Pregnancy to report.

- Be sure that they cover the following important points about ultrasound and ectopic pregnancy:
 - Ultrasound is not required for first-trimester abortion-related care.
 - Ultrasound can be used when there is difficulty assessing gestational age based on history and exam, to help detect ectopic pregnancies and to assess abortion completion.
 - Routine ultrasound may increase the cost of the procedure and likelihood of unnecessary intervention.

- Uterine evacuation methods cannot terminate ectopic pregnancies.
- Important to recognize the symptoms of and treat ectopic pregnancy.
- Risk factors for ectopic pregnancy include previous ectopic pregnancy, history of tubal surgery including sterilization, and presence of IUD.

Ask the group assigned to Section 6.0: Reproductive-Tract Infections to report.

- Be sure that they cover the following points:
 - Administer prophylactic antibiotics, if available, at the time of a vacuum aspiration abortion to reduce risk of infection.
 - If antibiotics are not available, vacuum aspiration should still be performed.
 - Prophylactic antibiotics are not recommended for medical abortion.
 - Women should be assessed for RTIs and treated for any active infection immediately, and the abortion procedure can still be performed.
- Refer participants to Appendix A: Provision of Antibiotics in Reference Manual for recommended doses.

Ask the group assigned to Section 7.0: Special Considerations During Clinical Assessment to report.

- Be sure that they cover the following points:
 - Be especially gentle and slow when examining young women or women who have experienced violence.
 - Women who have undergone female genital cutting (FGC) may need specialized care.
 - Evaluate signs of possible violence, such as bruises, burns, RTIs, etc. These signs may indicate the need for further discussion and screening for violence by providers or counselors to determine if a woman is in a dangerous situation. If this proves to be the case, providers should do what they can to help the woman before she leaves their care. Referrals to existing resources should be made before she leaves the facility, as many women may not return for follow-up appointments.



- Refer participants to Appendix A: Special Considerations of the Informed Consent, Information and Counseling Module in the Reference Manual for more information.

5. Considerations for postabortion care

Say: As mentioned earlier in this module, clinical assessment is one area of comprehensive abortion care that is somewhat different for postabortion care compared to induced abortion services.

Show and discuss slide: *Determine Whether Postabortion Care Is Needed*

If the woman presents with:

- Vaginal bleeding and/or
- Lower abdominal pain or cramping
- And is pregnant

Say: What types of abortion may have occurred?

Answers include: threatened, spontaneous, missed or incomplete abortion, safe or unsafe abortion, self-induced abortion, complications from previous abortion care.

Show and discuss slide: *Determine Whether Emergency Treatment Is Needed*

1. Perform rapid assessment for shock
2. Assess for other severe complications

Provide immediate treatment if woman is unstable.

Say: The woman may be unstable due to hemorrhage or sepsis, and treatment should be started immediately. Treatment may include immediate uterine evacuation. In these cases, clinical assessment occurs at the same time as treatment. We will cover more on how to treat abortion-related complications in the Complications module.

Show and discuss slide: *Rapid Initial Assessment for Shock*

Signs of shock

- Low blood pressure (SBP <90mm HG)
- Fast pulse
- Pallor or cold extremities
- Decreased capillary refill
- Dizziness or inability to stand
- Low urine output (<30 ml per hour)
- Difficulty breathing
- Impaired consciousness, lethargy, agitation, confusion

Say: More on shock and other complications will be covered in the Complications module.

Show and discuss slide: *Most Women Presenting for Postabortion Care...*

- Are clinically stable
- Have light to moderate bleeding
- Can proceed with:
 - Client history
 - Physical exam
 - Lab tests if needed

Show and discuss slide: *Once the Woman Is Stable Determine...*

- Type of abortion
- Whether there are non-life-threatening complications that need attention
- Eligibility for methods of uterine evacuation

Say: If uterine evacuation has already been performed to treat a woman in an unstable condition, her eligibility will have already been determined.

A noncritical condition may worsen and become life-threatening if treatment is delayed.

Show and discuss slide: *Management of the Abortion*

Depends on:

- Type of abortion
- Size of uterus
- Medical eligibility
- Availability of equipment and supplies
- Woman's preference
- Ask participants to review Appendix C: Diagnosis and Treatment of Types of Abortion in the Reference manual.

6. Role play for skills practice

Tell participants that the next activity will require the application of the information that has been discussed so far.

- Divide participants into groups of three.
- Give one Role Play Scenarios handout and one Clinical Assessment Skills Checklist to each group.
- In advance, select or adapt appropriate scenarios for these participants.
- Assign one of the case studies to each group.

- Ask the groups to follow the directions on the handout.

Ask the groups to indicate when they are finished, allowing adequate time for them to report back.

- Each group should present their scenario, findings, diagnosis and management considerations.
- After each group report, ask whether the large group agrees with their analysis.
- Use the Role Play Key to lead the discussion.

7. Summary and test

Ask participants for key points covered in this module. Use the objectives as a reference.

Say: What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.
- Thank the participants.

References

Achilles, S. L., & Reeves, M. F. (2011). Prevention of infection after induced abortion: Release date October 2010: SFP guideline 20102. *Contraception*, 83(4), 295-309.

American College of Obstetricians and Gynecologists Task Force on Female Genital Cutting. (2007). *Female genital cutting: Clinical management of circumcised women*. Washington, DC: American College of Obstetricians and Gynecologists.

Barnhart, K. T. (2009). Ectopic Pregnancy. *The New England Journal of Medicine*, 361(4), 379-387.

Blanchard, K., Cooper, D., Dickson, K., Cullingworth, L., Mavimbela, N., von Mollendorf, C., von Mollendorf, C., von Bogaert, L.J. & Winikoff, B. (2007). A comparison of women's, providers' and ultrasound assessments of pregnancy duration among termination of pregnancy clients in South Africa. *BJOG*, 114(5), 569-575.

Bracken, H., Clark, W., Lichtenberg, E. S., Schweikert, S. M., Tanenhaus, J., Barajas, A., Alpert, L., & Winikoff, B. (2011). Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. *BJOG*, 118(1), 17-23.

Castleman, L., Winikoff, B., & Blumenthal, P. (2009). Providing abortion in low resource settings. In M. E. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield, & M. D. Creinin (Eds.), *Management of unintended and abnormal pregnancy: Comprehensive abortion care* (2nd ed.). (319-334). West Sussex, UK: Wiley-Blackwell.

Clark, W., Panton, T., Hann, L., & Gold, M. (2007). Medication abortion employing routine sequential measurements of serum hCG and sonography only when indicated. *Contraception*, 75(2), 131-135.

Clark, W. H., Gold, M., Grossman, D., & Winikoff, B. (2007). Can mifepristone medical abortion be simplified? A review of the evidence and questions for future research. *Contraception*, 75(4), 245-250.

Davis, A., & Easterling, T. (2009). Medical Evaluation and Management. In M. Paul, S. E. Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield, & M. D. Creinin (Eds.), *Management of unintended pregnancy and abnormal pregnancy: Comprehensive abortion care*. West Sussex, UK: Wiley-Blackwell.

De Bruyn, M. (2003). *Violence, pregnancy and abortion: Issues of women's rights and public health* (2nd ed.). Chapel Hill, NC: Ipas.

Fielding, S. L., Schaff, E. A., & Nam, N.-Y. (2002). Clinicians' perception of sonogram indication for mifepristone abortion up to 63 days. *Contraception*, 66(1), 27-31.

Heise, L., Ellsberg, M., & Gottemoeller, M. (1999). Ending violence against women. *Population Report, Series L*(11), 1-43.

Ipas. (2009). *Uterine evacuation with manual vacuum aspiration (MVA): A training manual for conducting short courses*. Chapel Hill, NC: Ipas.

Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*. (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.

- Ipas. (2014). *Woman-centered, postabortion care: Reference manual*. (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Kaneshiro, B., Edelman, A., Sneeringer, R. K., & Ponce de Leon, R. G. (2011). Expanding medical abortion: Can medical abortion be effectively provided without the routine use of ultrasound? *Contraception*, 83(3), 194-201. doi: 10.1016/j.contraception.2010.07.023
- Løkeland, M., Iversen, O. E., Dahle, G. S., Nappen, M. H., Ertzeid, L. & Bjørge, L. (2010). Medical abortion at 63 to 90 days of gestation. *Obstetrics and Gynecology*, 115(5), 962-968.
- May, W., Gülmezoglu, A. M., & Ba-Thike, K. (2007). Antibiotics for incomplete abortion. *Cochrane Database of Systematic Reviews*, (4).
- Obed, S. (2006). Diagnosis of unruptured ectopic pregnancy is still uncommon in Ghana. *Ghana Medical Journal*, 40(1), 3-7.
- Rubin, G. L., Cates, W., Gold, J., Rochat, R. W., & Tyler, C. W. (1980). Fatal ectopic pregnancy after attempted legally induced abortion. *JAMA*, 244(15), 1705-1708.
- Stovall, T. G., Kellerman, A. L., Ling, F. W., & Buster, J. E. (1990). Emergency department diagnosis of ectopic pregnancy. *Annals of Emergency Medicine*, 19(10), 1098-1103.
- World Health Organization. (1994). *Clinical management of abortion complications: A practical guide*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2003). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2007). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors* (2nd ed.). Geneva, Switzerland: World Health Organization.
- World Health Organization. (2007). *Standard precautions in health care*. Retrieved from http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf
- World Health Organization. (2009). *Medical eligibility criteria for contraceptive use*. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf
- World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems* (2nd ed.). Geneva, Switzerland: World Health Organization.
- World health Organization. (2013). Female genital mutilation information fact sheet. 241. Retrieved from <http://www.who.int/mediacentre/factsheets/fs241/en/>
- Yao, M., & Tulandi, T. (1997). Current status of surgical and nonsurgical management of ectopic pregnancy. *Fertility and Sterility*, 67(3), 421-433.

Knowledge Test Key

1. d
2. c
3. d
4. True
5. True
6. True
7. True
8. d
9. d
10. d

Clinical Assessment Knowledge Test

Circle the correct response.

1. During clinical assessment, ensuring privacy requires:
 - a. A separate room
 - b. That no one be able to hear or see the provider or woman
 - c. Meeting with the woman alone, unless she gives permission for others to be present
 - d. b & c

2. Laboratory tests for provision of abortion-related care:
 - a. Are not routinely required
 - b. Can be helpful if available
 - c. a & b
 - d. Should never be performed

3. During clinical assessment, it is important to note any preexisting conditions because:
 - a. They may exacerbate or trigger complications
 - b. They may require the woman to be referred
 - c. Managing certain preexisting conditions requires advanced skills and equipment
 - d. All of the above

4. True or False One aspect of clinical assessment is determining if a woman has experienced violence.

5. True or False Accurately determining the length of pregnancy is a critical factor in both selecting a uterine evacuation method and preventing complications.

6. True or False The physical exam for uterine evacuation involves assessing the woman's general health and performing a physical exam.

7. True or False Where possible, prophylactic antibiotics should be administered at the time of vacuum aspiration to reduce the risks of post-procedure infection.

8. Ultrasound is not required for provision of first-trimester abortion-related care, but it may be helpful for:
 - a. Accurate gestational dating
 - b. Detecting ectopic pregnancies
 - c. Managing certain preexisting conditions
 - d. All of the above

9. If an RTI is suspected at the time of the clinical assessment, the provider should:
- a. Take samples for culture, if possible.
 - b. Require repeated cultures before any procedures to confirm if and what type of infection is present.
 - c. Treat an active infection regardless of the type of uterine evacuation procedure to be performed.
 - d. a & c
10. It is important to understand the signs and symptoms of ectopic pregnancy because:
- a. It can be challenging to rule out ectopic pregnancy.
 - b. Methods of uterine evacuation cannot treat ectopic pregnancies.
 - c. A woman with an ectopic pregnancy can be without symptoms.
 - d. All of the above.

Clinical Assessment Skills Checklist

Skill	Yes	No	Comments
Records Client History			
Asks about any pregnancy tests or ultrasounds and their results			
Asks about any bleeding or spotting during the pregnancy			
Determines drug allergies			
Obstetric and gynecological history: Live births, miscarriages, abortions, contraceptive use history, ectopic pregnancies, menstrual history, fibroids, infections or recent abortion-related care			
Asks about her sexual history			
Asks about recent medications taken, including misoprostol or herbs			
Determines HIV and STI status			
Asks about her surgical history			
Evaluates physical or cognitive disabilities or mental illness			
Asks about any known medical conditions that may affect eligibility for vacuum aspiration or medical abortion			
Assesses risk of ectopic pregnancy			
Addresses or refers for: Hypertension, seizure disorder, anemia, bleeding disorders, diabetes, heart disease, asthma, suspected ectopic pregnancy, cervical stenosis, alcohol or drug abuse			
Performs a Physical Exam			
<i>Evaluates general health</i>			
Checks her vital signs			
Notes general health, weakness, lethargy, anemia, malnourishment			
Checks her abdomen for masses, tenderness			
<i>Conducts a pelvic exam</i>			
Asks the woman to empty her bladder before the pelvic exam			
Explains to the woman what to expect, reassures her			
Uses towel, sheet, etc. to ensure her privacy is protected			

(continued on pages 188-189)

Clinical Assessment Skills Checklist

Skill (continued)	Yes	No	Comments
<i>Performs a speculum exam (may be done concurrently with the MVA procedure)</i>			
Notes ulcers or signs of STIs on the external genitalia			
Gently inserts a warm, appropriate-sized speculum			
Checks amount and source of any vaginal bleeding			
Notes any pus, discharge, lesions of the cervical os			
Takes culture if infection is suspected			
<i>Performs a bimanual exam (required for MA and MVA)</i>			
Assesses size, consistency, position of the uterus and adnexa			
Compares size of uterus with history of amenorrhea			
Asks another provider or uses ultrasound if uncertain of uterine size			
Orders Laboratory Tests			
Obtains any needed tests without delay of evacuation			
Administers Rh immunoglobulin, if routine protocol, at time of vacuum aspiration or when administering medical abortion			
Takes Proper Steps for Suspected Ectopic Pregnancy			
Evaluates woman's history and physical exam for possible ectopic pregnancy			
Uses appropriate testing (such as β hCG) or ultrasound imaging, if available, when ectopic pregnancy is suspected			
Performs vacuum aspiration instead of medical abortion to confirm products of conception if ectopic pregnancy is suspected			
Treats or refers immediately if ectopic pregnancy is suspected or confirmed			

Clinical Assessment Skills Checklist

Skill (continued)	Yes	No	Comments
Manages RTIs			
Administers prophylactic antibiotics, if available, to all women before vacuum aspiration			
Performs vacuum aspiration even if prophylactic antibiotics are not available			
Does not administer prophylactic antibiotics for medication abortion			
Assesses for and treats active infection, regardless of uterine evacuation method			
Prescribes a course of antibiotics to take after the uterine evacuation if infection presentpresent			

Clinical Assessment for Postabortion Care Skills Checklist

Skill	Yes	No	Comments
Identifies Abortion as Possible Diagnosis			
Performs a Rapid Initial Assessment for Shock			
Stabilizes woman without delay			
Identifies causes or refers			
Records Client History			
Determines first day of last menstrual period (LMP)			
Evaluates signs and symptoms of pregnancy			
Asks about any pregnancy tests or ultrasounds and their results			
Determines duration and amount of bleeding or spotting			
Determines duration and severity of cramping or pelvic pain			
Determines if there is a history of fever, chills or abdominal pain			
Determines drug allergies			
Asks about recent medications taken, including misoprostol or herbs			
Obstetric and gynecological history: Live births, miscarriages, abortions, contraceptive use history, ectopic pregnancies, menstrual history, fibroids, infections or recent abortion-related care			
Asks about her sexual history			
Determines HIV and STI status			
Asks about her surgical history			
Evaluates physical or cognitive disabilities or mental illness			
Asks about any known medical conditions that may affect eligibility for vacuum aspiration or medical abortion			
Assesses risk of ectopic pregnancy			
Addresses or refers for: Hypertension, seizure disorder, anemia, bleeding disorders, diabetes, heart disease, asthma, suspected ectopic pregnancy, cervical stenosis, alcohol or drug abuse			

(continued on pages 191-192)

Clinical Assessment for Postabortion Care Skills Checklist

Skill (continued)	Yes	No	Comments
Performs a Physical Exam			
<i>Evaluates general health</i>			
Checks her vital signs			
Notes signs of general health including weakness, lethargy, anemia or malnourishment			
Checks her abdomen for masses, tenderness			
<i>Conducts a pelvic exam</i>			
Asks the woman to empty her bladder before the pelvic exam			
Explains to the woman what to expect, reassures her			
Uses towel, sheet, etc. to ensure her privacy is protected			
<i>Performs a speculum exam</i>			
Notes ulcers or signs of STIs on the external genitalia			
Gently inserts a warm, appropriate-sized speculum			
Checks amount and source of any vaginal bleeding			
Notes any pus, discharge, lesions of the cervical os			
Gently removes any visible products of conception from the os with a ring forceps			
Identifies traumatic injuries and removes any foreign bodies			
Takes culture if infection is suspected			
Performs a Bimanual Exam			
Assesses size, consistency and position of the uterus and adnexa			
Notes any uterine or adnexal tenderness			
Compares size of uterus with history of amenorrhea			
Notes whether cervical os is open or closed			
Asks another provider or uses ultrasound if uncertain of uterine size			

Clinical Assessment for Postabortion Care Skills Checklist

Skill (continued)	Yes	No	Comments
Makes Diagnosis and Develops Treatment Plan			
Determines type and stage of abortion			
Diagnoses and manages severe complications of abortion			
Determines whether uterine evacuation is needed			
If uterine evacuation is needed, determines eligibility for vacuum aspiration or misoprostol. Counsels woman on available options			
Obtains voluntary informed consent			
Determines pain management plan and gives it without delay			
Orders Laboratory Tests			
Obtains any needed tests without delay of evacuation			
Administers Rh immunoglobulin, if routine protocol, at time of vacuum aspiration or when administering misoprostol			
Takes Proper Steps for Suspected Ectopic Pregnancy			
Evaluates woman's history and physical exam for possible ectopic pregnancy			
Uses appropriate testing (such as β hCG) or ultrasound imaging, if available, when ectopic pregnancy is suspected			
Performs vacuum aspiration instead of uterine evacuation with misoprostol to confirm products of conception if ectopic pregnancy is suspected			
Treats or refers immediately if ectopic pregnancy is suspected or confirmed			
Manages RTIs			
Administers prophylactic antibiotics, if available, to all women before vacuum aspiration			
Performs vacuum aspiration even if prophylactic antibiotics are not available			
Does not administer prophylactic antibiotics for uterine evacuation with misoprostol			
Assesses for and treats active infection, regardless of uterine evacuation method			
Prescribes a course of antibiotics to take after the uterine evacuation if infection present			

Role Play Scenarios

Instructions:

- One participant plays the woman using the provided scenario, another plays the provider and the third acts as an observer.
- The provider acts out a clinical assessment while the observer evaluates the provider's performance.
- Unless a symptom or condition is specifically mentioned in the scenario, the provider should consider the woman to be healthy. If an exam is indicated, the provider should act out the exam and associated questions.
- The observer should use the Clinical Assessment Skills Checklist and assess whether the provider did the assessment completely and correctly, offering appropriate support to the woman throughout. At the end of the role play, the person playing the role of the provider should give a self-assessment and the people playing the role of the woman and observer should then give feedback to the provider and make suggestions for improvement.
- All three in the group should then consider the results of the assessment and together develop a probable diagnosis and management considerations.

Scenarios

- P** 1. You are Mina, a 32-year-old woman. Your LMP was about 10 weeks ago. Yesterday, you took a drug which your friend gave you "to terminate the pregnancy at home." Since taking the drug, you have been experiencing constant nausea and vomiting. You are very upset and "want an abortion completed now."
- P** 2. You are Kim, a 28-year-old single woman. You have been treated by this provider for several RTIs over the past few years. Your menstruation is more than two weeks late and, believing you are pregnant, you have come to the clinic for an abortion. Upon conducting a bimanual exam, the provider finds that your uterus is smaller than expected and detects a possible mass on your left adnexa. Just before leaving for the waiting area, you experience an episode of sudden and intense lower abdominal pain.
3. You are Vanna, an extremely nervous 12-year-old. You come to the clinic with your mother. You have been referred to the clinic from a local emergency room, where you were treated for rape several weeks ago. You went to the emergency room one week after your assault and were given emergency contraception. You have rather large bruises on your left arm and a foul-smelling, purulent discharge coming from your cervix. It hurts when the provider presses on your cervix and uterus during the pelvic exam.
- P** 4. You are Esther, a nervous 16-year-old who comes to the clinic with your 18-year-old boyfriend, who is very supportive and helpful. You think your LMP might have been about seven weeks ago. You have never had irregular menstruation in the past. Also, you have had some breast tenderness and you are feeling sick to your stomach. You have heard about medical abortion and wonder if you might be able to have one. You want your boyfriend to be counseled with you. Before discussing your options, the provider decides to give you a physical exam to confirm that you are pregnant. The provider asks you to empty your bladder before the exam, but you are unable to because you are just too nervous. During the exam, the provider finds it very difficult to assess the size of your uterus: You are tensing your abdomen, making it difficult to determine the length of pregnancy. There is no ultrasound at this facility, although there are other abortion providers onsite.

- P** 5. You are Margaret, a 30-year-old mother of three. Your last menstrual period was six weeks ago. You believe you are pregnant because you know the symptoms from past pregnancies. You do not want to be pregnant and are interested in a medical abortion because your friend thinks it is a safe and easier way to abort. When asked if you have a history of any bleeding problems, you say that you don't. When discussing the birth of your last child, however, you recall being given a blood transfusion and hearing the provider say something about your blood not clotting well.
6. You are Anna, a 35-year-old woman with an unwanted pregnancy. The previous week, you inserted a hard root into your cervix in an unsuccessful attempt to end the pregnancy. You took medication this morning to try to bring on your menstruation, but you are not sure what it was. Your cervix is dilated and you have had some moderate bleeding and heavy cramping, but you are not sure if you have expelled any tissue. You now have a fever, chills, abdominal pain and strong-smelling discharge. You do not want more children because your husband beats you for not taking care of your four children in the way he wants. You are very scared and anxious about your husband finding out that you are at the facility.
7. (You play the mother and pretend that your daughter is with you.) You are Katherine, the mother of a 22-year-old woman, Monica, who comes in with you but you do all the talking. Monica does not understand that she is pregnant or why she and her mother are at the facility. Monica is cognitively disabled, and you have legal guardianship over her. Monica's cervix is slightly dilated, and she has been bleeding and cramping a moderate amount for three days. She cannot say whether she has passed any products. Monica will not say how she became pregnant.
8. You are Edna, a 14-year-old woman who comes to the clinic with a closed cervix and light bleeding and cramping for the last two days. Your uterine size corresponds to your LMP. You explain that your older boyfriend, who is at the facility with you, wants you to have his child. You are asking the provider to help you keep this pregnancy.

Role Play Key

Mina

What is her probable diagnosis?

- Incomplete abortion following self-administration of misoprostol

What are the management considerations for Mina?

- Provide counseling and then perform uterine evacuation with VA as soon as possible.
- Provide prophylactic antibiotics before vacuum aspiration.
- Consider that cervical dilatation may not be necessary.
- Counsel on pain management options.
- Discuss her reasons for using misoprostol and provide her with accurate information on MA
- Provide contraceptive counseling, desired methods if available and referrals.

Kim

What is her probable diagnosis?

- Ectopic pregnancy

What are the management considerations for Kim?

- Urgent resolution of her suspected ectopic pregnancy is paramount.
- Use or refer for ultrasound to help diagnose the ectopic pregnancy.
- Counsel her about her condition.
- Treat or refer her immediately for treatment, if treatment cannot be provided at this facility.
- MA drugs will not treat an ectopic pregnancy.

Vanna

What is her probable diagnosis?

- Acute purulent cervicitis and pregnancy post-rape

What are the management considerations for Vanna?

- Provide age-appropriate care and support.
- Counsel her, assess for pregnancy and screen for STIs, including HIV, if available.
- If pregnant, and pregnancy is unwanted, begin therapeutic antibiotic regimen and perform uterine evacuation using vacuum aspiration or medical methods as soon as coverage has been established.
- Counsel on pain management options.
- Refer her to services for women who experience violence.
- Refer her for further STI and HIV care if needed. Provide contraceptive counseling and methods if she is sexually active.

Esther

What is her probable diagnosis?

- Pregnancy

What are the management considerations for Esther?

- Counsel her and her boyfriend about pregnancy and uterine evacuation options, including medical abortion.
- Determine her pregnancy status by:
 - Performing a pregnancy test.
 - Waiting until she empties her bladder and encouraging her to relax.
 - Asking a support person to provide age-appropriate assistance during the exam to help her relax.
 - Asking another provider at the facility to assess length of pregnancy.
- Counsel on pain management options.
- Ensure the couple receives contraceptive counseling and desired methods and referrals to other resources if needed.

Margaret

What is her probable diagnosis?

- Pregnancy with possible clotting or bleeding disorder

What are the management considerations for Margaret?

- Counsel her about available methods of pregnancy termination, including medical abortion as an option.
- Discuss the possibility that she has a precaution for medical abortion.
- Evaluate her for a possible bleeding disorder.
 - Evaluate her condition onsite, if lab facilities are available.
 - If unable to evaluate her onsite, refer her to a facility that can manage her situation.
- Counsel on pain management options.
- Ensure she receives contraceptive counseling and methods and referrals to other resources.

Anna

What is her probable diagnosis?

- Incomplete abortion with infection, possible foreign body injury and misoprostol effects.

What are the management considerations for Anna?

- Provide increased emotional support due to heightened anxiety and fear.

- Administer therapeutic antibiotics prior to uterine evacuation.
- Counsel on pain management options.
- Perform uterine evacuation with VA, less dilatation may be required.
- Reassess foreign body cervical injury at time of procedure.
- Administer tetanus vaccine.
- Provide or refer for violence counseling and discuss a plan to stay safe.
- Provide contraceptive counseling and desired methods.
- Discuss proper use of MA drugs.

Monica

What is her probable diagnosis?

- Incomplete abortion

What are the management considerations for Anna?

- Provide increased support due to her disability; involve mother in all aspects of care.
- Counsel on pregnancy options.
- Offer MVA or MA according to woman's and mother's decision.
- If performing MVA, administer prophylactic antibiotics.
- Counsel on pain management options.
- Provide contraceptive counseling and methods.
- Refer for additional counseling and services, particularly to address safety.

Edna

What is her probable diagnosis?

- Threatened abortion

What are the management considerations for Edna?

- Offer age-appropriate counseling and support.
- Provide counseling on expectant management.
- If bleeding continues, conduct further clinical assessment.
- Counsel on pain management options.
- Provide the woman and her partner with information on contraception for the future.

Ipas MVA Instruments



Ipas MVA Instruments

This module provides information about the features, care and use of the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae used for uterine evacuation.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights in the abortion-related care setting
- ☐ Describe methods for evacuating the uterus
- ☐ Describe local procedures for processing medical instruments



Objectives

By the end of this module, participants should be able to:

- 1 Identify parts and features of the Ipas MVA Plus and Ipas EasyGrip cannulae
2. Describe processing, disassembly and assembly, maintenance, storage and handling of Ipas MVA Plus aspirators and Ipas EasyGrip cannulae



Materials

- ☐ Ipas MVA Plus aspirators, Ipas EasyGrip cannulae, lubricant and product insert: one set for trainer(s) and one set per participant or facility
- ☐ Samples of worn aspirators and cannulae that need replacing
- ☐ Barrier items for cleaning demonstration: face protection, apron, gown, gloves
- ☐ *Processing the Ipas MVA Plus Aspirators and Ipas EasyGrip Cannulae* wallchart (most current version) for each participant's facility (download from www.ipas.org or order from publications@ipas.org)
- ☐ Ipas Decontamination Statement
- ☐ Ipas MVA Instruments Knowledge Test and Test Key



Advance preparation

- ☐ Obtain local Ipas MVA instruments distributor name and contact information.
- ☐ Adapt this module if participants supervise instrument processing rather than process instruments themselves. Consider inviting the staff who perform instrument processing to attend the session.
- ☐ Identify local protocols for, as well as barriers to, processing MVA instruments.
- ☐ Make photocopies of Instrument Processing Skills checklist and Knowledge Test.

Time: 1.5 hours

Note to Trainer: This module does not describe the single-valve and double-valve aspirators or Karman cannulae. Trainers can refer to Appendix A: Comparison of Ipas Instruments in the Reference Manual. The processing steps for single valve aspirators are the same as for the Ipas MVA Plus.

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

Explain that the module provides information about the features, care and use of the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae used for uterine evacuation.

Show slide: *Objectives*

Say: By the end of this module, participants should be able to:

1. Identify parts and features of the Ipas MVA Plus and Ipas EasyGrip cannulae
2. Describe processing, disassembly and assembly, maintenance, storage and handling of Ipas MVA Plus aspirators and Ipas EasyGrip cannulae

2. Instrument features and use

Say: We will begin with a detailed examination of the instruments.

Show and discuss slide: *Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae*

- Woman-centered, appropriate technology
- Safe and effective for abortion-related care
- Can be used in decentralized health-care settings



WomanCare Global

Show slide: *WomanCare Global*

Tell participants that the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae are now manufactured and distributed globally by WomanCare Global. WomanCare Global (WCG) is a nonprofit organization working with partners around the world to improve the lives of women by providing access to affordable, quality reproductive health products.

Use your aspirator set to show the participants the instrument parts while presenting the slides below.

Show and discuss slide: *Parts Assembled*

Point to each part of the aspirator on the slide as you mention it.

- Describe each part:
 - Plunger with handle creates vacuum
 - Valve buttons control release of the vacuum
 - 60cc cylinder holds the products of conception (POC)
 - Collar stop with retaining clip prevents plunger from coming out

Say: The Ipas MVA Plus aspirator provides the same amount of vacuum as an EVA machine.

Hold up the cannulae and point to each aspect as you mention it.

Show and discuss slide: *About the Cannulae*

- Same dimensions, apertures (openings) as Karman cannulae
- Slightly more rigid
- Permanently affixed base with wings
- Sizes 4, 5, 6, 7 and 8mm have two opposing apertures
- Sizes 9, 10 and 12mm have one larger, single-scoop aperture
- Dots on each cannula at 1cm intervals indicate location of main aperture

Say: Ipas EasyGrip cannulae have permanent bases that act as built-in adapters. The cannulae connect directly to the Ipas MVA Plus aspirator without requiring a separate adapter.

Show and discuss slide: *Selection of Cannulae*

- Depends on uterine size and amount of dilation:

- Uterine size 4–6 weeks LMP: suggest 4–7mm
- Uterine size 7–9 weeks LMP: suggest 5–10mm
- Uterine size 9–12 weeks LMP: suggest 8–12mm

Say: It is important to use a cannula appropriate to the size of the uterus and amount of cervical dilation present. Using a cannula that is too small may result in retained tissue or loss of suction.

Explain that WomanCare Global also distributes a 3mm cannula for use in endometrial biopsy.

Show and discuss slide: *Applications for Endometrial Biopsy*

- Infertility
- Abnormal uterine bleeding
- Amenorrhea
- Screening for endometrial infections
- Screening for endometrial cancer

Show and discuss slide: *3mm cannulae*

- Two apertures and a winged base
- Adapter required for use with Ipas MVA Plus aspirator
- Sterilized with ethylene oxide (ETO) after packaging
 - Sterile if package is intact
 - Shelf life is three years for packaged cannulae
- Single-use devices, treat as infectious waste

Say: For the remainder of this module, we will focus on the cannulae used for the MVA procedure and not on the 3mm cannulae.

We will demonstrate how to disassemble the Ipas MVA Plus aspirator with cannula attached.

Use fully assembled aspirator with cannula attached for the demonstration.

- Ask for a volunteer to come up to disassemble the aspirator.
- Describe the steps for disassembling the instrument, pointing them out on the slide while the volunteer follows your directions.

Show and discuss slide: *Disassembling the Aspirator*

- Remove cannula by twisting its base and pulling it out of valve.
- Pull cylinder and remove from valve.
- Press cap-release tabs to remove cap.
- Open hinged valve by pulling open clasp.

Show and discuss slide: *Disassembling the Aspirator (cont.)*

- Remove valve liner.
- Disengage collar stop by sliding under retaining clip, or remove completely.
- Pull plunger completely out of cylinder.
- Displace O-ring by squeezing its sides and roll down into groove below.

Show and discuss slide: *Remove the O-Ring*

Point out that participants should never use a sharp object to remove the O-ring, as that could damage the ring.

Show and discuss slide: *MVA Parts Disassembled*

Say: Now we're going to demonstrate how to assemble the Ipas MVA Plus aspirator.

Ask for another participant to demonstrate the steps of instrument assembly using the now-disassembled instrument.

- Ask them to follow the steps described in the slides below.

Show and discuss slide: *Assembling the Ipas MVA Plus*

- Place valve liner in valve by aligning ridges.
- Close valve; ensure that it snaps into place.
- Snap cap onto end of valve.
- Push cylinder straight into base of valve.
- Place O-ring into groove near tip of plunger.

Show and discuss slide: *Assembling the Ipas MVA Plus (cont.)*

- Spread one drop of lubricant around O-ring with finger.
- Squeeze plunger arms, push straight into cylinder.
- Move plunger in and out to lubricate.
- Insert collar stop tabs into holes in cylinder.

Show and discuss slide: *When Assembling the Aspirator*

- Introduce plunger straight into cylinder.
- Do not introduce plunger at an angle.

Show and discuss slide: *Steps to Lubrication*

Say: It is important to only use one drop of lubricant because over-lubricating can interfere with vacuum capability. Silicone lubricant, which is not sterile, is provided in the packaging; other non-petroleum based lubricants can also be used.

Thank participants for their help with the demonstration.

Explain that getting the aspirator ready for use by creating a vacuum is called “charging” or “preparing” the aspirator.

Show and discuss slide: *Creating a Vacuum*

- Begin with valve buttons open, plunger all the way in and collar stop locked in place.
- Close valve by pushing buttons down and forward until they lock.
- Pull plunger back until plunger arms catch on wide sides of cylinder.
- Ensure that both arms are extended and secured over edge of cylinder.
- Incorrect positioning of plunger arms can allow plunger to slip back into cylinder.

Say: You should never grasp the charged aspirator by the plunger arms because it could lose vacuum or eject its contents.

Show and discuss slide: *Check Aspirator for Vacuum*

- Charge aspirator.
- Leave charged for several moments.
- Push buttons to release vacuum.
- A rush of air indicates vacuum was retained.

Show and discuss slide: *Checking Why Vacuum Fails*

- Check that instrument is properly assembled.
- Inspect O-ring for proper positioning and lubrication.
- If damaged, replace O-ring.
- Ensure no foreign bodies are present.
- Check cylinder is firmly seated on valve.
- Charge and test again.
- If vacuum is still not retained, use another aspirator.

Point out to participants the Ipas MVA Plus package insert containing product information that comes with every aspirator.

Say: Now you have the opportunity to practice disassembling, assembling and charging the instruments.

Distribute an instrument set to each participant.

- Allow participants a few minutes to inspect and handle the aspirator and cannulae.
- Circulate around the room, coaching participants on correct disassembly, assembly and charging.

- Tell them to leave their instruments charged and not release the vacuum until they are instructed to do so.

Demonstrate how to release the valve buttons.

- Ask one person at a time to release the vacuum in their aspirators.
- Ensure that everyone has properly tested their aspirators.
- If they did not hear the rush of air indicating vacuum release, determine together why the vacuum failed.

Say: We will now talk about the intended uses for the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae as described in the package insert.

Show and discuss slide: *Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae Uses and Indications*

- Intended use and indications:
 - Intended for uterine aspiration or evacuation
 - Treatment of incomplete abortion less than or equal to 12 weeks uterine size
 - First-trimester abortion (also called menstrual regulation in some countries)
 - Endometrial biopsy
 - Only contraindication: endometrial biopsy in cases of suspected pregnancy

Show and discuss slide: *Precautions for MVA*

- Treat any serious conditions that may be present.
- Determine size and position of uterus.
- Procedural difficulty may result with fibroids, uterine anomalies. Women with bleeding disorders might have excessive bleeding post-procedure.

Show and discuss slide: *Possible Complications*

- Vagal reaction
- Incomplete evacuation
- Uterine/cervical injury
- Pelvic infection
- Acute hematometra

Say: These conditions can occur with any uterine evacuation procedure. Once the woman is stabilized, the procedure should not be delayed.

What questions do you have about intended use and precautions?

- Answer questions.

Say: To obtain or reorder Ipas MVA instruments, contact your local distributor or WomanCare Global customer service.

Show and discuss slide: *WomanCare Global Customer Service*

E-mail: customerservice@womancareglobal.org

Website: www.womancareglobal.org

Provide local distributor name and contact information.

Reiterate the importance of maintaining minimum stock levels to ensure instruments are available when they need them. Refer to the Uterine Evacuation Methods Module Section 4: Sustainable supply of MVA and MA.

3. Instrument care and processing

Say: We will now talk about maintaining Ipas instruments.

Show and discuss slide: *Ipas MVA Plus Aspirator Care and Processing*

- Must be soaked, cleaned, and high level disinfected (HLD) or sterilized between patients
- Does not have to be HLD or sterile at time of use (like a speculum)
- Should be put in decontamination soak promptly after use to ease removal of tissue

Say: The MVA aspirator does not directly touch the woman's body. However, when it is used, the cylinder fills with blood. There is the potential risk that some contaminants from a previous woman could be introduced to another woman if the MVA aspirator is not fully processed (soaked, cleaned and sterilized or HLD) between each use. Therefore, after cleaning, the Ipas MVA Plus must undergo high-level disinfection or sterilization between patients to remove contaminants. Once processed, the aspirator may be kept in a clean container. We will go into more detail on these points later in this module.

Show and discuss slide: *Number of Times the Instruments Can be Used*

- Varies according to how they are used and maintained

Show and discuss slide: *Replace Ipas MVA Plus Aspirator When...*

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

Say: Now that we have examined maintaining the aspirator, let us discuss maintenance of the cannulae.

In the United States and some other countries, Ipas cannulae are labeled for single use only. In settings where instrument reuse is permitted by local regulations, Ipas EasyGrip cannulae are reusable devices.

Show and discuss slide: *Ipas EasyGrip Cannulae Care and Processing*

- Manufacturer-sterilized with ethylene oxide
- Should be sterilized or high-level disinfected (HLD) before reuse
- After use, process promptly to ease cleaning

Show and discuss slide: *Discard and Replace Cannula If...*

- It is brittle
- Tissue cannot be removed with cleaning
- It is cracked, twisted or bent, especially near the aperture

Pass around the worn aspirators and cannulae as samples of devices that should be replaced.

- Ask participants to explain why each should be replaced.

Say: Now let's turn our attention to methods for processing the Ipas MVA Plus. We process instruments to protect our clients and ourselves. Proper instrument processing also prevents the spread of infection from the health-care facility to the wider community.

Show and discuss slide: *Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae Processing*

- Reusable in settings where instrument reuse is permitted by local regulations
- Many processing options

Note to Trainer: If questions come up from participants about the Ipas double- and single-valve aspirators and Karman cannulae, please refer them to the Ipas MVA Instruments module in the Reference Manual, Appendix A: Comparison of Ipas Instruments.

Show and discuss slide: *Standard Precautions When Processing*

- Consider all blood and body fluids to be infectious
- Always wear gloves when handling any body fluids except sweat
- Use barriers when a part of the body may be exposed to body fluids: gloves, gown, face protection
- Guard against puncture injuries from sharp instruments

- Wash hands immediately before and after contact with contaminated items, even if gloves are worn

Show and discuss slide: *Difference Between Disinfectants and Antiseptics*

- Disinfectants are strong germicides used to clean equipment.
- Antiseptics are weak germicides used to clean the body.

Show slide: *Skin Antiseptics Cannot be Used for Instruments*

- | | |
|-------------|-------------|
| • Zephiran® | • Cetavlon® |
| • Savlon® | • Hibitane® |
| • Eusol® | • Lysol® |
| • PhisoHex® | • Phenol® |

Give the Instrument Processing Skills checklist to participants, allowing them a minute to look it over.

- Explain that, whether or not participants process instruments themselves, they should use this checklist to monitor instrument processing.

Say: As I present information about instrument processing, please follow the steps on the Instrument Processing Skills checklist.

- Explain that in addition to discussing the proper way to process MVA instruments, you are also going to discuss and identify processing mistakes that might be made.

Show and discuss slide: *Four Steps for Processing Instruments*

1. Decontamination soak
2. Cleaning
3. Sterilization or high-level disinfection
4. Storage

Say: The first step is decontamination soak.

Give each participant a copy of the Decontamination Statement. Give them a few minutes to read it. Ask if there are any questions.

Show and discuss slide: *Why Soak Instruments Before Cleaning?*

- Makes cleaning easier by keeping instruments wet
- Use of chlorine solution assists disinfection
- Removes some material

Items are still not safe to handle with bare hands.

Show and discuss slide: *Steps in Decontamination Soak*

- Fill a plastic container with solution.
- Can use 0.5 percent chlorine solution.
- Wearing gloves, submerge instruments completely.
- Then draw solution into cannula and aspirator.
- Soak instruments until ready to clean.
- Use gloves or forceps to remove instruments.

Say: What are some possible mistakes you might make in the soaking process?

- Gloves not worn; instruments not fully submerged; instruments allowed to dry.

Inform participants that instructions for producing a 0.5 percent chlorine solution for soaking instruments are in Appendix B of the Infection Prevention module in the Reference Manual.

Say: You must wear barriers when handling instruments after soaking.

Have a set of barriers that are worn for instrument cleaning: face protection, gloves, gown, apron.

- Ask for a volunteer to demonstrate the barriers by putting them all on briefly and then removing them as you mention each one.

Say: You have to disassemble the instrument before cleaning.

Ask a volunteer to demonstrate how to disassemble the instrument.

Say: Now that the aspirator is disassembled, it is ready to be cleaned.

Show and discuss slide: *Cleaning*

- WHO says is the most important step to ensure proper final decontamination of instruments.
- Wash all surfaces in warm water and detergent.
- Use probe or cloth to remove trapped material.
- Clean all crevices and inside cylinder, valve and plunger.
- Use a soft brush; nothing sharp or pointed.
- Don't splash.
- Clean until no blood or tissue is visible, then rinse.
- Allow items to dry.

Show and discuss slide: *Clean Instruments Thoroughly*

Say: What are some mistakes that commonly occur while cleaning?

- Barriers not worn; instrument not fully cleaned; antiseptics used instead of detergent.

Say: We will now discuss processing options.

Show and discuss slide: *Ipas MVA Plus Aspirator*

- Must be high-level disinfected (HLD) or sterilized between patients
- This prevents potential blood borne pathogens from being transmitted between patients in case of problems during the procedure where aspirator contents may make contact with a woman's body.
- The aspirator does not need to remain HLD or sterilized before the next patient.

Show and discuss slide: *Ipas EasyGrip Cannulae*

- Must be HLD or sterilized between patients
- Must be HLD or sterile at time of use

Show and discuss slide: *Common Options for Processing: Ipas MVA Plus and Ipas EasyGrip*

- Boiling
- Glutaraldehyde (Cidex)
- 0.5 percent chlorine solution
- Steam autoclave

Show and discuss slide: *Option: Boiling (HLD)*

- Place in water at a rolling boil – items do not need to be fully immersed.
- Boil for 20 minutes.
- Remove using HLD or sterile gloves or forceps.
- Dry with sterile cloth, if desired.
- Cool before use.

Show and discuss slide: *Boiling MVA Instruments*

Say: What mistakes can be made when boiling the instruments?

- Water not actually boiling; insufficient length of boiling time.

Say: Recently, significant attention has been paid to the effects of hazardous materials used in health-care settings on both staff and the environment. These materials include chlorine and glutaraldehyde.

Show and discuss slide: *Glutaraldehyde and Chlorine*

- Handle with care, as they are hazardous substances.
- Take necessary precautions, such as using personal protective equipment.
- Refer to manufacturer's safety instructions to establish safe use.

Show and discuss slide: *Option: Glutaraldehyde (Sterilization)*

- Fully immerse and ensure that solution fills instruments.
- Soak according to manufacturer's instructions.
- Soak for 10 hours when using Cidex
- Remove with sterile forceps or gloves.

Show and discuss slide: *Option: Glutaraldehyde (Sterilization) (cont.)*

- Rinse with sterile water.
- Dry with sterile towel, if desired.
- Change solution when it expires.

Show and discuss slide: *Option: Glutaraldehyde (HLD)*

- Fully immerse and ensure that solution fills instruments.
- Soak according to manufacturer's instructions.
- Soak for 20 minutes when using Cidex.
- Remove using HLD or sterile gloves or forceps.

Show and discuss slide: *Option: Glutaraldehyde (HLD) (cont.)*

- Rinse with sterile or boiled water.
- Dry with sterile cloth, if desired.
- Change solution when it expires.

Show and discuss slide: *Option: 0.5 percent Chlorine (HLD)*

- Use a plastic (non-metal) container.
- Fully immerse and ensure that solution fills instruments.
- Soak for 20 minutes.
- Remove using HLD or sterile gloves or forceps.
- Rinse with boiled or sterile water.
- Dry with sterile cloth, if desired.

Show and discuss slide: *HLD Disinfectant Soak and Rinse*

Say: What mistakes might be made during sterilization or HLD using chemicals?

- Items not submerged or filled
- Cannula opening obstructed
- Instrument not disassembled
- Solution expired or incorrectly mixed

- Time not correct
- Instruments not rinsed

Show and discuss slide: *Option: Steam Autoclave (Sterilization)*

- Wrap clean, disassembled items in paper or linen.
- Arrange items so steam penetrates all surfaces.
- Ensure instrument openings are not obstructed and parts do not touch.
- Cool before use.

Show slide: *Paper Wrap*

Say: It is very important to autoclave the instruments properly to avoid damaging them.

Show and discuss slide: *Steam Autoclave: Caution*

- Process at 121°C (250°F) with 106 kPa (15lbs/in2) pressure for 30 minutes.
- Be sure the autoclave is set to these parameters.
- Do not use other autoclave settings or “flash” the instruments.
- Higher temperature settings can damage instruments.

Say: What mistakes can be made when steam autoclaving MVA instruments?

- Temperature, pressure or time not correct
- Autoclave set on higher settings
- Items not wrapped or arranged properly for steam contact
- Cannula opening obstructed
- Instrument not properly disassembled

Show and discuss slide: *Storing MVA Instruments*

- Ideally, reprocess cannulae every day if boiled or soaked.
- Storing items even slightly wet invites microbial growth.
- Keep just a few cannulae in each container.
- Avoid touching cannulae tips; grasp cannulae by base.

Say: Reassemble and test the vacuum of the instrument before use or storage.

If you perform uterine evacuation with the Ipas MVA Plus aspirator, it is your responsibility to monitor the quality of instrument processing in order to protect your clients, yourself, your coworkers and your community from the spread of infection.

Give out enough copies of the *Processing the Ipas MVA Plus Aspirators and Ipas EasyGrip Cannulae* wallchart so that each facility will have one.

4. Summary and test

Summarize and conclude the module.

- Ask participants for key points covered in this module.
- Use the objectives as a reference.

What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect the tests.
- Review correct answers from the test key.
- Thank the participants for their participation.

References

- Allen, R. H., Kumar, D., Fitzmaurice, G., Lifford, K. L., & Goldberg, A. B. (2006). Pain management of first-trimester surgical abortion: Effects of selection of local anesthesia with and without lorazepam or intravenous sedation. *Contraception*, 74(5), 407-413. doi: 10.1016/j.contraception.2006.06.002
- American Medical Women's Association. (1997). Module 7: Abortion *Fourth-year elective curriculum in reproductive health*. Alexandria, VA: American Medical Women's Association.
- Atrash, H. K., Cheek, T. G., & Hogue, C. J. (1988). Legal abortion mortality and general anesthesia. *American Journal of Obstetrics and Gynecology*, 158(2), 420-424.
- Baird, T. L., Gringle, R. E., & Greenslade, F. C. (1995). *MVA in the treatment of incomplete abortion: Clinical and programmatic experience*. Chapel Hill, NC: Ipas.
- Bélanger, E., Melzack, R., & Lauzon, P. (1989). Pain of first-trimester abortion: A study of psychosocial and medical predictors. *Pain*, 36(3), 339-350.
- Billings, D. L., & Benson, J. (2005). Postabortion care in Latin America: Policy and service recommendations from a decade of operations research. *Health Policy and Planning*, 20(3), 158-166. doi: 10.1093/heapol/czi020
- Castleman, L., & Mann, C. (2009). *Manual vacuum aspiration (MVA) for uterine evacuation: Pain management* (2nd ed.). Chapel Hill, NC: Ipas.
- Castleman, L., & Blumenthal, P. (2009). *Spontaneous and induced abortion*. Philadelphia: American College of Physicians.
- Dalton, V. K., & Castleman, L. (2002). Manual vacuum aspiration for treatment of early pregnancy loss. *Postgraduate Obstetrics & Gynecology*, 22(19), 1-6.
- De Oliveira, G. S., Agarwal, D., & Benzon, H. T. (2012). Perioperative single dose ketorolac to prevent postoperative pain: A meta-analysis of randomized trials. *Anesthesia & Analgesia*, 114(2), 424-433. doi: 10.1213/ANE.0b013e3182334d68
- Dean, G., Cardenas, L., Darney, P., & Goldberg, A. (2003). Acceptability of manual versus electric aspiration for first trimester abortion: A randomized trial. *Contraception*, 67(3), 201-206.
- Goodman, S., Wolfe, M., Hufbauer, E., Flaxman, G., Jackson, E., Kaminski, A.,... Nelson-Munson, K. (2012). *Early Abortion Training Workbook* (4th ed.). San Francisco, CA: UCSF Bixby Center for Global Reproductive Health.
- Hern, W. M. (1984). *Abortion Practice*. Philadelphia, Pa: Lippincott Company.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Johnson, B. R., Benson, J., & Hawkins, B. L. (1992). Reducing resource use and improving quality of care with MVA. *Advances in Abortion Care*, 2(2).
- Kapp, N., Lohr, P. A., Ngo, T. D., & Hayes, J. L. (2010). Cervical preparation for first trimester surgical abortion. *Cochrane Database SystRev* (2), CD007207. doi: 10.1002/14651858.CD007207.pub2
- Mahomed, K., Healy, J., & Tandon, S. (1994). A comparison of manual vacuum aspiration (MVA) and sharp curettage in the management of incomplete abortion. *International Journal of Gynecology & Obstetrics*, 46(1), 27-32.

- Margolis, A., Leonard, A. H., & Yordy, L. (1993). Pain control for treatment of incomplete abortion with MVA. *Advances in Abortion Care*, 3(1).
- Murphy, E. (1997). *Client-provider interactions (CPI) in family planning services: Guidance from research and program experience*. Washington, DC: PATH.
- Paul, M., Lichtenberg, E. S., Borgatta, L., Grimes, D. A., & Stubblefield, P. G. (Eds.). (1999). *A clinician's guide to medical and surgical abortion*. New York: Churchill Livingstone.
- Planned Parenthood Federation of America. (2000). Manual of medical standards and guidelines. *Abortion, Section VII- A-1*. New York: PPFA.
- Policar, M. S., Pollack, A. E., Nicholas, C., & Dudley, S. (Eds.). (1999). *Principles of abortion care: A curriculum for physician assistants and advanced practice nurses*. Washington, DC: National Abortion Federation.
- Rademakers, J. (1995). *Abortus in Nederland 1991–1992*. Utrecht: Stimezo Nederland.
- Renner, R. M., Jensen, J. T., Nichols, M. D., & Edelman, A. (2009). Pain control in first trimester surgical abortion. *Cochrane Database of Systematic Reviews* (2), CD006712. doi: 10.1002/14651858.CD006712.pub2
- Renner, R. M., Jensen, J. T., Nichols, M. D., & Edelman, A. B. (2010). Pain control in first-trimester surgical abortion: A systematic review of randomized controlled trials. *Contraception*, 81(5), 372-388. doi: 10.1016/j.contraception.2009.12.008
- Renner, R. M., Nichols, M. D., Jensen, J. T., Li, H., & Edelman, A. B. (2012). Paracervical block for pain control in first-trimester surgical abortion: A randomized controlled trial. *Obstetrics & Gynecology*, 119(5), 1030-1037. doi: 10.1097/AOG.0b013e318250b13e
- Romero, I., Turok, D., & Gilliam, M. (2008). A randomized trial of tramadol versus ibuprofen as an adjunct to pain control during vacuum aspiration abortion. *Contraception*, 77(1), 56-59. doi: 10.1016/j.contraception.2007.09.008
- Rutala, W. A., & Weber, D. J. (2010). An overview of disinfection and sterilization. In W. A. Rutala (Ed.), *Disinfection, sterilization and antisepsis: Principles, practices, current issues, new research, and new technologies*. Washington, DC: Association for Professionals in Infection Control and Epidemiology.
- Singh, R. H., Ghanem, K. G., Burke, A. E., Nichols, M. D., Rogers, K., & Blumenthal, P. D. (2008). Predictors and perception of pain in women undergoing first trimester surgical abortion. *Contraception*, 78(2), 155-161. doi: 10.1016/j.contraception.2008.03.011
- Smith, G. M., Stubblefield, P. G., Chirchirillo, L., & McCarthy, M. J. (1979). Pain of first-trimester abortion: Its quantification and relations with other variables. *American Journal of Obstetrics and Gynecology*, 133(5), 489-498.
- Stewart, F., Weitz, T., Wilcox, N., & Tracey, J. (2002). *Abortion provider training manual*. San Francisco, CA: UCSF Center for Reproductive Health Research and Policy.
- Suprpto, K., & Reed, S. (1984). Naproxen sodium for pain relief in first-trimester abortion. *American Journal of Obstetrics and Gynecology*, 150(8), 1000-1001.
- Warriner, I. K., Meirik, O., Hoffman, M., Morroni, C., Harries, J., My Huong, N. T.,...Seuc, A. H. (2006). Rates of complication in first-trimester manual vacuum aspiration abortion done by doctors and mid-level providers in South Africa and Vietnam: A randomised controlled equivalence trial. *Lancet*, 368(9551), 1965-1972. doi: 10.1016/s0140-6736(06)69742-0

- Wiebe, E., Podhradsky, L., & Dijak, V. (2003). The effect of lorazepam on pain and anxiety in abortion. *Contraception*, 67(3), 219-221.
- Wiebe, E. R. (1992). Comparison of the efficacy of different local anesthetics and techniques of local anesthesia in therapeutic abortions. *American Journal of Obstetrics Gynecology*, 167(1), 131-134.
- Wiebe, E. R., & Rawling, M. (1995). Pain control in abortion. *International Journal of Gynecology and Obstetrics*, 50(1), 41-46.
- Wiebe, E. R., Rawling, M., & Janssen, P. (1996). Comparison of 0.5% and 1.0% lidocaine for abortions. *International Journal of Gynecology & Obstetrics*, 55(1), 71-72.
- Winkler, J., Oliveras, E., & McIntosh, N. (Eds.). (1995). *Postabortion care: A reference manual for improving quality of care*. United States of America: Postabortion Care Consortium.
- Wong, C. Y., Ng, E. H., Ngai, S. W., & Ho, P. C. (2002). A randomized, double blind, placebo-controlled study to investigate the use of conscious sedation in conjunction with paracervical block for reducing pain in termination of first trimester pregnancy by suction evacuation. *Human Reproduction*, 17(5), 1222-1225.
- World Health Organization. (1994). *Clinical management of abortion complications: A practical guide*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (1995). *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2003a). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2003b). *Safe Abortion: technical and policy guidance for health systems*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2007a). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors* (2nd ed.). Geneva, Switzerland: World Health Organization.
- World Health Organization. (2007b). Standard precautions in health care. Retrieved from http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf
- World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems* (2nd ed.). Geneva, Switzerland: World Health Organization.
- World Health Organization, United Nations Population Fund, UNICEF, & The World Bank. (2006). *Pregnancy, childbirth, postpartum and newborn care: A guide for essential practice*. Geneva, Switzerland: World Health Organization.
- Yellen, E., & Davis, G. C. (2001). Patient satisfaction in ambulatory surgery. *Association of Operating Room Nurses (AORN) Journal*, 74(4), 483-498.

Knowledge Test Key

1. b
2. d
3. a
4. c
5. d
6. c
7. c
8. b
9. d

Ipas MVA Instruments Knowledge Test

Circle the correct response

1. Ipas MVA Plus aspirators:
 - a. Must be used only once
 - b. Must be fully processed, including HLD or sterilized, between each patient
 - c. Should not be processed immediately
 - d. Are equipped with a 100cc cylinder
2. Replace Ipas MVA Plus aspirators when:
 - a. Vacuum is retained
 - b. Cylinder is clear
 - c. O-ring is lubricated
 - d. Plunger arms do not lock
3. The Ipas MVA Plus aspirator and Ipas EasyGrip cannulae are:
 - a. Intended for uterine aspiration or evacuation
 - b. Indicated for treatment of incomplete abortion in uterine size up to 18 weeks
 - c. Indicated for endometrial biopsy in cases of suspected pregnancy
 - d. Indicated for removal of uterine fibroids
4. Which of the following is not a possible complication with uterine evacuation, including MVA?
 - a. Vagal reaction
 - b. Pelvic infection
 - c. Migraine headaches
 - d. Uterine/cervical injury
5. Which is not true about the decontamination soak?
 - a. Removes some material
 - b. Makes cleaning easier
 - c. Use of chlorine solution assists with disinfection
 - d. Makes items safe to handle with bare hands

6. The Ipas MVA Plus aspirator:

- a. Can be used after cleaning
- b. Cannot be autoclaved or boiled
- c. Must be HLD or sterilized between each patient
- d. Cannot be reused in any setting

7. Ipas EasyGrip cannulae:

- a. Can be used after cleaning
- b. Cannot be autoclaved or boiled
- c. Must be HLD or sterile before entering the sterile uterus
- d. Cannot be reused in any setting

8. Instruments that have been boiled or soaked in chlorine or glutaraldehyde:

- a. Can be stored for a week in HLD or sterile containers with tight-fitting lids
- b. Must be reprocessed the next day, ideally
- c. Can be stored for a week if the container has not been opened
- d. Can be stored indefinitely

9. Monitoring the quality of instrument processing at a facility is:

- a. Only the responsibility of the staff person who performs instrument processing
- b. Optional; staff already know how to process instruments
- c. The responsibility of the Ministry of Health
- d. Every MVA providers' responsibility to clients, coworkers and the community

Ipas Decontamination Statement

Ipas's training materials call the first step in instrument processing a decontamination soak. Ipas's recommendations regarding this step represent a transition toward evidence-based information that is consistent with the WorldHealth Organization's (WHO) *Safe Abortion: Technical and Policy Guidance for Health Systems* and the second edition of this guidance.

Soaking instruments prior to cleaning is not required; however, if instruments are not cleaned immediately after use, it is important to keep them wet to facilitate cleaning. It is not wrong to use a chlorine soak, but the chlorine soak does not make instruments safe to handle without gloves.

Below is a summary of the recommendations, background information on the changes and supporting references.

Recommendation

To implement evidence-based services, providers should emphasize the following about soaking contaminated instruments:

- Barriers must be worn at all times when cleaning dirty instruments.
- The purpose of the soak step is to keep instruments wet for effective cleaning.
- Soaking in chlorine solution does not make instruments *safe* or *safer* to handle with bare hands.
- There is no 10-minute requirement for soaking.
- Any solution, including tap water, can be used; a 0.5 percent chlorine solution can be used if desired.

Because use of chlorine is optional, managers may consider reallocating resources to provide barriers, such as gloves, and behavioral change training for staff.

Background

In response to the threat of workplace-acquired blood-borne illnesses such as HIV, in the 1990s international groups began stressing the need for a "decontamination step" consisting of a 10 minute chlorine soak of dirty instruments before cleaning to make them "safer" to handle. Over the years, this step was emphasized as critically mandatory, leading to the assumption that a chlorine soak makes items safe to handle with bare hands, and field reports began to indicate that barriers were consequently not being worn by staff when cleaning instruments.

WHO and others expressed concern and reminded providers that "this step was *not* to be viewed as making instruments safe to handle" and that "the purpose of such soaking is to prevent drying of organic material"(WHO, 1989).

The effect of a 0.5 percent chlorine solution on instruments with protein bioburden has been documented as extremely variable. Studies show that dangerous microorganisms, including HIV, continue to thrive on instruments after a dilute chlorine soak, as even microscopic organic matter can inactivate chlorine. Although 0.5 percent chlorine solution is recommended for environmental surfaces, it is recommended that those surfaces be cleaned *first* to remove bioburden.

A 0.5 percent chlorine soak of instruments was not included in recommendations in the 2003 or 2012 WHO safe abortion guidelines, nor in national practice standards in the United States. U.S. standards include optionally soaking instruments in a variety of fluids—for example, enzymatic solutions or

soapy water—prior to washing. This is called a pre-soak and the main reason for this is to keep instruments wet so they can be cleaned easily. WHO recommends cleaning instruments immediately after use. The soaking step is not needed if instruments will be cleaned immediately. Barriers must be worn at all times when cleaning instruments.

References

- Association of Operating Room Nurses (AORN). (2013). *Perioperative Standards and Recommended Practices for Inpatient and Ambulatory Settings*. Denver, CO: AORN. Available online at <http://www.aorn.org/RecommendedPractices/>
- Garza, Brenda W., D. Peter Drotman, Linda S. Martin, J. Stephen McDougal, Walter W. Bond, T. Stephen Jones. (1994). HIV-1 and bleach. *Journal of Acquired Immune Deficiency Syndrome*, 7(2):169–170.
- Floyd, Roger. (1994). HIV inactivation by bleach. *Journal of Acquired Immune Deficiency Syndromes*, 7(2):204–205.
- Shapshank, Paul, Clyde B. McCoy, James E. Rivers, Dale D. Chitwood, Deborah C. Mash, Norman L. Weatherby, James A. Inciardi, Syed M. Shah and Barry S. Brown. (1993). Inactivation of human immune deficiency virus1 at short term intervals using undiluted bleach. *Journal of Acquired Immune Deficiency Syndromes*, 6: 218–219.
- Rutala, W. A., Weber, D. J. (2010). An overview of disinfection and sterilization. In W. A. Rutala (Ed.), *Disinfection, Sterilization and Antisepsis: Principles, Practices, Current Issues, New Research, and New Technologies*. Washington, DC: Association for Professionals in Infection Control and Epidemiology (APIC).
- Rutala, W. A., Weber, D. J., and the Healthcare Infection Control Practices Advisory Committee (HICPAC). (2008). *Guideline for Disinfection and Sterilization in Healthcare Facilities*. Atlanta: Centers for Disease Control and Prevention.
- World Health Organization. (2003). *Safe abortion: Technical and policy guidance for health systems*. Geneva: WHO.
- World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems*. (2nd edition). Geneva: WHO.
- World Health Organization. (1989). *Guidelines on sterilization and disinfection methods effective against human immunodeficiency virus (HIV)*. Geneva: WHO.

Instrument Processing Skills Checklist

Ipas MVA Plus and Ipas EasyGrip Cannulae

Skill	Yes	No	Comments
1. Decontamination Soak			
Fills a container with solution			
Wears gloves and face protection			
Draws solution into the aspirator and cannulae			
Submerges MVA instruments			
Uses gloves or forceps to remove			
2. Cleaning			
Wears barriers—gloves, gown, apron, face protection			
Cleans all instruments, removes tissue or blood, washes all surfaces in warm water and detergent if possible			
Flushes soapy water through the cannula; uses a cotton-tipped probe, soft brush or soft cloth to gently remove material			
Disassembles aspirator			
Uses a small brush to clean crevices and inside			
Cleans until no material is visible upon careful inspection			
Dries with a clean cloth if desired			
Discards the cannula if not possible to remove all matter			
3. HLD or Sterilize			
Method: Steam Autoclave (Sterilization)			
Places cannula and disassembled aspirator in paper or linen			
Places to allow steam contact to all surfaces, not obstructing openings			
Sterilizes at 121°C (250°F) for 30 minutes at 106 kPa (15 lbs/in ²)			
Cools before use			
Method: Glutaraldehyde (Sterilization)			
Immerses cannula and aspirator so solution fills them			
Soaks according to manufacturer's instructions (10 hours for Cidex)			
Removes with sterile forceps or gloves			
Rinses with sterile water			
Changes the solution every two weeks or per manufacturer's instructions			

(continued on page 223)

Instrument Processing Skills Checklist

Ipas MVA Plus and Ipas EasyGrip Cannulae

Skill	Yes	No	Comments
3. HLD or Sterilize (continued)			
Method: Glutaraldehyde (HDL)			
Immerses instruments so that solution fills them			
Soaks according to manufacturer's instructions (20 minutes for Cidex)			
Removes using HLD or sterile gloves or forceps			
Rinses with sterile or boiled water			
Method: 0.5 percent Chlorine (HLD)			
Immerses so that solution fills instrument			
Soaks in 0.5 percent chlorine solution for 20 minutes			
Removes using HLD or sterile gloves or forceps			
Rinses with boiled or sterile water			
Changes chlorine solution at least daily			
Method: Boiling (HLD)			
Ensures water is at a rolling boil			
Boils cannula and aspirator for 20 minutes			
Cools before removing			
Removes using HLD or sterile gloves or forceps			
Handles cannula by non-aperture end			
4. Handling, Storage, Reassembly			
Keeps in covered containers, protected from contaminants			
Processes instruments every day if processed using chemicals or boiling			
Keeps only a few instruments in each container			
Uses forceps to remove cannula by the non-aperture end; avoids touching the rest of the cannula			
Reassembles and tests vacuum of aspirator			

Uterine Evacuation with MVA Plus



Purpose

This module explains the steps for performing uterine evacuation with manual vacuum aspiration (MVA) using the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae within the context of woman-centered, abortion-related care.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe and uphold women's, including young women's, rights to abortion-related care
- ☐ Provide information and counseling and obtain informed consent
- ☐ Provide contraceptive counseling and method provision
- ☐ Explain blood-borne and other pathogens and the importance of using infection-prevention techniques, including aseptic technique
- ☐ Conduct a clinical assessment for abortion-related care
- ☐ Identify parts, features, processing, disassembly and assembly, maintenance, storage and handling of the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae
- ☐ Explain the basic physiology of pain and how to appropriately offer and administer pain medications
- ☐ Describe signs of normal recovery and know how to address problems that might arise after the procedure
- ☐ Explain procedures for client discharge and follow-up
- ☐ Diagnose continuing pregnancy, retained products of conception (POC), infection and other possible complications
- ☐ Assess need for and refer women to other sexual- and reproductive-health services
- ☐ Explain how young women may have different needs during abortion-related care



Objectives

By the end of this module, participants should be able to:

1. Describe steps for performing uterine evacuation with MVA and resolve technical problems
2. Explain how pain management is an essential component of MVA, help a woman develop a pain management plan and know how to use methods of pain management
3. Explain how to provide contraceptive services at the time of uterine evacuation and offer referrals as needed
4. Explain post-procedure assessment and monitoring and discharge procedures
5. Describe the types of care that could be offered at a follow-up visit, if needed or desired by the woman
6. Provide clinically and psychosocially appropriate abortion-related care to young women



Materials

- ☐ Pain Management Plan Case Studies and key
- ☐ Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training (also on CD-ROM)
- ☐ Adequate table space and supplies for demonstration and simulated practice (see list of Supplies for Uterine Evacuation Procedure Demonstration and Simulated Practice at the end of this module), including pelvic models, which can be ordered from customerservice@womancareglobal.com
- ☐ Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist
- ☐ Ipas MVA Plus instruments
- ☐ Manual Vacuum Aspiration Technique Using the Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae video (on CD-ROM)
- ☐ Steps for performing manual vacuum aspiration: Using the Ipas MVA Plus and EasyGrip cannulae wallchart (current version) for each participant's facility
- ☐ Post-Procedure Care Skills Checklist (trainings on PAC only should use the PAC-specific version also at end of this module)
- ☐ Follow-Up Care Skills Checklist (trainings on PAC only should use the PAC-specific version also at end of this module)
- ☐ Knowledge Test and Test Key



Advance preparation

- ☐ Be familiar with locally available drugs and local beliefs and practices concerning pain management for uterine evacuation.
- ☐ Adapt the Pain Management Plan Case Studies to reflect local circumstances, if needed.
- ☐ Adapt the Uterine Evacuation Procedure with Ipas MVA Plus Skills checklist to include local conditions and protocols, if needed.
- ☐ Familiarize yourself with post-procedure care protocols and practices at local facilities and adapt this module section accordingly.
- ☐ Determine if participants will provide post-procedure care themselves or will supervise other health-care workers and adapt section accordingly. Participants can use the Post-Procedure Care Skills Checklist for self-monitoring or to monitor other workers.
- ☐ Determine what is currently done in participants' facilities for follow-up care, including related reproductive health screening and referral.
- ☐ Familiarize yourself with the clinical and service delivery needs of young women that may differ from those of adults.
- ☐ Make photocopies of Case Studies worksheet, Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist, Post-Procedure Care Skills Checklist and Knowledge Test.

Time: 8 hours

Note to Trainer: This module does not describe the single-valve and double-valve aspirators or Karman cannulae. Trainers wishing to include this content should contact WomanCare Global at customerservice@womancareglobal.org for more information about these instruments.

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module explains the steps for performing uterine evacuation with manual vacuum aspiration (MVA) using the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae within the context of woman-centered, abortion-related care.

Show slide: *Objectives*

Say: By the end of this module, participants should be able to:

1. Describe steps for performing uterine evacuation with MVA and resolve technical problems
2. Explain how pain management is an essential component of MVA,

help a woman develop a pain management plan and know how to use methods of pain management

3. Explain how to provide contraceptive services at the time of uterine evacuation and offer referrals as needed
4. Explain post-procedure assessment and monitoring and discharge procedures
5. Describe the types of care that could be offered at a follow-up visit, if needed or desired by the woman
6. Provide clinically and psychosocially appropriate abortion-related care to young women

2. Preparation

Say: In the previous module, we became familiar with the Ipas MVA Plus instruments. Now we can discuss preparation for an MVA procedure, pain management and the MVA procedure.

Show and discuss slide: *Before the MVA Procedure*

- Provide information and counseling to the woman and obtain informed consent.
- Discuss her contraceptive needs.
- Perform a clinical assessment, including physical examination.
- Help the woman develop a pain management plan.
- Ensure the Ipas MVA Plus instruments have been prepared.

Say: We have already covered these skills in other modules. They are included here as a reminder because they are critical steps in providing MVA services.

3. Pain management

Say: Managing the woman's pain and anxiety is a vital component of high-quality, abortion-related care.

To help us empathize with women undergoing abortion-related care, think back to a specific time in your life when you were anxious about impending pain. Remember what you were thinking and how you were feeling as you anticipated the pain. What might have relieved some of your anxiety? If you could have had a person there to support you, what would you have wanted the person to say or do to provide comfort?

- Take several responses.
- Discuss how remembering our own experiences may help us empathize with women's anxiety about and experience of pain. Caution participants not to assume that what they experienced or would prefer is the same as for the women to whom they provide care.

Show and discuss slide: *Pain Management During MVA*

- Recommended by WHO for all women undergoing uterine evacuation by any method
- Should address physical, procedural and psychosocial factors associated with pain
- Minimizes procedural risk
- Woman determines with provider, based on individual needs and preferences
- Women's responses to pain vary, but all women should be offered pain management
- Providers consistently underestimate the amount of pain a woman experiences
- Young women may report higher levels of pain than older women

Say: All women who present for abortion-related care should be offered pain management and be provided it without delay.

What particular factors might be taken into consideration when helping the woman develop a personalized pain management plan?

Show and discuss slide: *Physical Factors Associated With Increased Pain With VA*

- Nulliparity
- Higher gestational age
- Dysmenorrhea
- Young age

Show and discuss slide: *Procedural Factors Associated With Pain With VA*

- Cervical dilatation
- Uterine manipulation
- Clinical technique

Show and discuss slide: *Psychosocial Factors Associated With Increased Pain With VA*

- Anxiety
- Depression

Show and discuss slide: *Addressing Pain From Cervical Dilatation*

- Anesthetic: paracervical block using lidocaine
- Non-steroidal analgesics (ibuprofen or naproxen)
- Conscious sedation

Show and discuss slide: *Addressing Pain From Uterine Manipulation*

- Gentle operative technique
- Non-steroidal analgesics (ibuprofen or naproxen)
- Conscious sedation

Say: Note that providing conscious sedation increases the expense, complexity and potential risks of an abortion procedure. Increased need for monitoring requires facility investments in training and equipment to deliver conscious sedation safely.

What pharmacological interventions might be provided to alleviate anxiety?

Show and discuss slide: *Pharmacological Means of Addressing Anxiety*

- Anxiolytics relieve anxiety for some women
- Non-steroidal analgesics relieve pain, which can reduce anxiety.
- Conscious sedation

Show and discuss slide: *Timing of Oral Medications*

- Drugs must be most effective at the time of the procedure.
- Administer drugs 30 to 45 minutes before the procedure.

Show and discuss slide: *Addressing Pain from Psychosocial Factors*

Support measures in addition to pain medications include:

- Calm environment
- Respectful interaction and communication
- Companion during procedure
- Verbal and physical support and reassurance
- Gentle clinical technique
- Non-pharmacological pain relief such as a heating pad or hot water bottle
- These supplement but do not replace medications

Say: Providers can arrange for a female staff person to accompany the woman during the procedure if she prefers. The companion can ask if the woman would prefer silence or distraction by talking with her or leading her through a guided visualization. She can offer to provide the woman information at each step. Facility staff can create a calming environment by de-medicalizing the procedure areas as much as possible and providing appropriate music, lighting, and décor. Music is effective for pain management during vacuum aspiration and may be helpful for uterine evacuation with medical methods as well.

All these methods of pain management may also address any preexisting pain the woman may have when she comes for abortion-related care.

Ask participants to turn to Appendix A: Pharmacological Approaches to Pain Management During MVA in the Reference Manual.

- Give them a minute to review the chart.

Say: We will now create a list of locally available drugs and usual practices.

- Ask participants to name anxiolytics that are locally available
— Write their answers in the space on the flipchart.
- Ask participants to name the drugs that are locally available for paracervical block
— Write their answers in the space on the flipchart.
- Ask participants to name oral non-steroidal anti-inflammatory drugs or narcotic analgesics that are locally available.
— Write their answers in the space on the flipchart.
- When the list is complete, ask participants to describe non-pharmacological support measures that could be locally provided to address pain.
— Write their answers in the spaces on the flipchart.
- This will result in a comprehensive list of locally-available drugs and non-pharmacological support measures for MVA pain management to use in the case study activity.

Show and discuss slide: *Helping the Woman Develop a Pain Management Plan*

- Discuss the type of pain she may experience during uterine evacuation
- Discuss options available to reduce pain
- Describe available medications, their effects and potential side effects
- Offer support measures that can be used in addition to pain medication
- Ask her to state her preferred support measures
- Help her decide on a pain management plan

Say: When developing a pain management plan, the woman is the decision maker. Providers should not impose their own preferences but offer the available medication and support options and help the woman decide what she prefers. A woman has the right to refuse pain medications once she has been fully informed about her options.

In the following case study activity, be sure to address each concern expressed by the woman when helping her develop her pain management plan.

Have participants complete the Pain Management Plan Case Studies activity.

- Divide participants into small groups.
- Distribute the Pain Management Plan Case Studies handouts.
- Ask each small group to write a pain management plan that addresses the concerns expressed by the woman in each of the case studies. Each group will develop a plan for every case study.
 - The groups should use the list of locally available drugs and support measures for MVA pain management that was just created.
 - Be sure participants address any preexisting pain, the woman's individual needs and the factors listed in Section 3.1 of the Reference Manual.
- Have each group briefly report on one of the case studies, asking other groups to comment only if their responses were different.
 - Correct or comment on responses as needed using the key.

Say: Once you have assessed the woman, helped her develop a pain management plan, obtained her informed consent and administered pain medication at the appropriate time, you are ready to proceed with the uterine evacuation procedure using Ipas MVA Plus instruments.

4. Uterine evacuation with Ipas MVA Plus

Show and discuss slide: *MVA for Uterine Evacuation*

- Many women will require uterine evacuation at some time in their lives.
- World Health Organization (WHO): Vacuum aspiration is a preferred method.

Have participants first watch the instructional video Manual Vacuum Aspiration Technique Using the Ipas Mva Plus Aspirator and Ipas Easygrip Cannulae (on CD-ROM) and then discuss each step of the procedure.

Show slide: *Steps of the MVA Procedure*

1. Prepare instruments.
2. Assist the woman.
3. Perform cervical antiseptic prep.
4. Perform paracervical block.
5. Dilate cervix.

Show slide: *Steps of the MVA Procedure (cont.)*

6. Insert cannula.
7. Suction uterine contents.
8. Inspect tissue.

9. Perform any concurrent procedures.
10. Take immediate post-procedure steps, including instrument processing.

Distribute a copy of the wallchart Steps for Performing MVA Using the Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae (most current edition) to each participant.

- Give them a minute to look over the wallchart.

Show and discuss slide: *Considerations for Postabortion Care with MVA*

- Remain alert for changes in the woman's condition throughout procedure.

Say: PAC treatment can be an emergency situation, and the woman's condition can change quickly at any point during her care. Any changes in the woman's emotions and physiology may indicate complications.

These are the general steps for the MVA procedure. The exact sequence will vary slightly based on local circumstances.

Show and discuss slide: *Step 1: Prepare Instruments*

Show and discuss slide: *Create a Vacuum*

- Check that the aspirator retains a vacuum.
- Have more than one aspirator available.

Say: When doing MVA procedures, have more than one aspirator available in case of technical problems or in case there are copious products of conception (POC).

Show and discuss slide: *Step 2: Prepare the Woman*

- Ensure pain medication is given at the appropriate time.
- Administer antibiotics.
- Ask the woman to empty her bladder.
- Help her onto the table.
- Ask for her permission to start.
- Wash hands and put on appropriate barriers.
- Perform a bimanual exam.
- Select and insert speculum.

Say: Research has shown that routinely providing antibiotics to women undergoing MVA reduces infection.

Show and discuss slide: *Pre-Procedure Provision of Antibiotics*

- Administer prophylactic antibiotics to all women.

- Prophylactic: reduces risk of infection.
- Administer therapeutic antibiotics to women with signs and symptoms of infection.
- Monitor for allergic reaction.

Show and discuss slide: *Wear Barriers for MVA Procedures*

Show and discuss slide: *Perform Bimanual Exam*

Say: The woman should empty her bladder before she gets on the table because a full bladder makes the pelvic exam difficult to perform.

Why conduct a bimanual exam now?

- To confirm previous findings regarding the size and position of the uterus.

Show and discuss slide: *Step 3: Perform Cervical Antiseptic Prep*

- Follow No-Touch Technique.
- Use antiseptic sponges to clean cervical os, cervix and, if desired, vaginal walls.
- Do not retrace areas previously cleaned.

Show and discuss slide: *Antiseptic Cervical Preparation*

Say: What is No-Touch Technique?

- Handling instruments so that the part that will enter the sterile uterus does not touch any other surface, including gloved fingertips or vaginal walls.

Emphasize that No-Touch Technique is important because infection can start when vaginal or other flora is introduced into the uterus during the procedure. No-Touch Technique must be used throughout the procedure.

Say: Why is the cervical antiseptic preparation important?

- During the procedure, microorganisms in and around the vagina are very often transferred through the os into the uterus, or by the block needle to deep cervical tissue, where they can cause infection.

Say: Why is it important not to retrace with the sponge?

- Retracing with the sponge can cause contamination by carrying microorganisms from unswabbed areas onto already-cleaned areas.

Show and discuss slide: *Step 4: Perform Paracervical Block*

- Recommended for all MVA procedures.
- Usually 10 to 20mL of 0.5-1.0 percent lidocaine (always less than 200mg).
- Always aspirate (pull back on the plunger) slightly before injecting to

prevent intravascular injection.

Explain that most women experience pain when the cannula is inserted through the os, as well as when the os contracts after the evacuation. Since paracervical block aids in preventing pain and is unlikely to cause harm, it is recommended that it be administered to all women needing uterine evacuation. Emphasize that paracervical block is safe and easy to do and may be done by midlevel providers.

Say: It is important to aspirate before injecting to be sure the needle is not in a vessel, which can cause very serious problems.

Show and discuss slide: *Administering Paracervical Block*

- Start with 20ml of 1 percent lidocaine (buffered or unbuffered).
- Inject 2mL of anesthetic where tenaculum will be placed (12 o'clock).
- Place tenaculum.
- Apply slight traction to move cervix, exposing transition from cervical to vaginal tissue.
- The remaining 18mL are injected in equal amounts at the cervicovaginal junction at 2, 4, 8 and 10 o'clock. The injection is continuous from superficial to deep to superficial to a depth of 3cm.
- Always aspirate (pull back on the plunger) before injecting to prevent injecting into a vein.
- Wait three minutes before dilating cervix.

Show and discuss slide: *Paracervical Block*

Tell participants they can refer to Step 4 in Section 4.1 of the Reference Manual for an image and more information about administering paracervical block.

Say: After the paracervical block has been administered, wait three minutes, then dilate the cervix if necessary.

Show and discuss slide: *Step 5: Dilate Cervix*

- Dilatation required in most but not all cases.
- Women with inevitable or incomplete abortion may require minimal or no dilatation.
- Cannula should fit snugly in os.
- Use gentle operative technique.
- Use progressively larger cannulae or mechanical dilators.
- After 12 to 14 weeks, cervical preparation with osmotics or misoprostol should be routinely used.

Say: Using gentle operative technique is important during dilatation to

avoid creating a false passage, cervical tear or perforation, especially as cervical tissue will be softened with pregnancy.

Show and discuss slide: *Step 6: Insert Cannula*

- Gently apply traction to the cervix.
- Rotate the cannula while gently applying pressure.
- Insert cannula just past internal os.
- Alternately, insert cannula slowly until it touches the fundus, then draw it back.

Show and discuss slide: *Insert Cannula Into Uterus*

Say: A cervical tear can occur if cervical traction is too strong. A uterine perforation can occur if the cannula is inserted too far through the os.

Show and discuss slide: *Attach Aspirator*

Show and discuss slide: *Step 7: Suction Uterine Contents*

- Attach charged aspirator to cannula.
- Release buttons to start suction.
- Gently rotate cannula 180 degrees in each direction.
- Use a gentle “in and out” motion.
- Do not withdraw cannula opening beyond external os.

Say: Remain alert to signs that may indicate perforation throughout the procedure and stop suction immediately if they appear.

Show slide: *Release Buttons*

Show and discuss slide: *Evacuate Uterine Contents*

Say: Why is it important not to withdraw the cannula opening beyond the external os?

- Vacuum will be lost.

Say: Though it is necessary, what is the risk with using an “in and out” motion?

- There is a risk of uterine perforation.

Show and discuss slide: *Signs That the Uterus Is Empty*

- Red or pink foam without tissue passing through cannula
- Gritty sensation over surface of uterus
- Uterus contracting around cannula
- Increased uterine cramping or pain

Show and discuss slide: *When the Procedure Is Finished*

- Depress buttons down and forward to close valve, then disconnect cannula from aspirator.
- OR withdraw cannula and aspirator from uterus without depressing buttons.
- Keep instruments ready to evacuate again after inspecting POC, if needed.

Show and discuss slide: *Use Care to Disconnect Cannula*

- Ipas EasyGrip cannulae fit firmly into the valve of the aspirator.
- Use care when disconnecting cannulae from the aspirator.

Show slide: *Detach Cannula From Aspirator*

Show and discuss slide: *Step 8: Inspect Tissue*

- Empty contents of aspirator into container.
- Look for POC; villi and decidua should be visible.

Show and discuss slide: *Inspect Tissue For:*

- Quantity and presence of POC
- Complete evacuation
- Molar pregnancy

Show and discuss slide: *Detailed Tissue Inspection*

Say: If the visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.

What might it mean if the POC inspection shows less tissue than expected or tissue sample is inconclusive?

Show and discuss slide: *Possible Reasons That No POC Visible*

- A spontaneous abortion has already completed itself
- Uterine cavity still contains POC
- Ectopic pregnancy
- Uterine anatomical variation prevented evacuation

Show and discuss slide: *Possible Reasons for Less Than Expected POC*

- Incomplete procedure; re-evacuation necessary
- Incorrect estimation of length of pregnancy

Say: The MVA procedure is almost done if the exam of POC is satisfactory.

In some circumstances, the POC may then be collected to be sent for pathologic examination. In all cases, POC are handled as infectious material.

If significant bleeding continues or other issues are identified, the provider should intervene as needed. We will cover this in the Complications module.

Show and discuss slide: *Step 9: Perform Any Concurrent Procedures*

- If POC inspection results satisfactory:
 - Wipe the cervix with swab to assess additional bleeding.
 - Perform concurrent procedure.

Say: What concurrent procedures might be done?

- IUD insertion, contraceptive implant insertion, contraceptive injection and sterilization; repair of cervical tear.

Show and discuss slide: *Step 10: Immediately Post-Procedure*

- Process or discard instruments.
- Remove barriers and wash hands.
- Reassure the woman that the procedure is finished.
- Help her into a comfortable position.
- Ensure she is escorted to the recovery area.
- Record information about procedure.

Say: What questions do you have about the steps for performing the uterine evacuation procedure before we proceed to a demonstration?

- Answer questions.

Note to Trainer: Refer to Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) clinical training for guidance on how to set up and conduct effective pelvic model demonstration and practice. Pelvic model practice should simulate clinical practice as closely as possible, including infection prevention and client interaction. All participants should achieve simulated competence on a pelvic model before they perform on actual women during the clinical practicum.

Perform a demonstration of the uterine evacuation procedure on a pelvic model for the entire group.

- Distribute the Uterine Evacuation Procedure With Ipas MVA Plus Skills Checklist.
- Ask a volunteer to stand next to you and read each step of the checklist aloud as you demonstrate.
- Ask another volunteer to sit at the head of the procedure table and act the part of the woman.

- Ask participants to follow along on their copy of the checklist as they watch the demonstration.

Note to trainer: Ensure that the demonstration is realistic. As you perform every step of the procedure, use standard precautions and speak to the volunteer “woman” as you would speak to an actual woman.

Say: What questions do you have about this demonstration of the procedure?

- Answer questions and incorporate discussion of possible adverse events as they might occur.

Switch roles: Ask the volunteer who played the role of the woman to demonstrate the procedure while you read the checklist out loud. Ask the volunteer who read the checklist to now play the role of the woman.

Tell participants that they will now practice the procedure themselves.

- Divide participants into groups of four.
- Each group is to perform simulated practice of the uterine evacuation procedure at pelvic model stations.
- Ask one participant to be the provider and perform the procedure while another participant plays the observer, reading the checklist aloud. Another participant should play the role of the woman and the fourth the support person.
- At the end of each demonstration, the provider should first give feedback describing their experience.
- Then the support person, the woman and the observer should give the provider feedback about skills that were performed well and areas for improvement.
- Participants should switch roles until all have had the opportunity to practice performing the procedure, using the checklist to observe, acting as the woman and practicing the support role.
- While participants are practicing, rotate to each pelvic model station to observe, listen, address issues that arise, correct technique as needed, and ensure that roles are being followed.

Evaluate each participant's performance using the checklist when they indicate that they are ready.

- Other participants can continue practicing while you conduct evaluations.
- All participants must be evaluated as competent with simulated practice on a pelvic model before they can perform on actual women during the clinical practicum.
- Make arrangements for participants who fail to reach competency at this time to have additional practice and evaluation.

What final questions do you have about the procedure?

- Answer questions.

Say: Now we will discuss technical problems that can occur during the procedure.

- Have instruments available to clarify or demonstrate as questions arise.
- Be sure that participants have instruments for practice.

Say: Why might vacuum decrease unexpectedly during the procedure?

Show and discuss slide: *Reasons for Decrease in MVA Vacuum*

- Aspirator is full.
- Cannula is withdrawn past os.
- Cannula is clogged.
- Aspirator is incorrectly assembled.

Say: What do you do if the aspirator is full?

Show and discuss slide: *When Aspirator Is Full*

- Close the valve buttons.
- Detach the cannula and leave in os.
- Replace aspirator.
- OR Empty aspirator into a container by pressing buttons and pushing plunger into cylinder.
- Establish new vacuum, attach aspirator to the cannula and resume.

Say: What should be done if the cannula is accidentally withdrawn past the os?

Show and discuss slide: *When Cannula Is Withdrawn Past Os*

- Remove cannula and aspirator; don't touch vaginal walls.
- Detach and empty aspirator.
- Reestablish vacuum.
- Reinsert cannula if it has not been contaminated.
- If contaminated, insert another sterile or HLD cannula instead.
- Reconnect aspirator to cannula, release vacuum and resume.

Ask for a volunteer to demonstrate these steps for the entire group.

Say: What should be done if the cannula becomes clogged?

Show and discuss slide: *When Cannula Is Clogged*

- Ease cannula back toward, but not through, the external os.

- OR Depress buttons and withdraw aspirator and cannula out of uterus, avoiding contamination.
- Remove tissue clogging cannula using sterile or high-level disinfected (HLD) forceps.
- Reinsert cannula using No Touch Technique.
- Reattach aspirator and continue aspiration.

Say: Never try to unclog the cannula by pushing the plunger back into the cylinder.

Ask for a volunteer to demonstrate these steps for the entire group.

Say: What should be done if vacuum is lost?

Show and discuss slide: *If Aspirator Does Not Hold Vacuum*

- Reassemble and test aspirator.

What questions do you have about technical problems during the procedure?

- Answer questions.

5. Post-procedure care

Say: Once the MVA procedure is finished, the woman will require high-quality post-procedure care.

Show and discuss slide: *Post-Procedure Care*

- Care provided after uterine evacuation completed
- Any physical complications addressed
- Woman informed about her condition and self-care
- Woman is provided with contraceptive method, if desired
- Ends when she is discharged

Say: As clinicians, we already know how to provide post-procedure care, sometimes called "after-care," for women in general. Many of the aspects of care for women who have received abortion-related services are the same as those of post-procedure care in general, as we will see during this module. What different conditions, physical or emotional, might be particular to women after abortion-related services?

- Woman may experience a range of emotions; she may have abdominal pain, undetected injuries or bleeding that is not visible to the provider.

Show and discuss slide: *Elements of Post-Procedure Care*

- Physical monitoring
- Other physical health issues

- Pain management
- Emotional monitoring and support

Show and discuss slide: *Elements of Post-Procedure Care (cont.)*

- Contraceptive counseling and provision
- Scheduling follow-up care if she desires and providing referrals
- Providing discharge instructions

Distribute Post-Procedure Care Skills Checklist.

- Ask participants to follow along with the checklist as you discuss the elements of post-procedure care.

Show and discuss slide: *Physical Monitoring*

- Take her vital signs immediately.
- Ensure that the woman is resting comfortably.
- Review chart for condition, history, baseline vital signs.
- Ensure recovery from procedure and medications.
- Evaluate bleeding and cramping at least twice.

Show and discuss slide: *Physical Monitoring (cont.)*

- Detect and manage complications:
 - Significant physical decline
 - Dizziness, shortness of breath, fainting
 - Severe vaginal bleeding
 - Severe abdominal pain, cramping
 - Enlarged and tender uterus

Show slide: *Taking Vital Signs*

Tell participants that they can evaluate bleeding and cramping from the woman's description or from observation. Cramping and bleeding should decrease over time; severe cramping and bleeding is not normal.

Say: Why is it important to evaluate bleeding, cramping, pain and vital signs at least twice during the post-procedure period?

- Answer: You need a baseline evaluation and then a second evaluation to determine if there has been any change—for better or worse—in her status.

Tell participants that levels of pain, bleeding and cramping cannot be measured in exactly the same way for all women. Although there are norms, providers must be alert to differences among women.

Show and discuss slide: *Post-Procedure Pain Management*

- Evaluate pain level, patterns.

- Offer choices for pain relief:
 - Analgesics, NSAIDs
- Administer, monitor pain medications.
- Offer empathy and non-pharmacologic support such as warm compresses in addition to pain medications.
- If a woman's pain increases, she needs attention.

Tell participants that one way to help women assess the level of the pain they are experiencing is by using a pain scale.

- Ask the woman how her pain compares to the most painful situation in her life on a scale of one to 10 (one is least painful and 10 is most painful).
- For low-literacy women, you could draw a line with a happy face at one end and a sad face at the other, then ask them to point to where they are along the line.

Show and discuss slide: *Other Physical- and Reproductive-Health Issues*

- Anemia: counsel on diet, supplements
- Rh-immunoglobulin: administer according to protocol
- Reproductive-tract infections (RTIs), HIV, violence, infertility, cancer screening: counsel, provide care and/or refer

Show and discuss slide: *Make Referrals If Necessary*

Say: So far we have focused on physical monitoring. The next element of post-procedure care is emotional monitoring and support.

Show the referral worksheet completed in the Informed Consent, Information and Counseling module. Ask participants to recall a time in their lives when they were in emotional pain and someone helped them feel better or made them feel worse.

- Ask one participant to share a positive recollection and another participant to share a negative one.
 - What did the person say or do? How did they make you feel better or worse?
- Discuss comments.

Show and discuss slide: *Emotional Monitoring and Support*

- Assess and monitor the woman's emotions.
- Respond sensitively to her emotional state.
- Treat a woman gently.
- Offer counseling or referrals.

Show and discuss slide: *Post-Procedure Contraceptive Counseling*

- Ideally, provide before the procedure.
- If a woman hasn't decided on contraception, discuss it again after the procedure when she may be better able to focus on her contraceptive needs.
- Ensure she receives counseling and a contraceptive method of her choice, which she understands how to use, or referral.
- Remember that some women may desire another pregnancy.

Refer participants to the Contraceptive Services module in the Reference Manual for more information.

Show and discuss slide: *Is Follow-Up Care Needed?*

- Not required after a routine MVA procedure.
- Make appointment if woman desires follow-up.
- Tailor appointment to the woman's condition and needs.
- Obtain consent to send her records to the follow-up provider.

Say: When her condition allows, the woman can be discharged.

Show and discuss slide: *Woman Is Ready for Discharge*

- Vital signs are normal.
- Bleeding and cramping are diminished.
- She is awake, alert and able to walk unassisted.
- She is ready to leave.

Tell participants that it is important to explain to the woman what she can expect and what she can do during the recovery period.

Show and discuss slide: *Normal Recovery*

- A few days of menstrual-like bleeding, cramping
- Analgesics, baths, compresses for cramping
- Next menses: four to eight weeks
- Can get pregnant almost immediately
- Intercourse, tampons when any complications resolved

Show and discuss slide: *Provide Instructions for Medications*

Say: What other medications might be necessary to administer and explain?

- Antibiotics or other drugs, depending on the woman's condition

Say: The woman should be informed about what conditions to be alert for and when to seek attention, with 24-hour contact information and emer-

gency phone numbers, if available.

Show and discuss slide: *Signs Needing Immediate Attention*

- Fever, chills, fainting, vomiting
- Heavy bleeding
- Severe pain

Show and discuss slide: *Signs to Monitor if They Worsen Over Time*

- Pain in abdomen or distention of abdomen
- Odd or bad-smelling vaginal discharge
- Prolonged cramping or bleeding
- Delay in resumption of menstruation (more than eight weeks)
- Dizziness

Say: Discharge instructions may be provided to women in writing as well because they may forget or want to verify their understanding later.

Show and discuss slide: *Before Discharge*

- The woman received contraceptive counseling and a method, if desired.
- A follow-up appointment or any referrals were made, if needed or desired.
- She was provided a list of counseling and other services available at the facility or in the community.

Say: There are many resources in the community to which links can be provided.

- Ask participants to brainstorm about services available in their communities to which they could provide referrals.
- Write all responses on a flipchart.
- Group responses by topic (for example, cancer-screening services) or by location (for example, next town).
- If desired, use the referral resource list created in the Community Linkages module.

Show and discuss slide: *Offer Contraceptive Methods*

Tell participants that this discharge procedure is routine for women who do not have any complications after abortion-related services. If a woman has suffered any complications:

- Give clear, evidence-based explanations of the situation.
- Include her in decision making about her treatment.
- May need additional discharge instructions.

- Stress the importance of a follow-up visit.

Explain that the Post-Procedure Skills Checklist describes all the steps prior to discharge.

- It can be used to develop facility protocols.
- It can be used as a monitoring tool for quality assurance.

Show and discuss slide: *Schedule Follow-Up Visit When Needed*

6. Follow-up care

Read the following scenario:

A 26-year-old woman comes to your facility after having received abortion-related services four weeks ago. She needs a resupply of oral contraceptive pills. She mentions that there is an unusual odor coming from her vagina.

- Ask participants to offer ideas about how best to care for the woman.
- Ensure the following are mentioned:
 - She might have an infection that could cause problems if left untreated.
 - If she does not get a resupply of contraceptives, she could have an unwanted pregnancy.
- Discuss barriers to contraceptive use in women who need monthly resupply. Are there alternatives for her?
- Tell participants that they just described some principles of follow-up care.

Say: Routine follow-up is not necessary. If there are complications, the woman should return to the facility immediately. If the woman desires follow-up care, an optional visit may be scheduled one to two weeks after a uterine evacuation with MVA.

Most women do not experience complications from the uterine evacuation procedure. Complications can occur prior to, during or following the procedure. Those women who do have acute problems should seek immediate care at an appropriate facility.

Show and discuss slide: *Follow-Up Care: Women With Complications*

- Ensure any complications have been resolved.
- Stabilize, treat or refer women with acute problems.
- Explain what the complication was and what it might mean for the woman.

While follow-up services vary depending on each facility's resources, there are some basic elements that may be included as part of a follow-up visit.

Show and discuss slide: *Follow-Up Care Elements*

1. Confirm success of the uterine evacuation.
 - Ask how she is feeling, including bleeding and any pregnancy symptoms
 - Conduct a physical examination
 - If needed, do or refer for ultrasound
2. Stabilize, treat or refer for acute problems; ensure that earlier complications are resolved.
3. Perform VA if the uterine evacuation is incomplete.

Show and discuss slide: *Follow-Up Care Elements (cont.)*

4. Inform the woman of what to expect following completion or continued treatment.
5. Review any laboratory tests results.
6. Provide a contraceptive method, if desired and not already provided.
7. Refer for other medical, gynecologic or counseling services where indicated.

7. Special considerations: Young women

We will now look at the special considerations involved in providing abortion-related care to young women.

Show and discuss slide: *Pelvic Exam For Young Women*

- More likely to be first pelvic exam.
- Same procedure as with adults, but be extra mindful to:
 - Ensure visual and auditory privacy
 - Explain what you are doing at each step
 - Perform exam gently and smoothly
 - If available and needed, use a smaller size speculum

Show and discuss slide: *During the MVA Procedure: Young Women*

- May benefit from cervical preparation.
- Cervix may need to be dilated more slowly.
- May experience more pain.

Say: A nulliparous woman is more likely to have a tight cervix and thus probably requires a slower dilation process. Although women of all ages need pain management, the perception of pain and use of analgesia has been found to be higher on average in younger women than in older women.

8. Summary and test

Summarize and conclude the module.

- Ask participants for key points covered in this module.
- Use the objectives as a reference.

What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect the tests.
- Review correct answers from the test key.

Thank the participants for their participation.

References

- Avraham, S., Gat, I., Duvdevani, N. R., Haas, J., Frenkel, Y., & Seidman, D. S. (2012). Pre-emptive effect of ibuprofen versus placebo on pain relief and success rates of medical abortion: A double-blind, randomized, controlled study. *Fertility and Sterility*, 97(3), 612-615. doi: 10.1016/j.fertnstert.2011.12.041
- Ashok, P. W., Penney, G. C., Flett, G. M., & Templeton, A. (1998). An effective regimen for early medical abortion: A report of 2000 consecutive cases. *Human Reproduction*, 13(10), 2962-2965.
- Bartley, J., Tong, S., Everington, D., & Baird, D. T. (2000). Parity is a major determinant of success rate in medical abortion: A retrospective analysis of 3161 consecutive cases of early medical abortion treated with reduced doses of mifepristone and vaginal gemeprost. *Contraception*, 62(6), 297-303.
- Bednarek, P. H., Creinin, M. D., Reeves, M. F., Cwiak, C., Espey, E., & Jensen, J. T. (2011). Immediate versus delayed IUD insertion after uterine aspiration. *New England Journal of Medicine*, 364(23), 2208-2217. doi: 10.1056/NEJMoa1011600
- Betstadt, S. J., Turok, D. K., Kapp, N., Feng, K. T., & Borgatta, L. (2011). Intrauterine device insertion after medical abortion. *Contraception*, 83(6), 517-521.
- Billings, D. L. (2004). Misoprostol alone for early medical abortion in a Latin American clinic setting. *Reproductive Health Matters*, 12(24 Supplement), 57-64.
- Blanchard, K., Winikoff, B., & Ellertson, C. (1999). Misoprostol used alone for the termination of early pregnancy: A review of the evidence. *Contraception*, 59(4), 209-217.
- Borgatta, L., Mullally, B., Vragovic, O., Gittinger, E., & Chen, A. (2004). Misoprostol as the primary agent for medical abortion in a low-income urban setting. *Contraception*, 70(2), 121-126.
- Bracken, H., Gliozheni, O., Kati, K., Manoku, N., Moisiu, R., Shannon, C.,...Winikoff, B. (2006). Mifepristone medical abortion in Albania: results from a pilot clinical research study. *European Journal of Contraception and Reproductive Health Care*, 11(1), 38-46.
- Bugalho, A., Mocumbi, S., Faúndes, A., & David, E. (2000). Termination of pregnancies of <6 weeks gestation with a single dose of 800 microg of vaginal misoprostol. *Contraception*, 61(1), 47-50.
- Callen, P. W. (2011). *Ultrasonography in obstetrics and gynecology*. Philadelphia, PA: Saunders, Elsevier.
- Carbonell Esteve, J. L., Varela, L., Velazco, A., Cabezas, E., Tanda, R., & Sánchez, C. (1998). Vaginal misoprostol for late first trimester abortion. *Contraception*, 57(5), 329-333.
- Carbonell, J. L., Rodríguez, J., Velazco, A., Tanda, R., Sánchez, C., Barambio, S., ...Salvador, I. (2003). Oral and vaginal misoprostol 800 microg every 8 h for early abortion. *Contraception*, 67(6), 457-462.
- Carbonell, J. L., Varela, L., Velazco, A., Tanda, R., & Sánchez, C. (1999). Vaginal misoprostol for abortion at 10-13 weeks' gestation. *European Journal of Contraception and Reproductive Health Care*, 4(1), 35-40.
- Carbonell, J. L., Velazco, A., Varela, L., Tanda, R., Sánchez, C., Barambio, S.,...Mari, J. (2001). Misoprostol for abortion at 9-12 weeks' gestation in adolescents. *European Journal of Contraception and Reproductive Health Care*, 6(1), 39-45.
- Creinin, M. D. (2003). Current medical abortion care. *Current Women's Health Report*, 3(6), 461-469.
- Creinin, M. D., & Aubény, E. (1999). Medical abortion in early pregnancy. In M. E. Paul, S. Lichtenberg, L. Borgatta, D. A. Grimes & P. G. Stubblefield (Eds.). *A clinician's guide to medical and surgical abortion*. New York: Churchill Livingstone.
- Creinin, M. D., & Danielsson, K. G. (2009). Medical abortion in early pregnancy. *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*. Oxford, UK: Blackwell.
- Creinin, M. D., Fox, M. C., Teal, S., Chen, A., Schaff, E. A., & Meyn, L. A. (2004). A randomized comparison of misoprostol 6 to 8 hours versus 24 hours after mifepristone for abortion. *Obstetrics and Gynecology*, 103(5 Pt 1), 851-859.

- Creinin, M. D., & Shulman, T. (1997). Effect of nonsteroidal anti-inflammatory drugs on the action of misoprostol in a regimen for early abortion. *Contraception*, 56(3), 165-168.
- Davis, A., Westhoff, C., & De Nonno, L. (2000). Bleeding patterns after early abortion with mifepristone and misoprostol or manual vacuum aspiration. *Journal of American Medical Women's Association*, 55(3 Suppl), 141-144.
- Demetroulis, C., Saridogan, E., Kunde, D., & Naftalin, A. A. (2001). A prospective randomized control trial comparing medical and surgical treatment for early pregnancy failure. *Human Reproduction*, 16(2), 365-369.
- Elul, B., Hajri, S., Ngoc, N. N., Ellertson, C., Slama, C. B., Pearlman, E., & Winikoff, B. (2001). Can women in less-developed countries use a simplified medical abortion regimen? *Lancet*, 357(9266), 1402-1405.
- Faúndes, A., Fiala, C., Tang, O. S., & Velasco, A. (2007). Misoprostol for the termination of pregnancy up to 12 completed weeks of pregnancy. *International Journal of Gynecology & Obstetrics*, 99 Suppl 2, S172-177.
- Federation, N. A. (2001). *Early options: A provider's guide to medical abortion*. Washington DC: National Abortion Federation.
- Fiala, C., Winikoff, B., Helström, L., Hellborg, M., & Gemzell-Danielsson, K. (2004). Acceptability of home-use of misoprostol in medical abortion. *Contraception*, 70(5), 387-392.
- Fielding, S. L., Schaff, E. A., & Nam, N.Y. (2002). Clinicians' perception of sonogram indication for mifepristone abortion up to 63 days. *Contraception*, 66(1), 27-31.
- Gilles, J. M., Creinin, M. D., Barnhart, K., Westhoff, C., Frederick, M. M., & Zhang, J. (2004). A randomized trial of saline solution-moistened misoprostol versus dry misoprostol for first-trimester pregnancy failure. *American Journal of Obstetrics and Gynecology*, 190(2), 389-394. doi: 10.1016/j.ajog.2003.08.024
- Goldberg, A. B., Greenberg, M. B., & Darney, P. D. (2001). Misoprostol and pregnancy. *New England Journal of Medicine*, 344(1), 38-47.
- Graziosi, G. C., Mol, B. W., Ankum, W. M., & Bruinse, H. W. (2004). Management of early pregnancy loss. *International Journal of Gynecology and Obstetrics*, 86(3), 337-346. doi: 10.1016/j.ijgo.2004.04.038
- Guengant, J.-P., Bangou, J., Elul, B., & Ellertson, C. (1999). Mifepristone-misoprostol medical abortion: Home administration of misoprostol in Guadeloupe. *Contraception*, 60(3), 167-172.
- Gynuity Health Projects. (2009). *Misoprostol for treatment of incomplete abortion: An introductory guidebook*. New York, NY: Gynuity Health Projects.
- Hamoda, H., Ashok, P. W., Flett, G. M., & Templeton, A. (2004). Analgesia requirements and predictors of analgesia use for women undergoing medical abortion up to 22 weeks of gestation. *BJOG*, 111(9), 996-1000.
- Hamoda, H., Ashok, P. W., Flett, G. M., & Templeton, A. (2005). Medical abortion at 9-13 weeks' gestation: A review of 1076 consecutive cases. *Contraception*, 71(5), 327-332.
- Hamoda, H., Ashok, P. W., Flett, G. M., & Templeton, A. (2005). A randomised controlled trial of mifepristone in combination with misoprostol administered sublingually or vaginally for medical abortion up to 13 weeks of gestation. *BJOG*, 112(8), 1102-1108.
- Harper, C., Winikoff, B., Ellertson, C., & Coyaji, K. (1998). Blood loss with mifepristone--misoprostol abortion: Measures from a trial in China, Cuba and India. *International Journal of Gynecology Obstetrics*, 63(1), 39-49.
- Hausknecht, R. (2003). Mifepristone and misoprostol for early medical abortion: 18 months experience in the United States. *Contraception*, 67(6), 463-465.

- Honkanen, H., Piaggio, G., Hertzen, H., Bártfai, G., Erdenetungalag, R., Gemzell-Danielsson, K.,... Wu, S.C. (2004). WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. *BJOG*, 111(7), 715-725. doi: 10.1111/j.1471-0528.2004.00153.x
- Ingham, R., & Lee, E. (2008). *Evaluation of Early Medical Abortion (EMA) pilot sites*. United Kingdom: Department of Health.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2009). *Training tips for using pelvic models in manual vacuum aspiration (MVA) clinical training*. Chapel Hill, NC: Ipas.
- Ipas & Venture Strategies Innovations. (2011). *Misoprostol use in postabortion care: A service delivery toolkit*. Chapel Hill, NC: Ipas.
- Jackson, E., & Kapp, N. (2011). Pain control in first-trimester and second-trimester medical termination of pregnancy: a systematic review. *Contraception*, 83(2), 116-126.
- Jain, J. K., Dutton, C., Harwood, B., Meckstroth, K. R., & Mishell, D. R. (2002). A prospective randomized, double-blinded, placebo-controlled trial comparing mifepristone and vaginal misoprostol to vaginal misoprostol alone for elective termination of early pregnancy. *Human Reproduction*, 17(6), 1477-1482.
- Jain, J. K., Meckstroth, K. R., & Mishell, D. R. (1999). Early pregnancy termination with intravaginally administered sodium chloride solution-moistened misoprostol tablets: Historical comparison with mifepristone and oral misoprostol. *American Journal of Obstetrics Gynecology*, 181(6), 1386-1391.
- Kruse, B., Poppema, S., Creinin, M. D., & Paul, M. (2000). Management of side effects and complications in medical abortion. *American Journal of Obstetrics and Gynecology*, 183(2 Suppl), S65-75.
- Kulier, R., Kapp, N., Gülmezoglu, A. M., Hofmeyr, G. J., Cheng, L., & Campana, A. (2011). Medical methods for first trimester abortion. *Cochrane Database SystRev*(11), CD002855.
- Lipscomb, G. H., Stovall, T. G., & Ling, F. W. (2000). Nonsurgical treatment of ectopic pregnancy. *New England Journal of Medicine*, 343(18), 1325-1329. doi: 10.1056/NEJM200011023431807
- Livshits, A., Machtinger, R., David, L. B., Spira, M., Moshe-Zahav, A., & Seidman, D. S. (2009). Ibuprofen and paracetamol for pain relief during medical abortion: A double-blind randomized controlled study. *Fertility and Sterility*, 91(5), 1877-1880. doi: 10.1016/j.fertnstert.2008.01.084
- Mayo Clinic. (2012). Fetal development: The first trimester. Retrieved from <http://www.mayoclinic.com/health/prenatal-care/PR00112>
- Meckstroth, K. R., Whitaker, A. K., Bertisch, S., Goldberg, A. B., & Darney, P. D. (2006). Misoprostol administered by epithelial routes: Drug absorption and uterine response. *Obstetrics and Gynecology*, 108(3 Pt 1), 582-590.
- Muffley, P. E., Stitely, M. L., & Gherman, R. B. (2002). Early intrauterine pregnancy failure: A randomized trial of medical versus surgical treatment. *American Journal of obstetrics and gynecology*, 187(2), 321-325; discussion 325-326.
- Neilson, J. P., Gyte, G. M., Hickey, M., Vazquez, J. C., & Dou, L. (2010). Medical treatments for incomplete miscarriage (less than 24 weeks). *Cochrane Database SystRev*(1), CD007223.
- Ngoc, N. T., Blum, J., Raghavan, S., Nga, N. T., Dabash, R., Diop, A., & Winikoff, B. (2011). Comparing two early medical abortion regimens: Mifepristone + misoprostol vs. misoprostol alone. *Contraception*, 83(5), 410-417.
- Ngoc, N. T., Blum, J., Westheimer, E., Quan, T. T., & Winikoff, B. (2004). Medical treatment of missed abortion using misoprostol. *International Journal of Gynecology and Obstetrics*, 87(2), 138-142. doi: 10.1016/j.ijgo.2004.07.015

- Ngoc, N., Winikoff, B., Clark, S., Ellertson, C., Am, K. N., Hieu, D. T., & Elul, B. (1999). Safety, efficacy and acceptability of mifepristone-misoprostol medical abortion in Vietnam. *International Family Planning Perspectives*, 25(1), 10-14.
- Paul, M. (2007). Abortion. In R. A. Hatcher, J. Trussell, A. L. Nelson, J. W. Cates, F. H. Stewart & D. Kowall (Eds.), *Contraceptive Technology* (19th ed.). New York, NY: Ardent Media, Inc.
- Perriera, L. K., Reeves, M. F., Chen, B. A., Hohmann, H. L., Hayes, J., & Creinin, M. D. (2010). Feasibility of telephone follow-up after medical abortion. *Contraception*, 81(2), 143-149.
- Planned Parenthood Federation of America (2002). *Medical abortion: Questions and answers*. New York, NY: Planned Parenthood Federation of America.
- Renner, R. M., Jensen, J. T., Nichols, M. D., & Edelman, A. (2009). Pain control in first trimester surgical abortion. *Cochrane Database SystRev*(2), CD006712.
- Reproductive Health Technologies Project & Gynuity Health Projects. (2003). *Instructions for use: Abortion induction with misoprostol (Cytotec®) in pregnancies up to 9 weeks LMP*. Expert Meeting on Misoprostol sponsored by Reproductive Health Technologies Project and Gynuity Health Projects: Washington DC.
- Rossi, B., Creinin, M. D., & Meyn, L. A. (2004). Ability of the clinician and patient to predict the outcome of mifepristone and misoprostol medical abortion. *Contraception*, 70(4), 313-317.
- Salakos, N., Kountouris, A., Botsis, D., Rizos, D., Gregoriou, O., Detsis, G., & Creatsas, G. (2005). First-trimester pregnancy termination with 800 microg of vaginal misoprostol every 12 h. *European Journal of Contraception and Reproductive Health Care*, 10(4), 249-254.
- Schaff, E. A., DiCenzo, R., & Fielding, S. L. (2005). Comparison of misoprostol plasma concentrations following buccal and sublingual administration. *Contraception*, 71(1), 22-25.
- Schaff, E. A., Eisinger, S. H., Stadalius, L. S., Franks, P., Gore, B. Z., & Poppema, S. (1999). Low-dose mifepristone 200 mg and vaginal misoprostol for abortion. *Contraception*, 59(1), 1-6.
- Schaff, E. A., Fielding, S. L., Eisinger, S. H., Stadalius, L. S., & Fuller, L. (2000). Low-dose mifepristone followed by vaginal misoprostol at 48 hours for abortion up to 63 days. *Contraception*, 61(1), 41-46.
- Schaff, E. A., Fielding, S. L., & Westhoff, C. (2001). Randomized trial of oral versus vaginal misoprostol at one day after mifepristone for early medical abortion. *Contraception*, 64(2), 81-85.
- Schaff, E. A., Fielding, S. L., & Westhoff, C. (2002). Randomized trial of oral versus vaginal misoprostol 2 days after mifepristone 200 mg for abortion up to 63 days of pregnancy. *Contraception*, 66(4), 247-250.
- Schaff, E. A., Fielding, S. L., Westhoff, C., Ellertson, C., Eisinger, S. H., Stadalius, L. S., & Fuller, L. (2000). Vaginal misoprostol administered 1, 2, or 3 days after mifepristone for early medical abortion: A randomized trial. *Journal of the American Medical Association*, 284(15), 1948-1953.
- Schaff, E. A., Stadalius, L. S., Eisinger, S. H., & Franks, P. (1997). Vaginal misoprostol administered at home after mifepristone (RU486) for abortion. *Journal of Family Practice*, 44(4), 353-360.
- Schreiber, C. A., Sober, S., Ratcliffe, S., & Creinin, M. D. (2011). Ovulation resumption after medical abortion with mifepristone and misoprostol. *Contraception*, 84(3), 230-233.
- Shulman, L. P., Lipscomb, G. H., & Ling, F. W. (1999). Management of abnormal pregnancies. In M. E. Paul, S. Lichtenberg, L. Borgatta, D. A. Grimes, & P. G. Stubblefield (Eds.), *A clinician's guide to medical and surgical abortion*. New York: Churchill Livingstone.
- Stanek, A. M., Bednarek, P. H., Nichols, M. D., Jensen, J. T., & Edelman, A. B. (2009). Barriers associated with the failure to return for intrauterine device insertion following first-trimester abortion. *Contraception*, 79(3), 216-220. doi: 10.1016/j.contraception.2008.09.003
- Stewart, F. H., Wells, E. S., Flinn, S. K., & Weitz, T. A. (2001). *Early medical abortion: Issues for practice*. San Francisco, California: UCSF Center for Reproductive Health Research & Policy.

- Suhonen, S., Heikinheimo, O., Tikka, M., & Haukkamaa, M. (2003). The learning curve is rapid in medical termination of pregnancy--first-year results from the Helsinki area. *Contraception*, 67(3), 223-227.
- Suhonen, S., Tikka, M., Kivinen, S., & Kauppila, T. (2011). Pain during medical abortion: Predicting factors from gynecologic history and medical staff evaluation of severity. *Contraception*, 83(4), 357-361.
- Swica, Y., Chong, E., Middleton, T., Prine, L., Gold, M., Schreiber, C. A., & Winikoff, B. (2012). Acceptability of home use of mifepristone for medical abortion. *Contraception*, 88(1), 122-127.
- Tang, O. S., Lau, W. N., Ng, E. H., Lee, S. W., & Ho, P. C. (2003). A prospective randomized study to compare the use of repeated doses of vaginal with sublingual misoprostol in the management of first trimester silent miscarriages. *Human Reproduction*, 18(1), 176-181.
- Tang, O. S., Ong, C. Y., Tse, K. Y., Ng, E. H., Lee, S. W., & Ho, P. C. (2006). A randomized trial to compare the use of sublingual misoprostol with or without an additional 1 week course for the management of first trimester silent miscarriage. *Human Reproduction*, 21(1), 189-192. doi: 10.1093/humrep/dei303
- Teal, S. B., Dempsey-Fanning, A., & Westhoff, C. (2007). Predictors of acceptability of medication abortion. *Contraception*, 75(3), 224-229.
- Velazco, A., Varela, L., Tanda, R., Sánchez, C., Barambio, S., Chami, S.,...Mari, J. (2000). Misoprostol for abortion up to 9 weeks' gestation in adolescents. *European Journal of Contraception and Reproductive Health Care*, 5(4), 227-233.
- Von Hertzen, H., Honkanen, H., Piaggio, G., Bartfai, G., Erdenetungalag, R., Gemzell-Danielsson, K., ... Wu, S.C.. (2003). WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. *BJOG*, 110(9), 808-818.
- Von Hertzen, H., Huong, N. T., Piaggio, G., Bayalag, M., Cabezas, E., Fang, A. H.,... Peregoudov, A. (2010). Misoprostol dose and route after mifepristone for early medical abortion: A randomised controlled noninferiority trial. *BJOG*, 117(10), 1186-1196.
- Von Hertzen, H., Piaggio, G., Huong, N. T., Arustamyan, K., Cabezas, E., Gomez, M.,...Peregoudov, A. (2007). Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: A randomised controlled equivalence trial. *Lancet*, 369(9577), 1938-1946.
- Westhoff, C., Dasmahapatra, R., Winikoff, B., & Clarke, S. (2000). Predictors of analgesia use during supervised medical abortion. The Mifepristone Clinical Trials Group. *Contraception*, 61(3), 225-229.
- Westhoff, C., Dasmahapatra, R., & Schaff, E. (2000). Analgesia during at-home use of misoprostol as part of a medical abortion regimen. *Contraception*, 62(6), 311-314.
- Winikoff, B., Dzuba, I. G., Chong, E., Goldberg, A. B., Lichtenberg, E. S., Ball, C.,... Swica, Y. (2012). Extending outpatient medical abortion services through 70 days of gestational age. *Obstetrics and Gynecology*, 120(5), 1070-1076.
- World Health Organization (1997). *Medical methods for termination of pregnancy: Report of a WHO scientific group*. Geneva: World Health Organization.
- World Health Organization. (2009). *Medical eligibility criteria for contraceptive use*. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241563888_eng.pdf
- World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems*, (2nd ed.). Geneva: World Health Organization.
- Zhang, J., Gilles, J. M., Barnhart, K., Creinin, M. D., Westhoff, C., & Frederick, M. M. (2005). A comparison of medical management with misoprostol and surgical management for early pregnancy failure. *New England Journal of Medicine*, 353(8), 761-769. doi: 10.1056/NEJMoa044064

Knowledge Test Key

Uterine Evacuation with Ipas MVA Plus:

1. b
2. d
3. a
4. d
5. c

Post-Procedure Care:

1. c
2. b
3. c
4. a

Follow-Up Care:

1. d
2. d
3. c
4. a
5. False
6. True
7. False

Uterine Evacuation Procedure With Ipas MVA Plus Knowledge Test

Uterine Evacuation Procedure

1. Which of the following is not true about pain and its management during a uterine evacuation procedure?
 - a. WHO recommends that all women routinely be offered pain medication during both medical and surgical abortions.
 - b. Non-pharmacologic measures and a calm environment are adequate substitutions for pain medications.
 - c. Anxiety and/or depression may be associated with increased pain.
 - d. Paracervical block is safe, easy to do and may be done by midlevel providers.
2. No Touch Technique means:
 - a. The provider should not touch the woman.
 - b. If the aspirator is not sterile, the provider's fingertips can be used to unclog a cannula.
 - c. The vaginal walls are sterile and cannot be touched.
 - d. The tip of the cannula should not touch anything that is not sterile.
3. Which of the following is a possible reason that POC are not visible during post-procedure inspection?
 - a. Ectopic pregnancy
 - b. Villi and decidua are present
 - c. Estimation of length of pregnancy was correct
 - d. POC were not passed prior to the procedure
4. The already very low risk of serious complications of paracervical block can be reduced by:
 - a. Injecting anywhere in the cervix
 - b. Using more than 200mg of lidocaine
 - c. Only using paracervical block when the os is open
 - d. Pulling the plunger back (aspirating) before injecting
5. Uterine perforation is a risk that can be minimized by:
 - a. Firmly inserting a larger cannula all the way into the uterus
 - b. Underestimating the length of pregnancy
 - c. Using gentle operative technique
 - d. Estimating size and position of the uterus based on the woman's weight

Post-Procedure Care:

1. Which of the following is not an element of post-procedure care?
 - a. Physical monitoring
 - b. Pain management
 - c. Required contraception
 - d. Emotional monitoring and support
2. Physical monitoring includes which of the following?
 - a. Waiting 20 minutes to take vital signs
 - b. Reviewing chart for condition and history
 - c. Ensuring the woman remains physically active throughout
 - d. Referring her to another facility to monitor complications
3. Which of the following is *not* part of emotional monitoring and support?
 - a. Assessing the woman's emotional state
 - b. Showing empathy
 - c. Gently touching the woman frequently regardless of her preference
 - d. Offering counseling and referrals
4. One sign that a woman is ready for discharge is:
 - a. Her vital signs are normal.
 - b. Bleeding and cramping have increased.
 - c. She is still groggy.
 - d. Her partner is ready for her to leave.

Follow-up Care

1. Which of the following is not true about follow-up visits?
 - a. Routine follow-up is not necessary.
 - b. If there are complications, the woman should return to the facility immediately.
 - c. If the woman desires follow-up care, an optional visit may be scheduled one to two weeks after an abortion.
 - d. A follow-up visit should be routinely scheduled for five to seven days after the procedure.

2. During abortion-related care, contraception should be offered to:
 - a. Married women
 - b. Women 18 years and older
 - c. Women who have three or more children
 - d. All women

3. A sign that a woman needs medical attention is:
 - a. Use of analgesics for pain
 - b. Sore throat
 - c. Prolonged bleeding and cramping
 - d. Current contraceptive use

4. Contraceptive counseling should always include which important message?
 - a. Women can become pregnant almost immediately following a uterine evacuation.
 - b. Women cannot become pregnant until at least four weeks after a uterine evacuation.
 - c. Women who receive abortion-related care should not try to become pregnant again immediately.
 - d. Women who receive abortion-related care do not need contraception until they have had three normal menstrual cycles.

5. True or False Most women experience complications from a uterine evacuation procedure.

6. True or False WHO does not recommend a routine follow-up visit after an uncomplicated uterine evacuation with MVA.

7. True or False All women receiving abortion-related care want to prevent future pregnancy.

Pain Management Plan Case Studies

Instructions: Read each case study and develop a pain management plan that addresses the woman's concerns, as if she were present to represent herself. Consider every issue expressed by the woman and be sure to address each of the three sources of pain. Describe use of pharmacological and non-pharmacological methods.

1. Shalini is 30 years old with three children. She has no medical problems and has an early, unwanted pregnancy. She is slightly nervous about the MVA procedure because she has heard it can be painful. She wants the provider to be quiet but would like someone to hold her hand. She doesn't want to be groggy after the procedure. Based on your discussion, she decides on this plan:

Anxiety: Preferred support measures? _____

Anxiolytics/sedatives? _____

Pain of cervical dilatation: _____

Pain of uterine manipulation: _____

2. A small cervical tear complicated Eva's previous uterine evacuation, which was performed by another provider. A 19-year-old, healthy single woman, she agrees to cervical repair and an MVA. She is extremely nervous. After hearing the risks, benefits and alternatives, she wants as much sedation as she can have. She agrees to this pain management plan:

Anxiety: Preferred support measures? _____

Anxiolytics/sedatives? _____

Pain of cervical dilatation: _____

Pain of uterine manipulation: _____

3. Fifteen years old, nulliparous and otherwise healthy, Nancy has an unwanted pregnancy and unhealed vaginal tear from a violent rape 10 weeks ago. She is crying uncontrollably and in great emotional pain. She does not want anyone to touch her genitals. She agrees to the following:

Anxiety: Preferred support measures? _____

Anxiolytics/sedatives? _____

Pain of cervical dilatation: _____

Pain of uterine manipulation: _____

Pain Management Plan Case Studies Key

Case 1: Shalini

Anxiety: Preferred support measures? Provider will be quiet; someone will hold her hand.

Anxiolytics/sedatives? Does not want to be groggy and wants to go home quickly, so none used.

Pain of cervical dilatation: Paracervical block.

Pain of uterine manipulation: Oral analgesic such as ibuprofen 45 minutes before the MVA procedure.

Case 2: Eva

Anxiety: Preferred support measures? An assistant will provide her desired type of support.

Anxiolytic/sedatives? Consider conscious sedation if the facility has that capability, or administer PO or IV anxiolytic, such as Diazepam or sedative; consider slightly higher or additional dosage; closely monitor respirations.

Pain of cervical dilatation: Paracervical block; consider priming cervix with misoprostol or administering laminaria. If stenosis is present or tear is extensive, consider increasing sedation.

Pain of uterine manipulation: Oral analgesic such as ibuprofen 45 minutes before the MVA procedure.

Case 3: Nancy

Anxiety: Preferred support measures? An assistant will provide her desired type of support.

Anxiolytics/sedatives? May need conscious sedation.

Pain of cervical dilatation: Paracervical block.

Pain of uterine manipulation: Oral analgesic such as ibuprofen 45 minutes before the MVA procedure.

Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training

Demonstration and hands-on practice are critical components of training for clinical procedures such as manual vacuum aspiration (MVA). Simulated practice reinforces key information and steps covered during didactic sessions and significantly increases their recall. Additionally, practice with a pelvic model helps trainees become more comfortable handling the instruments before performing the procedure on a woman. Demonstration and practice on pelvic models should be routinely included as a component of MVA training.



Pelvic models may be used for a range of training or orientation situations.

These include instructor-led demonstrations of procedures (trainees do not perform the simulated procedure), short courses designed to familiarize trainees with the procedure but without a clinical practicum with patients, and competency-based trainings that include clinical practice. This tip sheet provides basic information on the use of pelvic models for competency-based MVA training. Trainers should refer to the Ipas training curricula (see resources) for in-depth training information; this guidance can also be adapted to other contexts.

Uterine evacuation procedure demonstration and simulated practice

Use of the pelvic models in training generally follows theory and interactive content that may cover topics such as uterine evacuation (UE) methods, counseling, infection prevention, clinical assessment, uterine evacuation procedure with the Ipas MVA Plus including instrument features, care, use, and processing.

Trainers perform a demonstration of the UE procedure on a pelvic model for the entire group, and then allow participants to perform simulated practice. It is important to simulate the procedure exactly as participants should perform it in actual clinical settings (including glove use, draping the woman for modesty, etc).

Demonstration and simulated practice

Perform a demonstration of the uterine evacuation procedure on a pelvic model for the entire group.

- Distribute the Uterine Evacuation Procedure With Ipas MVA Plus Skills Checklist to each participant.
- Ask a volunteer to stand next to you and read each step of the checklist aloud as you demonstrate.
- Ask another volunteer to sit at the head of the procedure table and act the part of the woman.
- Ask participants to follow along on their copy of the checklist as they watch the demonstration.

Trainer's note: During this demonstration, act as if the procedure were taking place in an actual clinic setting. As you perform the procedure, answer questions, discuss possible adverse events as they might occur, use standard precautions and speak to the volunteer “woman” as you would speak to a woman during an actual procedure.

Ask and answer questions: What questions do you have about this demonstration of the procedure?

Next, switch roles: Ask the volunteer who played the role of the woman to demonstrate the procedure while you read the checklist out loud. Ask the volunteer who read the checklist to now play the role of the woman.

Participants now practice the procedure in small groups.

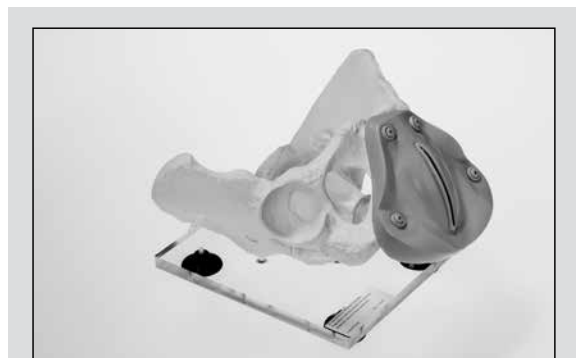
Divide participants into groups of three or four.

- Each group will perform simulated practice of the uterine evacuation procedure at pelvic model stations.
- Ask one trainee to be the provider and perform the procedure while another participant plays the observer, reading the checklist aloud. The third trainee plays the role of the woman and the fourth plays the support person.
- At the end of each procedure, the provider should first give feedback describing her or his experience.
- The support person, the woman and the observer should then give the provider feedback about skills that were performed well and areas for improvement.
- Trainees should switch roles until all have had the opportunity to practice performing the procedure, using the checklist to observe, acting as the woman and practicing the support role.
- While participants are practicing, rotate to each pelvic model station to observe, listen, address issues that arise, correct technique as needed, and ensure that roles are being followed.

Trainer's note: This may be a good time to bring in additional trainers as the simulated practice evaluation can be time-consuming, depending on the number of participants.

At the end of the training, evaluate each trainee's performance using the checklist.

- Other participants can continue practicing while you conduct evaluations.
- Each trainee must be evaluated as competent with simulated practice on a pelvic model before he/she can perform on live women during the clinical practicum.



Important

Always check pelvic models and other equipment to ensure that all parts are present and set-up is fully functional.

Store pelvic models in a dry environment protected from direct sunlight and high temperatures which can cause melting and disfigurement.



- Make arrangements for trainees who fail to reach competency at this time to have additional practice and evaluation.

To conclude the demonstration and simulated practice, ask and answer any remaining questions: What final questions do you have about the procedure?

Ordering Supplies

For more information about ordering MVA demonstration supplies, please contact WomanCare Global at customerservice@womancareglobal.org.

Supplies for Uterine Evacuation Procedure Demonstration and Simulated Practice

- Participants can share a mock sink and table (for examining the tissue) while practicing at individual stations.
- Some pelvic models can only accommodate size 6mm cannulae and smallest dilators.

Each station needs:

- ☐ Pelvic model
- ☐ Fabric to cover the model's perineum for "privacy"
- ☐ Towel or other fabric to create "work field"
- ☐ Gloves
- ☐ Speculum
- ☐ Small metal cup for antiseptic
- ☐ Sponge clamp for preparing cervix and wiping it at end of procedure
- ☐ Gauze X 2 for prep and wiping cervix at end of procedure
- ☐ 10cc hypodermic syringe
- ☐ 1.5 inch hypodermic needle (or spinal needle)
- ☐ Tenaculum
- ☐ Dilators (a few small ones for simulation purposes)
- ☐ 6mm cannulae
- ☐ Aspirator
- ☐ Medium basin to hold discharged POC

For the tissue examination table:

- ☐ Lamp
- ☐ Glass dish

For the sink:

- ☐ Strainer

Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist

Skill	Yes	No	Comments
Creates pain management plan			
Tailors pain management to the woman's needs			
Discusses sources of pain, options, potential side effects			
Includes combination of support and pharmacological measures			
Takes into account her medical and psychological status, staff skills, nature of the procedure and availability of supplies			
Prepares the instruments			
Checks vacuum retention of aspirator			
Has more than one instrument available			
Prepares the woman			
Administers pain medication in timely fashion			
Administers prophylactic antibiotics to all women, and therapeutic antibiotics if indicated			
Asks woman to empty her bladder			
Asks what supportive measures she would like and provides them			
Asks for permission to start			
Puts on barriers and washes hands			
Performs pelvic exam to confirm assessment findings			
Warms and inserts speculum gently			
Performs cervical antiseptic prep			
Follows No Touch Technique			
Uses antiseptic sponges to clean os and, if desired, vagina			
Administers paracervical block			
Uses 20mL of 1% lidocaine (less than 200mg lidocaine)			
Aspirates before injecting 2mL at tenaculum site			
Places tenaculum			
Applies slight traction to expose tissue transition			
Aspirates before slowly injecting the remaining 18mL in equal amounts at the cervicovaginal junction to 3cm depth at 2, 4, 8 and 10 o'clock			
Dilates cervix if needed			
Gently dilates cervix until cannula fits snugly			

(continued on pages 265-267)

Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist

Skill (continued)	Yes	No	Comments
Inserts cannula			
Applies gentle traction to cervix			
Rotates cannula while gently applying pressure			
Inserts cannula just past internal os into uterus or to fundus and pulls back			
Suctions uterine contents			
Holds tenaculum and end of cannula in one hand			
Attaches charged aspirator			
Releases buttons to start vacuum			
Rotates cannula 180 degrees in each direction			
Uses an "in and out" motion			
Does not withdraw aperture beyond os			
Uses gentle operative technique			
Uses positive, respectful, supportive reassurance			
Stops when pink foam without tissue passes through cannula, gritty sensation is felt, uterus contracts around cannula and uterine cramping increases			
Removes the instrument			
Is ready to evacuate again after inspecting tissue if needed			
Inspects tissue			
Empties aspirator into container			
Looks for POC			
Evaluates amount based on estimated length of pregnancy			
Determines all POC have been removed			
Completes remaining steps			
Wipes cervix to assess bleeding			
Considers if pelvic exam is advisable			
Reassures the woman that the uterine evacuation procedure is finished			
Performs any concurrent procedures (such as inserting an IUD or implant, performing female sterilization or repairing a cervical tear)			
If inserting an IUD or implant, follows steps in skills checklists			

Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist

Skill (continued)	Yes	No	Comments
Performs post-procedure care			
Removes barriers and washes hands			
Ensures woman is escorted to recovery area			
Processes instruments			
Resolves technical problems that arise			

Post-MVA IUD Insertion Skills Checklist	Yes	No	Comments
Maintains rapport with the woman, ensures continued privacy and comfort			
Confirms that the woman received counseling and gave informed consent for IUD insertion			
If speculum was removed, reinserts speculum and swabs cervix with antiseptic solution			
Sounds uterus			
Opens IUD package sterilely			
Prepares IUD according to uterine size			
Inserts IUD using appropriate no-touch technique			
Trims strings			
Ensures that woman knows aftercare information			

Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist

Implant Insertion Skills Checklist	Yes	No	Comments
Maintains rapport with the woman; ensures continued privacy and comfort			
Confirms that woman received counseling and gave informed consent for implant insertion			
Positions woman comfortably with forearm exposed			
Marks insertion point, swabs arm with antiseptic solution			
Injects local anesthesia into insertion point			
Places implant appropriately using sterile technique			
Confirms appropriate implant placement with the woman			
Places dressing on arm			
Gives woman instructions on wound and dressing care			

Post-Procedure Care Skills Checklist

Skill	Yes	No	Comments
Monitors the woman's physical status			
Ensures the woman is resting comfortably			
Takes vital signs immediately			
Reviews chart for condition and history			
Monitors physiological status, including vital signs			
Evaluates bleeding and cramping at least twice			
Continues therapy for any existing problems			
Assesses and manages complications			
Manages pain			
Evaluates pain levels			
Administers and monitors desired options for pain relief			
Addresses other physical-health issues			
Addresses other physical-health needs and provides referrals if needed for: anemia, RTIs/HIV, cervical cancer, violence, infertility			
Administers Rh-immunoglobulin, if protocol			
Provides emotional monitoring and support			
Responds sensitively to emotions			
Monitors emotional status			
Provides counseling and referrals for emotional-health needs			
Provides contraceptive counseling (if not done before the procedure)			
Determines desire for future pregnancy and reproductive needs			
Provides contraceptive counseling, methods and resupply information			
Makes sure that the woman knows how to use the method of contraception she has chosen and answer any of her questions			
Arranges for follow-up care as desired or needed			
Schedules follow-up appointment according to her condition and/or request			
Secures her consent before releasing records to other providers			
Discharges the woman			
Ensures recovery before discharging according to protocols			
Provides instructions on: self-monitoring normal recovery; pain relief/medications; behaviors that increase problems; when and how to seek treatment for complications; follow-up care			

Follow-Up Care Skills Checklist

Reminder: Routine follow-up after uterine evacuation using MVA is not necessary. If there are complications, the woman should return to the facility immediately. If the woman desires follow-up care, an optional visit may be scheduled one to two weeks after an abortion. If the woman returns for follow-up care, the provider should:

Skill	Yes	No	Comments
Confirms the success of the uterine evacuation			
Asks how the woman has been feeling since the procedure, including her bleeding pattern and whether pregnancy symptoms have resolved or continued			
Conducts a physical examination <ul style="list-style-type: none"> • Vital signs • Assess uterine size, tone, tenderness • Evaluate for completion of evacuation, infection 			
If there is any doubt, conducts or refers for an ultrasound to look for a gestational sac or an ongoing pregnancy			
Stabilizes, treats or refers for any acute problems and ensures that any earlier complications have been resolved			
Performs vacuum aspiration to complete the process in the case of a continuing pregnancy			
Informs the woman of what to expect following completion or continued treatment			
Reviews any laboratory tests results			
Provides a contraceptive method, if desired and not already provided			
Refers for other medical, gynecologic or counseling services where indicated			

Postabortion Care (PAC) Post-Procedure Care Skills Checklist

Skill	Yes	No	Comments
Monitors the woman's physical status			
Ensures the woman is resting comfortably			
Takes vital signs immediately			
Reviews chart for condition and history			
Monitors physiological status, including vital signs			
Evaluates bleeding and cramping at least twice			
Continues therapy for any existing problems			
Assesses and manages complications			
Manages pain			
Evaluates pain levels			
Administers and monitors desired options for pain relief			
Addresses other physical-health issues			
Addresses other physical-health needs and provides referrals if needed for: anemia, RTIs/HIV, cervical cancer, violence, infertility			
Administers Rh-immunoglobulin, if protocol			
Administers or refers for tetanus vaccine			
Provides emotional monitoring and support			
Responds sensitively to emotions			
Monitors emotional status			
Provides counseling and referrals for emotional-health needs			
Provides contraceptive counseling (if not done before the procedure)			
Determines desire for future pregnancy and reproductive needs			
Provides contraceptive counseling, methods and resupply information			
Makes sure that the woman knows how to use the method of contraception she has chosen and answer any of her questions			
Informs about risks and alternatives to unsafe abortion and legal options			
Arranges for follow-up care as desired or needed			
Schedules follow-up appointment according to her condition and/or request			
Secures her consent before releasing records to other providers			

(continued on page 271)

Postabortion care (PAC) Post –Procedure Care Skills Checklist

Skill (continued)	Yes	No	Comments
Discharges the woman			
Ensures recovery before discharging according to protocols			
Provides instructions on: self-monitoring normal recovery; pain relief/medications; behaviors that increase problems; when and how to seek treatment for complications; follow-up care			

Postabortion Care (PAC) Follow-Up Care Skills Checklist

Reminder: Routine follow-up after an uncomplicated MVA procedure is not necessary. If there are complications, the woman should return to the facility immediately. If the woman desires follow-up care, an optional visit may be scheduled one to two weeks after the postabortion care visit. If the woman returns for follow-up care, the provider should:

Skill	Yes	No	Comments
Confirm the success of the uterine evacuation			
Ask how the woman has been feeling since the procedure, including her bleeding pattern and whether pregnancy symptoms have resolved or continued			
Conduct a physical examination <ul style="list-style-type: none"> • Vital signs • Assess uterine size, tone, tenderness • Evaluate for completion of evacuation, infection 			
If there is any doubt, the provider can conduct or refer for an ultrasound to look for a gestational sac or an ongoing pregnancy			
Stabilize, treat or refer for any acute problems and ensure that any earlier complications have been resolved			
Perform vacuum aspiration to complete the process in the case of a continuing incomplete abortion			
Inform the woman of what to expect following completion or continued treatment			
Review any laboratory tests results			
Provide a contraceptive method, if desired and not already provided			
Refer for other medical, gynecologic or counseling services where indicated			

Uterine Evacuation With Medical Methods



Purpose

This module covers the knowledge, attitudes and skills health-care providers need to provide medical methods for first-trimester uterine evacuation.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered abortion care, which includes postabortion care
- ☐ Describe a woman's rights in an abortion-care setting
- ☐ Demonstrate knowledge of the anatomy and physiology of the female reproductive system
- ☐ Demonstrate good skills in taking a medical history and conducting a physical examination
- ☐ Accurately assess the duration of an early pregnancy
- ☐ Describe warning signs for and diagnose ectopic pregnancy
- ☐ Perform or refer women for vacuum aspiration uterine evacuation services
- ☐ Provide abortion-related and contraceptive counseling



Objectives

By the end of this module, participants should be able to:

1. List the eligibility requirement and contraindications for uterine evacuation with medical methods
2. Describe the essential information to be given to clients having uterine evacuation with medical methods
3. Discuss regimens for uterine evacuation with medical methods using mifepristone plus misoprostol and misoprostol only
4. Explain the expected effects, side effects and potential complications of uterine evacuation with medical methods
5. List effective pain-management approaches and medication regimens for uterine evacuation with medical methods

6. Describe post-procedure care and follow-up visit for uterine evacuation with medical methods



Materials

- ☐ Expected and Side Effects Cards
- ☐ Uterine Evacuation With Medical Methods Role Plays (CAC) handout
- ☐ Uterine Evacuation With Medical Methods Role Plays (PAC) handout
- ☐ Uterine Evacuation With Medical Methods Skills Checklist(s)
- ☐ Various items for mimes (first aid supplies, props, miscellaneous supplies)
- ☐ Chime or timer
- ☐ Knowledge Test and Test Key



Advance preparation

- ☐ Assemble IEC materials such as client brochures for providers to practice using visual aids when counseling women on uterine evacuation with medical methods.
- ☐ Assess what regimens are used and which medications are available locally and focus content of training on those regimens and medications.
- ☐ Procure and prepare items for mime activities.
- ☐ Select the appropriate checklist according to the needs in your setting:
 - Uterine Evacuation With Medical Methods Checklist – Mifepristone and Misoprostol
 - Uterine Evacuation With Medical Methods Checklist – Misoprostol only
 - Misoprostol for Incomplete Abortion Checklist
- ☐ Duplicate Uterine Evacuation With Medical Methods Role Plays, Uterine Evacuation With Medical Methods Skills Checklist(s) and Knowledge Test.
- ☐ Prepare Expected and Side Effects Cards.
- ☐ Review local policies, standards and protocols to guide any module adaptations.
- ☐ If participants' facilities are considering a change in protocol pertaining to location of misoprostol administration (home or clinic), trainers can add the activity (Location of Misoprostol Administration Debate) from the Additional Module Activities file on the CD-ROM.

Time: 6 hours, 30 minutes

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module covers the knowledge, attitudes and skills health-care providers need to provide medical methods for first-trimester uterine evacuation.

Show slide: *Objectives*

1. List the eligibility requirement and contraindications for uterine evacuation with medical methods
2. Describe the essential information to be given to clients having uterine evacuation with medical methods
3. Discuss regimens for uterine evacuation with medical methods using mifepristone plus misoprostol and misoprostol only
4. Explain the expected effects, side effects and potential complications of uterine evacuation with medical methods
5. List effective pain-management approaches and medication regimens for uterine evacuation with medical methods
6. Describe post-procedure care and follow-up visit for uterine evacuation with medical methods

Explain that this module will comprehensively cover the skills needed to provide uterine evacuation with medical methods.

Provide key background information about uterine evacuation with medical methods based on Section 1.0 in the Reference Manual, including:

- The medications used for uterine evacuation with medical methods are mifepristone and misoprostol.
- The World Health Organization's (WHO) recommended regimen is a combination of mifepristone and misoprostol, or misoprostol only if mifepristone is not available.
- Misoprostol can be used for uterine evacuation for women with incomplete or missed abortion.
- This module will focus on two regimens: mifepristone and misoprostol and misoprostol only.
- High-quality services include trained staff, available medications, private spaces in clinic facilities, the ability to manage or refer complications, and contraceptive and counseling services.

P Show and discuss slide: *Mifepristone*

- First developed and approved for clinical use in 1988 in France (RU-486)
- Blocks progesterone activity in the uterus, leading to detachment of the pregnancy
- Causes the cervix to soften and uterus to contract

Show and discuss slide: *Misoprostol*

- Prostaglandin analogue that stimulates uterine contractions
- Inexpensive, stable at room temperature and readily available in many countries
- Easily absorbed through many routes
- Commonly used for treatment of gastric ulcers
- Many obstetrical and gynecologic uses including treatment of incomplete and missed abortion, induction of labor, cervical preparation, and prevention and treatment of postpartum hemorrhage

Show and discuss slide: *Effectiveness*

- P • Combination of two drugs more effective than either used alone.
- P • Combined regimen is more than 95 percent effective in pregnancies \leq 13 weeks since last menstrual period (LMP)
- P • Misoprostol only results in successful abortion in approximately 85 percent of cases
- Misoprostol for incomplete abortion is more than 90 percent effective up to 13 weeks uterine size

Explain that taking misoprostol vaginally, sublingually and buccally has been studied and is recommended over oral administration for medical abortion.

2. Preparation

P Show and discuss slide: *Preparation*

Say: First we will discuss the steps to take prior to providing a uterine evacuation with medical methods. We will brainstorm a list of all the things that should take place before the woman receives the medication.

Write participants' responses on a flipchart. Ensure that the following elements of care are included.

Before administering any medications:

- Provide information and counseling and obtain informed consent
- Perform a clinical assessment, including physical examination
- Provide contraceptive counseling and provide methods, if desired, to meet woman's contraceptive needs

Say: We have already covered these topics in other modules. They are included here as a reminder because they are critical steps in providing uterine evacuation with medical methods.

We will now focus on the essential information that women should have about uterine evacuation with medical methods.

Show and discuss slide: *Essential Information About UE With Medical Methods*

- What she may experience
- What pills to take, when and how to take them
- When to follow up, if at all
- When and where to seek medical help in case of a problem

Show and discuss slide: *Explain the MA Process*

- Bleeding and cramping
- Timing of expulsion
- What she might see
- Disposal

Explain that providers should follow all the basic principles covered in the Informed Consent, Information and Counseling module.

Explain and discuss with participants:

- P • It is very important to take adequate time to solicit and answer each woman's questions and clarify any misunderstandings.

- P *Say: Each woman needs to be informed about the small risk of a failed medical abortion.*

- P Show and discuss slide: *Risk of Continuing Pregnancy*

- Small risk that medical abortion will not work and pregnancy will continue
- Very small risk that misoprostol could cause birth defects if the pregnancy continues
- If medical abortion does not work, women should be willing to undergo vacuum aspiration to complete abortion

Say: The risk of continuing pregnancy is one to three percent for MA with mifepristone and misoprostol, and four to eight percent for MA with misoprostol only.

Describe the key points below:

- Confirm the woman's decision about uterine evacuation with medical methods after she has been fully informed.
- Should the woman decide not to have UE with medical methods, offer

her vacuum aspiration.

Ask participants for questions and comments about the information discussed thus far.

Show and discuss slide: *Diagnose and Date Pregnancy for Eligibility*

- Confirm that the pregnancy is thirteen weeks or less since the LMP.
- In the case of an incomplete or missed abortion, confirm that uterine size is less than 13 weeks; LMP is less important than uterine size in postabortion care.
- Date pregnancy through medical history, pregnancy test (if available) and bimanual exam.
- Using ultrasound to date pregnancy can be helpful but is not required.

Show and discuss slide: *Additional Eligibility for Misoprostol for Incomplete Abortion*

- Open cervical os
- Vaginal bleeding or history of vaginal bleeding during the pregnancy

Say: To provide uterine evacuation with medical methods, you must be able to rule out contraindications and detect the signs and symptoms of ectopic pregnancy.

Show and discuss slide: *Contraindications*

- Ectopic pregnancy (confirmed or suspected)
- Allergy to mifepristone, misoprostol or other prostaglandin
- Chronic adrenal failure (only for mifepristone with misoprostol)
- Inherited porphyria (only for mifepristone with misoprostol)
- For PAC: Signs of pelvic infection and/or sepsis
- For PAC: Hemodynamic instability or shock

Say: Why is ectopic pregnancy such a concern when performing uterine evacuation with medical methods?

Discussion should include the following information:

- Women seeking uterine evacuation with medical methods often come early in pregnancy, when ectopic pregnancy can still be diagnosed and treated.
- Mifepristone and/or misoprostol are not effective in treating ectopic pregnancy.
- Ectopic pregnancy can easily go undetected after a uterine evacuation with medical methods because the products of conception (POC) are usually not inspected by the clinician to confirm complete termination, as they are after a vacuum aspiration procedure.
- If ectopic pregnancy is suspected but unconfirmed:

- Perform vacuum aspiration and examine tissue to confirm termination of intrauterine pregnancy.
- If no aspiration services are available, she should be referred for further evaluation.
- Women with symptoms of a ruptured ectopic pregnancy must be treated or referred immediately as this condition is life-threatening.
- Refer participants to Section 5.0 of Clinical Assessment in the Reference Manual for more information regarding ectopic pregnancy.

Show and discuss slide: *Precautions*

- IUD in place. Evaluate for ectopic pregnancy. If no evidence of ectopic pregnancy, remove the IUD before giving first medication
- Severe/unstable health problems
- Severe uncontrolled asthma or long-term corticosteroid therapy (only for mifepristone with misoprostol)

Make sure to discuss the following points:

- Health problems to consider include but are not limited to hemorrhagic disorders, heart disease and severe anemia. No evidence exists on the use of mifepristone or misoprostol in women with hemorrhagic disorder, heart disease, severe anemia or severe/unstable health problems. Whether to provide uterine evacuation with medical methods to women with these conditions will depend on the available options for safe abortion-related care, referrals, and clinical judgment. If medical methods are given, they should be given under close observation.
- No evidence exists regarding use of mifepristone in steroid-dependent women. Providers must use clinical judgment if no alternatives for safe uterine evacuation exist. Increase steroid dose for three to four days and monitor the woman very closely. Conditions such as poorly-controlled asthma may be worsened.

Say: Before we move to the clinical aspects of providing uterine evacuation with medical methods, what questions do you have?

- Answer questions.

3. Regimens

Say: First we will talk about mifepristone and misoprostol.

Explain that:

- P • Mifepristone used in combination with misoprostol has proven to be most successful for medical abortion.
- This module will focus on regimens that have proven to be most effective by clinical trials and evidence-based practice and are recommended by the World Health Organization.

- Once the woman has been clinically diagnosed as eligible for uterine evacuation with medical methods, received detailed information and given her informed consent, providers can proceed with one of the regimens.
- There is only one recommendation here for mifepristone but there are variations available for misoprostol.

P Show and discuss slide: *Administration of Mifepristone*

- Administer 200mg mifepristone orally.
- Most women will feel no change after taking the pill.
- Some women (8-25 percent) will begin bleeding before taking the next pill (misoprostol).

Do your facilities routinely test for Rh-factor?

- Take a few answers.

P • State that if the facility protocol is to provide Rh-immunoglobulin for Rh-negative women, it should be given at the time of administering mifepristone or prior to taking misoprostol.

Refer participants to the subsection titled Administration of Misoprostol under Section 3.0 of the Reference Manual while discussing the slides below.

P Show and discuss slide: *Administration of Misoprostol for Medical Abortion*

- There is a range of options in route, dosage and timing.
- Buccal, sublingual or vaginal are the recommended routes for first-trimester abortion.
- Under 10 weeks LMP, misoprostol may be taken at home or in a clinic.
- Between 10 and 13 weeks, the woman should return to the facility to take misoprostol and stay there until the abortion is complete.
- Institutional or national policy should be followed.
- Client safety and convenience should be considered.

Say: With the mifepristone and misoprostol regimen before nine weeks gestation, the median time from misoprostol use to expulsion has been found to be three hours for women who used sublingual misoprostol and four hours for women who used vaginal misoprostol. The buccal route shows timing similar to that of the vaginal route.

P Show and discuss slide: *Protocol for Misoprostol Administration for Medical Abortion*

- Up to nine weeks LMP: 24-48 hours after mifepristone, 800mcg buccally, sublingually or vaginally for one dose
- 9-10 weeks LMP: 24-48 hours after mifepristone, 800mcg buccally for one dose

- 10-13 weeks LMP: 36-48 hours after mifepristone, 800mcg vaginally, followed by 400 mcg vaginally or sublingually every three hours for a maximum of five doses of misoprostol

Show and discuss slide: *Instructions for Vaginal Insertion*

- Empty the bladder.
- Wash hands and put on clean gloves.
- Insert misoprostol tablets, one after the other.
- Push tablets far up into the vagina.
- Tablets may not fully dissolve.
- If pills fall out after 30 minutes, they do not need to be reinserted.

Show and discuss slide: *Instructions for Buccal Use*

- Place two pills between each cheek and gums (four total).
- After 30 minutes, swallow any remaining pill fragments.

Show and discuss slide: *Instructions for Sublingual Use*

- Place four pills under the tongue.
- After 30 minutes, swallow any remaining pill fragments.

The woman may insert the pills herself if she chooses.

Show slide: *Provide Instructions for Pills*

Show slide: *Write Out Instructions*

Transition to a discussion about misoprostol only use.

Say: We've discussed the regimens and steps for administering mifepristone used with misoprostol. In some parts of the world, however, mifepristone is not available or is not easy to access.

Briefly discuss the availability of mifepristone in the participants' setting.

- Discuss how, in many settings, women self-medicate with misoprostol and then present to a health facility for treatment of incomplete abortion.
- Discuss whether women self-medicate in the participants' settings.

- P • State that misoprostol is often used alone for medical abortion when there is no access to mifepristone. Misoprostol is widely available worldwide, whereas mifepristone can be costly and inaccessible.
- P • Emphasize that misoprostol only for medical abortion is less effective than the combined regimen; however, it is an important option where mifepristone or other methods are not available.
- State that most of the issues already discussed regarding the combined regimen also apply to the use of misoprostol only.

Show and discuss slide: *Misoprostol Only for Medical Abortion*

- Effectiveness: about 85 percent up to 13 weeks LMP
- Current recommended regimen:

Dose	Route	Timing
Misoprostol 800mcg (four 200mcg pills)	Vaginal	Every three to 12 hours for a maximum of three doses
Misoprostol 800mcg (four 200mcg pills)	Sublingual	Every three hours for a maximum of three doses

Say: Sublingual dosing is as effective as vaginal dosing up to nine weeks but is associated with an increased risk of side effects. There have been relatively few studies that have looked at misoprostol-only abortion between nine and 13 weeks. A follow-up visit is recommended after a misoprostol-only abortion.

Show and discuss slide: *Misoprostol for Incomplete Abortion*

Dose	Route	Timing
Misoprostol 600mcg (three 200mcg pills)	Oral	Single dose
Misoprostol 400mcg (two 200mcg pills)	Sublingual	Single dose

Effectiveness: 91-99 percent up to 13 weeks uterine size

Show and discuss slide: *Administration of Misoprostol for Incomplete Abortion*

- Oral and sublingual are the recommended routes for incomplete abortion.
- Misoprostol for incomplete abortion may be taken at home or in a clinic.
- Institutional or national policy should be followed.
- Client safety and convenience should be considered.

Say: Both routes of misoprostol administration have similar safety and efficacy. Timing of expulsion is related to how far along the incomplete abortion is at time of misoprostol administration.

Show and discuss slide: *Protocol for Misoprostol Administration for Incomplete Abortion*

- Oral use of misoprostol: Swallow three pills (600mcg).
- Sublingual use of misoprostol: Place two pills (400mcg) under the tongue. After 30 minutes, swallow the remaining pill fragments.

Say: A routine follow-up visit after misoprostol for incomplete abortion is usually not necessary.

4. Expected effects, side effects, pain management and complications

Say: We are now going to do an activity called a “mime,” during which you will act something out, but you cannot speak. You might think of how you would communicate with someone if you did not speak the same languages.

Ask for five volunteers to each perform a “mime” about one expected or side effect of uterine evacuation with medical methods. They will then explain that effect in more detail to the larger group.

- Give one Expected and Side Effects Card to each volunteer, along with enough photocopies of that card for each participant. Give the volunteers a few minutes to read through their cards.
- Provide volunteers with various props to use in their mime, such as office equipment or first-aid supplies.
- Have one of the volunteers go first, acting out (miming) the effect. Ask them to use only body language and no sounds.
 - Ask the large group to guess what effect is being acted out.
 - The volunteer should then read aloud the bullets on their Effect Card.
- After the effect has been mimed and explained, ask for questions and have a short discussion before moving on to the next one. Go through all five effects.
- Summarize the activity, including:
 - Uterine evacuation drugs produce a range of effects which are almost always short-term and relatively minor, although they may not seem minor to the woman undergoing the process. Treatment is not usually required.
 - Women must know in advance what effects to expect and be able to distinguish between expected effects and signs of more serious complications.

Show and discuss slide: *Expected Effects*

- Bleeding
- Cramping

Show and discuss slide: *Bleeding*

- Usually heavier than a menstrual period and accompanied by passage of clots
- Usually starts within three hours after taking misoprostol
- Usually decreases after the pregnancy has been expelled
- Can continue for several weeks

Say: The number of days of bleeding and spotting is greater with MA compared to MVA, but the amount of blood loss is not clinically different.

Women who express discomfort with heavy bleeding may prefer vacuum aspiration.

Show slide: *Cramping (graphic)*

Show and discuss slide: *Cramping*

- Can begin 30 minutes after taking misoprostol
- Pain levels vary greatly among women and may be higher for young women
- Occurs during uterine contractions and when the pregnancy is expelled
- Diminishes after the pregnancy has expelled

Say: Now we are going to talk about pain management in uterine evacuation with medical methods.

Show and discuss slide: *Pain During UE With Medical Methods*

- It is important to address pain before it gets severe.
- Pain usually begins within a few hours after taking the misoprostol.
- Cramping occurs during uterine contractions and POC expulsion.
- Pain levels vary greatly among women.
- Pain diminishes after uterine evacuation is complete.
- Young women and women who have never been pregnant often report higher levels of pain than older women.

Show and discuss slide: *Pain Medications*

- Should be taken before cramping begins
- Non-narcotic and narcotic analgesics can be used :
 - NSAIDs such as ibuprofen are recommended
 - Narcotics such as codeine may be used as well
 - NSAIDs are more effective than acetaminophen
- NSAIDs do not interfere with misoprostol

Say: The best regimen for pain control for uterine evacuation with medical methods has not been established. In medical abortion-related research, NSAIDs have been found to be more effective than acetaminophen.

Show and discuss slide: *Complementary Pain Management Methods*

- Verbal support
 - Information about what to expect
 - Reassurance during counseling and the process
- Low heat to the abdomen or lower back
 - Hot-water bottle

— Warm cloths

- Music may be helpful

What are locally available medications you might use for pain relief during uterine evacuation?

- Take a few answers.

Note that NSAIDs such as ibuprofen are more effective than acetaminophen. However, acetaminophen may reduce the dose of narcotics that a woman uses during MA. Refer participants to Appendix A: Pharmacologic Approaches to Pain Management During MVA in the Uterine Evacuation Procedure with Ipas MVA Plus module of the Reference Manual for pain medication dosage details.

Say: What questions do you have regarding expected effects and pain management during uterine evacuation with medical methods?

- Answer any questions.

Say: Now we're going to look at the possible side effects of uterine evacuation with medical methods.

Show and discuss slide: *Possible Side Effects*

- Nausea
- Vomiting
- Diarrhea
- Fever, warmth or chills
- Headache
- Weakness
- Dizziness

Say: Many of these may be caused by the pregnancy itself rather than the medications. Most side effects are temporary and do not need treatment. With adequate information in advance, most women are able to manage their side effects without major difficulties.

Show and discuss slide: *Fever Side Effect*

Say: Fever is a common side effect of misoprostol. It is usually mild, self-limited and can be treated with acetaminophen. Fever that occurs the day after using misoprostol may be the sign of an infection. Any woman with a fever the day after using misoprostol should be seen in the health facility.

What questions do you have regarding expected effects and pain management during uterine evacuation with medical methods?

- Answer any questions.

Say: Explain that uterine evacuation with medical methods, like vacuum aspiration, very rarely has complications. However, complications can occur.

What do women need to know regarding the potential complications of uterine evacuation with medical methods?

- Take a few answers. Answers should include:
 - Women need to know when and where to call for help.
 - Women who experience complications need clear, honest information about their situation and should be involved in decisionmaking about their treatment.

Show and discuss slide: *Complications of UE with Medical Methods*

- Uterine evacuation with medical methods is associated with few serious complications.
- Rare complications include:
 - Incomplete abortion
 - Hemorrhage
 - Infection

Say: We will discuss the management of these complications during the module on Complications because they are handled the same way whether they arise with medical methods or vacuum aspiration.

What questions do you have about the complications related to uterine evacuation with medical methods?

- Answer any questions.

5. Instructions and care before and after leaving the facility

Say: Before leaving the facility, the woman should receive instructions about the usual experience of uterine evacuation with medical methods, what pills to take, when and how to take them, when to follow up, and when and where to seek medical help in case of a problem.

Explain the following:

- Most women who have been well-informed about the process will have a successful, problem-free uterine evacuation.
- Providers should use simple language and, if possible, drawings to visually aid her in understanding how medications should be taken.
- Ask for suggestions about what important information women should know before leaving the health-care facility.
 - Write answers on a flipchart.

Show and discuss slide: *What Women Need to Know Before Leaving the Facility*

- Regimen and effectiveness
- What she will experience

- How long the process typically takes
- The signs of a successful uterine evacuation
- Expected effects, potential side effects and complications
- Warning signs to seek help
- Ensuring access to emergency care
- Contraceptive needs
- When and where to obtain follow-up care if necessary

Say: A follow-up visit is recommended after a misoprostol-only medical abortion.

Thorough information on what the woman might expect helps her to be prepared. Reassurance and support during the counseling and uterine evacuation process, either by clinic staff or a person at home, can also be helpful.

Show slide: *Supply Contraception*

Show and discuss slide: *Warning Signs During or After Uterine Evacuation*

- Excessive bleeding (soaking more than two or three thick pads per hour for two consecutive hours)
- Persistent fever: 38°C/100.4°F or higher any day after the day misoprostol is taken
- Unusual or bad-smelling vaginal discharge
- Severe abdominal pain any day after the day misoprostol is taken
- Feeling very sick, with or without fever, and persistent severe nausea or vomiting any day after the day misoprostol is taken
- No bleeding within one to two days of taking misoprostol

Explain the following:

- Women with these warning signs should call or visit the facility.
- Routine antibiotics are not necessary for women who have had a uterine evacuation with medical methods because no instruments have been inserted into the uterus. Antibiotics should be reserved for women who exhibit signs and symptoms of potential infection.

Say: What questions do you have thus far about what we've discussed?

- Answer any questions.

Say: Providers should encourage women to contact the clinic where they received the mifepristone and/or misoprostol, rather than going elsewhere, if they have concerns or problems. Staff there will be familiar with uterine evacuation protocols and side effects generally and her situation specifically.

Point out that women may be reluctant to return to the same place they

received care if they experience problems.

Say: How can we as providers help women return to the original facility if they experience problems?

- Take a few answers.
- Discuss this issue with participants. Emphasize that it is important to:
 - Provide good counseling prior to and during the uterine evacuation process in order to help women feel more comfortable with and confident in the health-care staff.
 - Make sure women clearly understand the warning signs and specifically how to contact someone for help.
 - Make sure that all staff are familiar enough with the uterine evacuation process, expected effects, side effects and complications to either respond directly or to refer women to the appropriate provider onsite.
 - Reassure women that the staff want to do all they can to help them through this process. Stress that they should return if there are problems, because other facilities may be unfamiliar with uterine evacuation with medical methods and unsure of how to handle effects and symptoms.
 - Address women supportively and empathetically, following all the rules of good communication and counseling.

Spend extra time with young women, if needed, to explain the procedure and reassure them about the safety and effectiveness of uterine evacuation with medical methods.

Say: Next we will discuss care for women after they have left the facility.

Ask the participants whether telephone systems are in place in their settings.

- Point out that many concerns and potential problems can be managed over the telephone.
- Optimally, a 24-hour telephone contact should be available for women to call if they have any problems or concerns. Ask participants whether 24-hour phone coverage is feasible in their setting.
 - Discuss the realities of implementing such a system in participants' contexts.
- If telephone access is not available, discuss what other options for seeking help may be available. Ideas may include:
 - Linking with community health workers, women's groups and/or other community leaders to set up a community response system.
 - Providing women with written information on uterine evacuation with medical methods to which they can easily refer.
 - Providing pictorial information for low-literate women.

- Including a partner or friend in the information session, at the woman's consent, so that they are able to provide assistance if needed during the uterine evacuation process.

Say: It is important to be prepared to treat or refer women in the event that they face problems and need assistance.

Explain that:

- Although persistent side effects or serious complications are rare, facility staff need to be able to provide timely treatment and/or referrals.
- If ultrasound is not available onsite, a referral system for ultrasound services should be set up.
- Vacuum aspiration should be available onsite or through referral as a back-up for failed uterine evacuation with medical methods.
- Answer any questions.

Say: What questions do you have about instructions for women prior to leaving or after leaving the facility?

Now we're going to practice providing uterine evacuation with medical methods.

- P • Distribute the Uterine Evacuation With Medical Methods Skills Checklist and any IEC materials that participants will be using. Note to trainers: Use the checklist that corresponds to the regimen that these participants will be using, either mifepristone and misoprostol or misoprostol-only. If training only on postabortion care, distribute the Misoprostol for Treatment of Incomplete Abortion Skills Checklist.
- Explain that this can be used as a guide while learning the steps of talking to women about uterine evacuation with medical methods. It is also a way to monitor and provide facilitative supervision to providers in their provision of care.
- P • Explain that the next activity demonstrates information sharing about uterine evacuation with medical methods.
- Ask for a volunteer to come to the front of the room to act as a woman who has requested a medical abortion while you act as the health-care provider, demonstrating good information giving and counseling skills.
- Tell the volunteer that you have already confirmed she is clinically eligible for a medical abortion using mifepristone and misoprostol since she is eight weeks pregnant and has no contraindications. Note: Misoprostol only or misoprostol for incomplete abortion can be substituted for the role play if those are more likely to be the methods these participants will be providing.
- Ask other participants to observe the demonstration, following along on the checklist to confirm that all the steps have been covered.
- Conduct the demonstration for about 10 minutes, following all the

steps on the checklist.

- Ask for questions about the demonstration and about providing information on uterine evacuation with medical methods in general.
 - Answer questions and lead a discussion on the issues raised.

Say: Now we will all have a chance to practice.

Divide the participants into groups of three.

- One person will play the provider, one the woman and the other the observer.
 - Each participant will get the chance to play each role during the exercise.

Hand out a different role play to each group. *Note to trainers:* If training on postabortion care only, use Uterine Evacuation With Medical Methods Role Plays (PAC).

- Allow participants a few minutes to read through their role play and assign roles.
- Tell participants they have 15 minutes to conduct the role play.
- The observer is to use the checklist to note observations and then provide feedback when the group discusses the role play.
 - Tell the groups that they have five minutes for discussion.
 - Consider reminding them of the rules of giving and receiving feedback described in Effective Training in Reproductive Health: Course Design and Delivery in the Reference Manual.
- Ask participants to switch roles so that a different person plays the woman, the provider and the observer.
- Continue per the instructions above until the three small-group members have each played the provider, the woman and the observer once.
- Bring the large group back together for a summary of the exercise.

Say: What did you feel you did especially well while playing the provider?

- Take a few answers and lead a discussion.

What did you find most challenging about playing the provider?

- Take a few answers and lead a discussion. Additional questions can include: What was the most difficult to explain? What questions did the woman ask that were most difficult to answer?

Ask everyone to write in their notebooks, as a personal reminder, what they want to work on to improve their counseling skills for uterine evacuation with medical methods during this training course and/or afterward.

6. Follow-up care

P *Say: A routine follow-up visit after medical abortion with mifepristone*

followed by misoprostol is not necessary. However, if a woman desires reassurance after the abortion, she may return in approximately two weeks to confirm that she has had a successful abortion or to receive additional desired services. After a misoprostol-only MA, the woman should return for a follow-up visit within two weeks of taking the medical abortion pills.

A routine follow-up visit after misoprostol for incomplete abortion is usually not necessary.

If a woman is concerned about ongoing bleeding or other problems, she may return at any time.

Show and discuss slide: *Follow-Up Care*

- Inquire about the woman's experience with the uterine evacuation.
- Assess whether the process is complete.
- Perform VA to complete the process in the case of a continuing pregnancy.
- Inform the woman of what to expect following completion or continued treatment.
- Review any laboratory tests results.
- Provide a contraceptive method, if desired and not already provided.

Show and discuss slide: *Assess Completeness of Uterine Evacuation*

- Ask the woman if she thinks the process was complete.
- Take a history: Amount and duration of bleeding, cramping, passage of clots.
- Conduct a physical examination.
- If it is unclear whether the uterine evacuation is complete, perform ultrasound or offer vacuum aspiration

Show and discuss slide: *Failed Uterine Evacuation*

- If the uterine evacuation is not complete, treatment options include:
 - Expectant management, giving more time for expulsion of the POC
 - A repeat dose of vaginal misoprostol
 - Vacuum aspiration
- P • Emphasize the importance of discussing treatment options with the woman if she has a continuing pregnancy, failed abortion or ongoing incomplete abortion.

Now let's look at some scenarios of follow-up care.

- P *Note to trainers:* If training on postabortion care only, the slides will be Scenario 1, 2 & 3 (PAC). See PAC Follow-up Care Scenario at end of this module for scenarios and points to discuss.

Show and discuss slide: *Scenario 1 (CAC)*

A 35-year-old woman with two children presents at the facility with eight weeks of amenorrhea and some vaginal spotting. She has a positive pregnancy test. Her uterus is smaller than expected. She chooses a medical abortion and is given 200mg of mifepristone orally and 800mcg of misoprostol to take at home vaginally on day three. She returns four days later and says that she didn't have much bleeding and is having some abdominal pain.

Ask trainees: *What if any additional care does she need?*

- Make sure the following points are covered:
 - A positive pregnancy test and a non-enlarged uterus may make you question whether she has an ectopic pregnancy. Further investigation with ultrasound might be warranted.
 - Vacuum aspiration with visual inspection of the POCs would confirm the diagnosis of ectopic pregnancy or terminate an intrauterine pregnancy.
 - Medical abortion does not treat ectopic pregnancy.
 - If a woman has a confirmed or suspected ectopic pregnancy she should be treated or referred immediately for this life-threatening condition.

Say: Some women will have medical abortion even with an ectopic pregnancy in place because ectopic pregnancy is often difficult to diagnose.

Give additional information: There is a questionable right adnexal mass.

Say: What do you think is going on and what would you do next?

- Refer her for ultrasound to see if she has an ectopic pregnancy.

Say: The ultrasound reveals a right ectopic pregnancy. How would you manage the ectopic pregnancy?

- She should have immediate treatment or referral for this life threatening condition.

Say: The lack of bleeding after the abortion medications is typical when ectopic pregnancy is present. Ectopic pregnancy is an uncommon yet very serious condition. Although some women have risk factors for ectopic pregnancy, most women with an ectopic pregnancy do not. Ectopic pregnancy commonly has vaginal spotting and one-sided abdominal pain once the ectopic pregnancy becomes large enough (commonly about eight weeks LMP). Because there was a discrepancy between the LMP and the size of the uterus, an ultrasound examination would have been helpful at the initial clinical assessment.

Show and discuss slide: *Scenario 2 (CAC)*

A 19-year-old nulliparous woman presents at the facility. She has been bleeding heavily for two days and has an LMP of 10 weeks but a uterine size consistent with a seven-week pregnancy. She chooses to take misoprostol for incomplete abortion and swallows 600mcg of misoprostol. Four hours later she calls with excruciating pains. She has no prescription pain medications at home.

Say: What would you tell her to do?

- Make sure the following points are covered:
 - Instruct her to take 600 to 800mg of ibuprofen orally and try using a hot water bottle or hot cloths on her abdomen.
 - Explain that most likely she is in the process of passing large pieces of tissue (some women find their cramping peaks as this tissue passes through the cervix).
 - Reassure her that as soon as it passes, she will feel much better; generally this process occurs within four to six hours of taking misoprostol. It can be very helpful for women to have a better understanding of what is causing their discomfort and to know that the pain peaking most likely means that the uterine evacuation is successful.
 - Ask her to call her back in 30 to 60 minutes, if possible, so that you can make sure she is feeling better.

Say: Two hours later, she has not yet called back. What would you do next?

- Contact her by phone to inquire about her status.

Say: You reach her on the phone and she reports feeling much better after having passed several large clots. Her bleeding has decreased to light spotting and her cramping is minimal. She says that she would like to return for a follow-up appointment.

Say: When counseling women about what to expect during uterine evacuation with medical methods, pain-management options should be discussed. Ibuprofen may be taken at the time of misoprostol or when cramping begins to manage pain. In addition, a narcotic such as codeine can be used to relieve the discomfort that commonly occurs within a few hours of taking misoprostol. Other pain-relieving techniques some women find useful include heating pads and massages.

Show and discuss slide: *Scenario 3 (CAC)*

A 24-year-old woman with two children has had one previous abortion. She comes to the facility with nine weeks of amenorrhea. She has a positive pregnancy test. On exam, her uterus is consistent with nine weeks of pregnancy. She chooses a medical abortion and receives 200mg of mifepristone orally and then inserts 800mcg of misoprostol vaginally on day three. She returns six days later. She reports passing clots and having a lot of cramping shortly after the misoprostol, but over the past few days she has just had minimal spotting. On exam, her uterus seems smaller than when she first presented. You tell her she is done and she goes home. Two weeks later, however, she calls and complains of feeling weak and tired. On further questioning, she reports having continued irregular bleeding, with occasional spotting but a lot of intermittent heavy bleeding “like a heavy period.” You have her come into the clinic; she is pale and feels dizzy when she stands up. On conducting a pelvic exam, you find that she has bleeding consistent with a normal menses; her uterus is not tender or enlarged.

Say: What would you do?

- Ask for details about her history, including how she is feeling, her blood loss, her level of activity, other medications and any other concurrent illnesses. Conduct a physical examination.

Say: On examination, she is orthostatic as her pulse increases significantly when she stands. On conducting a pelvic exam, you find that she has bleeding consistent with a normal menses; her uterus is not tender or enlarged. Her hemoglobin is found to be 7.1. How would you manage her situation?

- Possible answers include:
 - Treatment options include fluid replacement with IV fluids, blood and/or iron supplementation.
 - Strong consideration should be given to performing a vacuum aspiration to remove any remaining pregnancy tissue.
 - An ultrasound is rarely helpful in this case.

Say: Approximately two to four percent of women will require vacuum aspiration for persistent or heavy bleeding up to four weeks after medical abortion. A history of persistent bleeding that is greater than the woman's normal menses or acute heavy bleeding that soaks more than one to two pads per hour over several hours requires further evaluation. The woman's symptoms combined with a low hemoglobin, as in this case, are cause for concern. Be aware that a drop in hemoglobin may take some time to equilibrate and therefore a normal value can be falsely reassuring. Debris and a widened endometrial stripe following a medical abortion are normal on ultrasound. A woman's symptoms should be treated over the ultrasound findings.

What questions do you have about follow-up care?

- Answer any questions.

7. Summary and test

Ask participants to name key points from this module. Use the objectives as a reference.

What questions do you have about anything discussed during this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect the tests.
- Review correct answers from the test key.

Thank participants for their participation.

References

- Abuabara, K., Blum, J. (eds. 1st edition), & Bracken, H. (ed. 2nd edition). (2009). *Providing medical abortion in low-resource settings: An introductory guidebook* (2nd ed.). New York: Gynuity Health Projects.
- Achilles, S. L., & Reeves, M. F. (2011). Prevention of infection after induced abortion. *Contraception*, 83(4), 295-309. doi: 10.1016/j.contraception.2010.11.006
- Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science*, 248(4951), 41-44.
- American Psychological Association, Task Force on Mental Health and Abortion. (2008). *Report of the APA task force on mental health and abortion*. Washington DC: Author.
- Ashok, P. W., G. C. Penney, G. M. Flett, & A. Templeton. (1998). An effective regimen for early medical abortion: A report of 2000 consecutive cases. *Human Reproduction*, 13(10): 2962–5.
- Atrash, H. K., Cheek, T. G., & Hogue, C. J. (1988). Legal abortion mortality and general anesthesia. *American Journal of Obstetrics and Gynecology*, 158(2), 420-424.
- Chen, B. A., & Creinin, M. D. (2007). Contemporary management of early pregnancy failure. *Clinical Obstetrics and Gynecology*, 50(1), 67-88. doi: 10.1097/GRF.0b013e31802f1233
- Cleland, K., Creinin, M. D., Nucatola, D., Nshom, M., & Trussell, J. (2013). Significant adverse events and outcomes after medical abortion. *Obstetrics and Gynecology*, 121(1), 166-171. doi: <http://10.1097/AOG.0b013e3182755763>
- Committee on Gynecologic Practice. (2009). ACOG Committee Opinion No. 434: Induced abortion and breast cancer risk. *Obstetrics and Gynecology*, 113(6), 1417-1418.
- Copeland, L. J., Jarrell, J. F., & Dodson, R. (2000). *Textbook of gynecology* (2nd ed.). Philadelphia: W. B. Saunders.
- Creinin, M.D., Fox, M.C., Teal, S., Chen, A., Schaff, E.A., & Meyn, L.E. (2004). A randomized comparison of misoprostol 6 to 8 hours versus 24 hours after mifepristone for abortion. *Obstetrics and Gynecology*, 103, 851-9.
- Creinin, M.D. & Gemzell-Danielsson, K. (2009). Medical abortion in early pregnancy. In: Paul M, Lichtenberg E.S, Borgatta L., Grimes D.A., Stubblefield P.G., Creinin M.D., (Eds.). *Management of unintended pregnancy and abnormal pregnancy: Comprehensive abortion care* (111–34). West Sussex, UK: Wiley-Blackwell.
- Creinin, M. D., Schwartz, J. L., Guido, R. S., & Pymar, H. C. (2001). Early pregnancy failure: Current management concepts. *Obstetrical and Gynecological Survey*, 56(2), 105-113
- Davey, A. (2006). Mifepristone and prostaglandin for termination of pregnancy: Contraindications for use, reasons and rationale. *Contraception*, 74(1), 16-20.
- Goldstone, P., Michelson, J., & Williamson, E. (2012). Early medical abortion using low-dose mifepristone followed by buccal misoprostol: A large Australian observational study. *Medical Journal Australia*, 197(5), 282-286.
- Gynuity Health Projects and Reproductive Health Technologies Project. (2003). *Consensus statement: Instructions for use—Abortion induction with misoprostol in pregnancies up to 9 weeks LMP*. Expert Meeting on Misoprostol sponsored by Reproductive Health Technologies Project and Gynuity Health Projects. Washington DC: Gynuity.
- Gynuity Health Projects & Ipas. (2012). *Misoprostol for treatment of incomplete abortion: Training guide*. New York, NY and Chapel Hill, NC: Gynuity Health Projects and Ipas.

- Hakim-Elahi, E., Tovell, H. M., & Burnhill, M. S. (1990). Complications of first-trimester abortion: a report of 170,000 cases. *Obstetrics and Gynecology*, 76(1), 129-135.
- Ipas. (2009). *Uterine evacuation with manual vacuum aspiration (MVA): A training manual for conducting short courses*. Chapel Hill, NC: Ipas.
- Ipas. (2013). *Medical abortion study guide* (second ed.). K. L. Turner (Ed.). Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual* (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered, comprehensive abortion care: Trainer's manual* (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Jackson E. & Kapp N. (2011). Pain control in first-trimester and second-trimester medical termination of pregnancy: A systematic review. *Contraception*, 83(2), 116-126.
- Kaunitz, A. M., Rovira, E. Z., Grimes, D. A., & Schulz, K. F. (1985). Abortions that fail. *Obstetrics and Gynecology*, 66(4), 533-537.
- Lichtenberg, E. S., & Grimes, D. A. (2009). Surgical complications: Prevention and management. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield & M. D. Creinin (Eds.), *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* (pp. 224-251). West Sussex, UK: Wiley-Blackwell.
- Livshits, A., Machtinger, R., David, L.B., Spira, M., Moshe-Zahav, A., & Seidman, D.S. (2009). Ibuprofen and paracetamol for pain relief during medical abortion: A double-blind randomized controlled study. *Fertility and Sterility*, 91(5), 1877-80.
- March, C. M. (2011). Asherman's syndrome. *Seminars in Reproductive Medicine*, 29(2), 83-94. doi: 10.1055/s-0031-1272470
- National Cancer Institute. (2010). *Summary report: Early reproductive events and breast cancer workshop* (2nd ed.). National Cancer Institute
- Policar, M. S., Pollack, A. E., Nicholas, C., & Dudley, S. (1999). *Principles of abortion care: A curriculum for physician assistants and advanced practice nurses*. Washington, DC: National Abortion Federation.
- Royal College of Obstetrics and Gynecology. (2011). *The care of women requesting induced abortion: Evidence-based guideline no. 7*. London: RCOG Press.
- Schaff, E.A., Fielding, S.L., Westhoff, C., Ellertson, C., Eisinger, S.H., Stadalius, L.S., & Fuller, L. (2000). Vaginal misoprostol administered 1, 2, or 3 days after mifepristone for early medical abortion: A randomized trial. *Journal of the American Medical Association*, 284(15): 1,948-53.
- Schaff, E.A., Stadalius, L.S., Eisinger, S.H. & Franks, P. (1997). Vaginal misoprostol administered at home after mifepristone (RU-486) for abortion. *Journal of Family Practice*, 44, 353-60.

- Solter, C., Miller, S., & Gutierrez, M. (2000). Module 11: Manual Vacuum Aspiration (MVA) For Treatment of Incomplete Abortion. *Comprehensive Reproductive Health and Family Planning Curriculum*. Watertown, MA: Pathfinder International.
- Stewart, F. H., Wells, E. S., Flinn, S. K., & Weitz, T. A. (2001). *Early Medical Abortion: Issues for Practice*. San Francisco, California: UCSF Center for Reproductive Health Research & Policy.
- Thonneau, P., Fougereyrollas, B., Ducot, B., Boubilley, D., Dif, J., Lalande, M., & Soulat, C. (1998). Complications of abortion performed under local anesthesia. *European Journal Obstetrics Gynecology Reproductive Biology*, 81(1), 59-63.
- Von Hertzen, H., Honaken, H., Piaggio, G., Bartfai, G., Erdenetungalag, R., Gemzell-Danielsson, K., ... & Wu, S.C. (2003). WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. *British Journal of Obstetrics and Gynecology*, 110(9): 808–18.
- World Health Organization. (1994). *Clinical management of abortion complications: A practical guide*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (1995). *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2007). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors* (2nd ed.). Geneva, Switzerland: World Health Organization.
- World Health Organization. (2009). *World Health Organization's guidelines for the management of postpartum hemorrhage and retained placenta*. Geneva, Switzerland: World Health Organization.
- World Health Organization. (2011). *IMAI district clinician manual: Hospital care for adolescents and adults: guidelines for the management of common illnesses with limited resources* (Vol. 1). Geneva, Switzerland: World Health Organization.
- World Health Organization. (2012a). *Safe abortion: Technical and policy guidance for health systems*, (Second ed.). Geneva, Switzerland: World Health Organization.
- World Health Organization. (2012b). *World Health Organization's recommendations for the prevention and treatment of postpartum hemorrhage*. Geneva, Switzerland: World Health Organization.

Knowledge Test Key

1. True
2. True
3. False
4. True
5. True
6. False
7. True
8. False
9. c
10. b
11. d

Uterine Evacuation With Medical Methods Knowledge Test

Circle True or False.

1. True or False Mifepristone used together with misoprostol is more effective than misoprostol only for medical abortion.
2. True or False Oral misoprostol is a recommended route for treatment of incomplete abortion.
3. True or False Narcotics cannot be used to treat pain in women undergoing uterine evacuation with medical methods.
4. True or False Complications from uterine evacuation with medical methods are rare.
5. True or False Uterine evacuation is recommended in the case of continuing pregnancy, as there is a slight risk of birth defects after misoprostol.
6. True or False Women must remain in the facility to have a safe uterine evacuation with medical methods.
7. True or False Heavy bleeding is normal in the process of uterine evacuation with medical methods.
8. True or False Uterine evacuation with medical methods is less effective in young women than older women.

Circle the correct response.

9. All of the following information should be covered with a woman prior to a uterine evacuation with medical methods except:
 - a. The importance of completing the evacuation process once it has begun
 - b. Basic information about uterine evacuation with medical methods
 - c. The necessity of obtaining spousal consent
 - d. Expected effects, side effects and complications
10. Which of the following is not a potential side effect of uterine evacuation with medical methods?
 - a. Diarrhea
 - b. Tingly sensation
 - c. Vomiting
 - d. Fever and/or chills

11. All of the following should be provided to every woman before she leaves the facility except:

- a. Warning signs for complications and when and where to receive medical help
- b. The information that she can become pregnant again almost immediately
- c. A contraceptive method of her choice, if desired

☐ d. A scheduled routine follow-up visit after an abortion with mifepristone and misoprostol

Expected and Side Effects Cards

Vaginal bleeding

- Usually begins within three hours after taking misoprostol but can begin after taking mifepristone.
- Usually greater than a heavy menstrual period; heaviest during the passage of fetal tissue.
- Often accompanied by the passage of blood clots.
- Bleeding and spotting tends to last longer than with a vacuum aspiration.
- Bleeding can last an average of 14 days.
- Some women can bleed even longer than this.
- Excessive bleeding is uncommon and is most successfully treated with vacuum aspiration.
- Blood transfusion is very rarely needed.
- Providers should have clearly defined protocols to evaluate and treat abnormal bleeding.
 - Saturating less than two thick sanitary pads per hour after taking misoprostol, with a decreasing flow over time, is normal. Saturating more than two to three pads per hour for two consecutive hours should alert the provider to monitor the woman's progress closely.
- Severe hemorrhage and prolonged heavy bleeding require immediate attention.

Cramping

- Most women will have cramping.
- The degree of pain depends on individual and cultural factors.
- It is helpful to inform women during counseling about what to expect and how to manage cramping.
- Providers should give women pain medications prior to the uterine evacuation procedure.
- Clinical judgment must be used to distinguish “expected pain” from pain signifying potential pathology.
- Pain that is persistent should be evaluated.
- Pain in combination with other symptoms of potential ectopic pregnancy should be evaluated.
- Women should be advised to contact the clinic if pain associated with bleeding is accompanied by persistent fever.

Gastrointestinal side effects

- Over half of women experience gastrointestinal side effects (nausea, vomiting and diarrhea) following use of misoprostol.
- Usually these side effects are mild and limited in duration.
- It is unclear whether antiemetic and antidiarrheal medications are helpful, but they may be prescribed if needed.

Fever, warmth and chills

- Short-lived fever, warmth, chills or shivering can accompany uterine evacuation with medical methods. These side effects are common with misoprostol.
- Treatment is not required, but women should be aware beforehand that they may experience these side effects. If desired, fever can be treated with antipyretics.
- Although postabortion infection rarely accompanies uterine evacuation with medical methods, a persistent fever occurring the day after misoprostol is taken could indicate an infection and should be evaluated.

Headache or dizziness

- Headache or dizziness are common side effects of uterine evacuation with medical methods.
- Headache is treatable with analgesics.
- Mild dizziness of short duration is managed by hydration, rest and avoiding rapid changes in position.
- Women experiencing dizziness in combination with heavy bleeding should be promptly evaluated for excessive blood loss.

P Uterine Evacuation With Medical Methods Role Plays (CAC)

Client 1: A 20-year-old university student has been dating a classmate for many months. She started having sex with him recently. They were using condoms and one broke. She was worried that she might be pregnant and so came to the facility for a pregnancy test, which was positive. She wants to have an abortion because she wants to continue her studies and does not think that the man she is dating will prove to be a long-term partner. She lives in the university's student housing where she shares a bathroom with her roommate. Her roommate has been very understanding. The roommate came with the student to the facility and is waiting in the courtyard.

Client 2: A 30-year-old married woman has discovered that her period is three weeks late. She has two children under the age of six and cannot manage having another child right now. However, she and her husband belong to a religion that prohibits abortion, and she is afraid of her husband or other family members finding out about the abortion. She is determined to have an abortion and then to start using a contraceptive method that her husband won't detect, because she worries that he would disapprove of her using contraception.

Client 3: A 33-year-old woman desperately wanted to be pregnant and was very excited when she missed her period two weeks ago. However, when she went to her doctor for a pregnancy test, she also had an HIV test and learned that she is HIV-positive. She is concerned about whether being pregnant and carrying a child will adversely affect her health; however, she is devastated to think about not having the baby she wanted so much. She has not informed her husband that she is living with HIV. She is not sure about his HIV status.

Client 4: A woman came to the facility because she heard that you now provide medical-abortion services. She had a traumatic, unsafe abortion procedure 10 years ago when the law was more restrictive and she was unable to access safe, induced abortion care. She vowed that she would never repeat that terrible experience. Her last period was about eight weeks ago, and she is worried that it might be too late for her to have an abortion using pills. She is afraid of medical procedures but wants to terminate this pregnancy because she does not want to be a parent.

Client 5: A 25-year-old woman lives with her boyfriend. She is pregnant and is less than eight weeks LMP. She fought with her boyfriend because she wanted to terminate the accidental pregnancy. He beat her during the argument, causing her to begin bleeding vaginally quite heavily. She has come to the clinic for treatment and does not want providers to try to stabilize the pregnancy if that is even possible. Her boyfriend followed her to the clinic and wants to talk to her and the provider too. The young woman is afraid of him.

Client 6: A 35-year-old married woman with three children took a home pregnancy test, which was positive. She wants to have an abortion. Her husband does not know about the pregnancy. She thinks he would not approve of abortion, but she has never discussed it with him. She has childcare responsibilities as well as household chores and farming duties. Her husband is sporadically employed. She feels tired and depressed about this pregnancy.

Uterine Evacuation With Medical Methods Role Plays (PAC)

Client 1: A 35-year-old woman with an unwanted pregnancy believes products were expelled from her vagina a few days ago, but she wants to be sure. Her cervix is quite dilated, and she has been bleeding lightly but slightly increasingly for the last four days. She had cramping as well for the last four days, also increasing in severity. A friend of hers had given her some medication to help end the pregnancy, possibly misoprostol, which she took this morning. She is very scared and anxious, especially about her husband coming to the facility.

Client 2: A 13-year-old comes to the facility with an unwanted pregnancy. She has been bleeding lightly, with moderate cramping for about one day. She went to the traditional village midwife's house a day ago, where the midwife helped her attempt to terminate the pregnancy using a surgical instrument. When examined, there is no pus or other sign of infection. She is scared about what is wrong, as is her boyfriend, who is at the facility. Her support system, which includes her family and boyfriend, is very good. Her cervix is slightly dilated.

Client 3: A 25-year-old woman lives with her boyfriend. She is pregnant and is less than eight weeks LMP. She fought with her boyfriend over the accidental pregnancy, and he beat her during the argument, causing her to begin bleeding vaginally quite heavily. She has come to the clinic for treatment, and does not want providers to try to stabilize the pregnancy if that is even possible. Her boyfriend followed her to the clinic and wants to talk to her and the provider too. The young woman is afraid of him.

Client 4: A 24-year-old woman is at the facility with symptoms of a miscarriage. She is very apprehensive about anyone examining her vagina and says she is fearful of medical procedures. She does not remember the date of her LMP.

Uterine Evacuation With Medical Methods Skills Checklist – Mifepristone and Misoprostol

Instructions: Check whether the skill was performed well (Yes/No) and add comments.

First Clinic Visit	Yes	No	Comments
Ensures privacy during the visit			
Greets woman in a friendly, respectful manner			
Uses age-appropriate, non-clinical language			
Provides basic information about conception, pregnancy and options, if needed			
Confirms with her that she wants to terminate her pregnancy and her decision is voluntary			
Explores what kind of support she has for her decision			
Asks if she came with someone and if she would like that person to join her in the information and counseling session			
Determines whether someone can be with her during the MA process			
Explains what to expect during the clinic visit			
Asks about medical conditions and allergies to any medicines			
Asks about her general health and reproductive health history			
Determines medical eligibility for MA			
If routine in local protocols, determines Rh status and gives Rh-immunoglobulin to Rh-negative women (if available and feasible)			
If routine in local protocols, performs pre-MA hemoglobin or hematocrit if indicated and equipment available <i>(Note: This may be part of local protocols but may not be feasible or routine in many settings)</i>			
Confirms gestational age through clinical assessment			
Explains which abortion methods are available, including characteristics, effectiveness and the timing/visits required			
Explores views on MA vs. MVA and what method is best for her			
If she chooses MA, provides more information on it in simple terms			
Clarifies her feelings on possibility of having heavy bleeding at home			
Explains how to take mifepristone and misoprostol			
Explains what to expect after taking the medications			
Explains how to take pain management medications (analgesics) and suggests other methods to reduce pain (e.g., hot water bottle)			

(continued on pages 306-309)

Uterine Evacuation With Medical Methods Skills Checklist – Mifepristone and Misoprostol

First Clinic Visit (continued)	Yes	No	Comments
Ensures she understands:			
• The normal, expected effects and common side effects and symptoms			
• Warning signs indicating the need to return to the clinic			
Explains what to do in case of questions or problems at home			
Provides contact information if problem or emergency arises			
Explains that if the MA should fail, further steps will be necessary to terminate the pregnancy			
Solicits and answers questions			
Obtains informed consent			
Discusses with the woman:			
• Information about return to fertility, sexuality and contraception			
• Contraceptive methods, if desired, with instructions for beginning			
Has woman swallow the mifepristone pills			
If DMPA, implant or hormonal contraceptive chosen for contraception, provides method. If IUD is chosen, gives instructions for follow-up in 1-2 weeks for insertion. If other methods are chosen, provides methods with instructions.			
If the woman will take the misoprostol pills at home and does not need to return to get them, provide misoprostol pills to take home			
Advises the woman that follow-up care is available if needed or desired			
Possible Visit for Misoprostol <i>(if misoprostol was not given on the first visit for home use)</i>	Yes	No	Comments
Ensures privacy for counseling session			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up clinic visit			
Provides misoprostol for in clinic or to take home (per protocol)			

Uterine Evacuation With Medical Methods Skills Checklist – Mifepristone and Misoprostol

Possible Visit for Misoprostol (continued) (if misoprostol was not given on the first visit for home use)	Yes	No	Comments
If the woman leaves the clinic before she aborts:			
• Gives verbal and written instructions for aborting at home			
• Gives supplies (pain medications)			
• Reminds the woman that follow-up care is available if needed or desired			
Provides information and makes referrals if needed about other reproductive health issues, including sexual and gender-based violence, cancer screening and HIV			
If DMPA, implant or hormonal contraceptive chosen for contraception, provides method. If IUD is chosen, gives instructions for follow-up in 1-2 weeks for insertion. If other methods are chosen, provides methods with instructions.			
If the woman aborts at the clinic:			
• POC's may be examined to confirm expulsion			
Reviews after-care instructions			
Provides information on warning signs that indicate the need to return to the clinic or seek medical assistance			
Provides contact information for emergencies			
Asks the woman whether she has additional questions			
Possible Follow-Up Visit (if needed or desired by the woman)	Yes	No	Comments
Ensures privacy for the visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up clinic visit			
Inquires about the woman's experience with the abortion process, asking her if she thinks she is no longer pregnant			

Uterine Evacuation With Medical Methods Skills Checklist – Mifepristone and Misoprostol

Possible Follow-Up Visit (continued) (if needed or desired by the woman)	Yes	No	Comments
Assesses status of the abortion by:			
• Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping)			
• Asking about current cramping and current amount of bleeding			
• Conducting a physical examination			
If it is unclear whether the woman is still pregnant, discusses options:			
• Have another or more experienced clinician do an exam to check			
• Ask the woman to return in one week and re-check her (provided the pregnancy would not be too advanced to receive a vacuum aspiration if needed)			
• Perform vacuum aspiration now			
Give a second dose of misoprostol 800mcg per vagina and follow-up in 7-14 days (if vacuum aspiration is not available)			
• Perform an ultrasound, if available			
If the woman is no longer pregnant, provides:			
• Information on how to contact clinic if she has questions/problems			
• Information about return to fertility and contraception			
• A contraceptive method if desired by the woman			
If bleeding is prolonged or heavier than usual discusses treatment options:			
• Expectant management (depending on how heavy bleeding is)			
• Vacuum aspiration			
• Misoprostol. A second dose of misoprostol is sometimes given in clinical practice to treat problematic bleeding although there is no evidence that is effective and side effects are common.			

Uterine Evacuation With Medical Methods Skills Checklist – Mifepristone and Misoprostol

Possible Follow-Up Visit (continued) (if needed or desired by the woman)	Yes	No	Comments
If the woman is still pregnant, discusses options:			
<ul style="list-style-type: none"> • Vacuum aspiration (recommended, standard treatment) • Repeat dose of misoprostol 800mcg vaginally with close follow-up (less studied; not a first line recommendation but can be considered where access to VA is limited) 			
Provides information and makes referrals if needed about other reproductive health issues, including sexual and gender-based violence, cancer screening and HIV			
Asks the woman whether she has additional questions			

Uterine Evacuation With Medical Methods Skills Checklist – Misoprostol Only

Instructions: Check whether the skill was performed well (Yes/No) and add comments.

First Clinic Visit	Yes	No	Comments
Ensures privacy during the visit			
Greets woman in a friendly, respectful manner			
Uses age-appropriate, non-clinical language			
Provides basic information about conception, pregnancy and options, if needed			
Confirms with her that she wants to terminate her pregnancy and her decision is voluntary			
Explores what kind of support she has for her decision			
Asks if she came with someone and if she would like that person to join her in the information and counseling session			
Determines whether someone can be with her during the MA process			
Explains what to expect during the clinic visit			
Asks about medical conditions and allergies to any medicines			
Asks about her general health and reproductive health history			
Determines medical eligibility for MA			
If routine in local protocols, determines Rh status and gives Rh-immunoglobulin to Rh-negative women (if available and feasible)			
If routine in local protocols, performs pre-MA hemoglobin or hematocrit if indicated and equipment available (<i>Note: this may be part of local protocols but may not be feasible or routine in many settings</i>)			
Perform bimanual exam to confirm gestational age			
Explains which abortion methods are available, including characteristics, effectiveness and the timing/visits required			
Explores views on abortion options and what method is best for her			
If she chooses MA, provides more information on it in simple terms			
Clarifies her feelings on possibility of having heavy bleeding at home			
Explains how to take misoprostol			
Explains what to expect after taking the misoprostol			
Explains how to take pain management medications (analgesics) and suggests other methods to reduce pain (e.g., hot water bottle)			

(continued on pages 311-312)

Uterine Evacuation With Medical Methods Skills Checklist – Misoprostol Only

First Clinic Visit (continued)	Yes	No	Comments
Ensures she understands: <ul style="list-style-type: none"> • The normal, expected effects and common side effects and symptoms • Warning signs indicating the need to return to the clinic 			
Explains what to do in case of questions or problems at home			
Provides contact information if problem or emergency arises			
Explains that if the MA should fail, further steps will be necessary to terminate the pregnancy			
Solicits and answers questions			
Obtains informed consent			
Discusses with the woman: <ul style="list-style-type: none"> • Information about return to fertility, sexuality and contraception • Contraceptive methods, if desired, with instructions for beginning. If woman chooses DMPA or implant, these methods may be supplied with the first pill of the medical abortion. If she desires other hormonal methods, these may be provided and started immediately. If she desires IUD, she needs follow-up appointment in 1-2 weeks for insertion. • If contraceptive method is declined, discuss rapid return to fertility, usually within two weeks 			
Provides misoprostol in clinic or to take home (per protocol)			
Provides information and makes referrals if needed about other reproductive health issues, including domestic violence, cancer screening, HIV and AIDS			
Advises the woman that follow-up care is recommended			
Follow-Up Visit	Yes	No	Comments
Ensures privacy for the visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up clinic visit			
Inquires about the woman's experience with the abortion process, asking her if she thinks the abortion is complete			

Uterine Evacuation With Medical Methods Skills Checklist – Misoprostol Only

Follow-Up Visit (continued)	Yes	No	Comments
Assesses the status of the abortion by:			
• Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping)			
• Asking about current cramping and current amount of bleeding			
• Conducting a physical examination			
If it is unclear whether the woman is still pregnant, discuss options:			
• Have another or more experienced clinician do an exam to check			
• Perform an ultrasound, if available			
• Ask the woman to return in one week and re-check her (provided the pregnancy would not be too advanced to receive a vacuum aspiration if needed)			
• Perform VA now			
If the woman is no longer pregnant, provides:			
• Information on how to contact clinic if she has questions/problems			
• Information about return to fertility and contraception			
• A contraceptive method if desired by the woman			
If the bleeding is prolonged or heavier than usual, discusses options:			
• Expectant management (depending on how heavy bleeding is)			
• Vacuum aspiration			
• Misoprostol. A second dose of misoprostol is sometimes given in clinical practice to treat problematic bleeding although there is no evidence that is effective and side effects are common.			
If the woman is still pregnant, discusses and provides (or refers her) for the recommended vacuum aspiration			
Provides information and makes referrals if needed about other reproductive health issues, including domestic violence, cancer screening, HIV and AIDS			
Asks the woman whether she has additional questions			

Misoprostol for Treatment of Incomplete Abortion Skills Checklist

First Clinic Visit	Yes	No	Comments
Ensures privacy during the visit			
Greets woman in a friendly, respectful manner			
Uses age-appropriate, non-clinical language			
Asks the woman the reason for her visit			
Asks about her LMP			
Find out if she has been experiencing vaginal bleeding (how long, severity, patterns)			
Asks the woman if she believes she was or is pregnant			
Asks the woman if she has passed clots, tissue or had bleeding like a heavy period			
(Depending on setting): Asks the woman if she had an abortion procedure, has used medicines or inserted objects into her vagina/uterus to end a pregnancy			
Explains what to expect during the clinic visit			
Asks if she came with someone and if she would like that person to join her in the information and counseling session			
Asks about medical conditions and allergies to any medicines			
Asks about her general health and reproductive health history			
Explains which uterine evacuation methods are available, including characteristics and effectiveness			
Explores what uterine evacuation method is best for her			
If the woman chooses misoprostol, provides more information on the method in simple terms (Note: If the woman chooses vacuum aspiration, refer to checklist in Uterine Evacuation Procedure With Ipas MVA Plus module for the remainder of the counseling steps)			
Determines medical eligibility for misoprostol for incomplete abortion			
Determines whether someone can be with her during the misoprostol process			
Clarifies the woman's feelings on the possibility of having the evacuation at home and asks what support she has there			
Ensures that she understands: <ul style="list-style-type: none"> • Expected effects and common side effects and symptoms • Warning signs indicating the need to return to the clinic 			
Performs bimanual exam to confirm uterine size			
Explains how to take the misoprostol and what to expect after taking it			

(continued on pages 314-315)

Misoprostol For Treatment Of Incomplete Abortion Skills Checklist

First Clinic Visit (continued)	Yes	No	Comments
Explains how to take pain-management medications (analgesics) and suggests other methods to reduce pain (e.g. hot water bottle)			
Explains what to do in case of questions or problems at home			
Provides contact information if problem or emergency arises			
Explains that if the uterine evacuation with misoprostol should fail, vacuum aspiration will be necessary to terminate the pregnancy			
Asks the woman whether she has additional questions			
Obtains informed consent			
Discusses with the woman: <ul style="list-style-type: none"> • Information about return to fertility, sexuality and contraception • Contraceptive methods, if desired, with instructions for beginning. If woman chooses DMPA or implant, these methods may be supplied with the misoprostol. If she desires other hormonal methods, these may be provided and started immediately. If she desires IUD, she needs follow-up appointment in 1-2 weeks for insertion. • If contraceptive method is declined, discuss rapid return to fertility, usually within two weeks. 			
Provides misoprostol in clinic or to take home (per protocol)			
Provides information and makes referrals if needed about other reproductive health issues, including domestic violence, cancer screening, HIV and AIDS			
Advises the woman that follow-up care is available if needed or desired			
Possible Follow-Up Visit	Yes	No	Comments
Ensures privacy for the visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up clinic visit			
Inquires about the woman's experience with the evacuation process, asking her if she thinks the process is complete			
Assesses the completeness of the uterine evacuation by: <ul style="list-style-type: none"> • Taking a history of the process (amount and duration of bleeding, side effects, cramping) • Conducting a physical examination • Performing an ultrasound, if available, if it is still unclear whether the evacuation is complete 			

Misoprostol For Treatment Of Incomplete Abortion Skills Checklist

Possible Follow-Up Visit (continued)	Yes	No	Comments
If the misoprostol for incomplete abortion is successful, provides: <ul style="list-style-type: none"> • Information on how to contact the clinic if she has questions or problems • Contraceptive counseling (if not done earlier) • Information about return to fertility and contraception • A contraceptive method if desired by the woman 			
If the misoprostol for incomplete abortion is not successful, discusses treatment options: expectant management, additional misoprostol administration or vacuum aspiration			
If the pregnancy is continuing, discusses need for vacuum aspiration to terminate it			
Makes sure she has started contraceptive method if desired			
Provides information and makes referrals if needed about other reproductive health issues, including domestic violence, cancer screening, HIV and AIDS			
Asks the woman if she has any additional questions			

PAC Follow-Up Care Scenario Key

Scenario 1 (PAC)

A 19-year-old nulliparous woman presents at the clinic. She has been bleeding heavily for two days and has an LMP of 10 weeks but a uterine size consistent with a seven-week pregnancy. She chooses to take misoprostol for incomplete abortion and swallows 600mcg of misoprostol. Four hours later she calls with excruciating pains. She has no prescription pain medications at home.

Ask trainees: *What would you tell her to do?*

- Instruct her to take 600 to 800mg of ibuprofen orally and try using a hot water bottle or hot cloths on her abdomen.
- Explain that most likely she is in the process of passing large pieces of tissue (some women find their cramping peaks as this tissue passes through the cervix).
- Reassure her that as soon as it passes, she will feel much better; generally this process occurs within four to six hours of taking misoprostol. It can be very helpful for women to have a better understanding of what is causing their discomfort and to know that the pain peaking most likely means that the uterine evacuation is successful.
- Ask her to call back in 30 to 60 minutes, if possible, so that you can make sure she is feeling better.

Tell trainees: *Two hours later, she has not yet called back. What would you do next?*

- Contact her by phone to inquire about her status.

Tell trainees: *You reach her on the phone and she reports feeling much better after having passed several large clots. Her bleeding has decreased to light spotting and her cramping is minimal. She says that she would like to return for a follow-up appointment.*

Discuss with trainees: *When counseling women about what to expect during uterine evacuation with medical methods, pain-management options should be discussed. Ibuprofen may be taken at the time of misoprostol or when cramping begins to manage pain. In addition, a narcotic such as codeine can be used to relieve the discomfort that commonly occurs within a few hours of taking misoprostol. Other pain-relieving techniques some women find useful include heating pads and massages.*

Scenario 2 (PAC)

A 17-year-old woman was eight weeks LMP at the time she received misoprostol for an incomplete abortion that she tried to induce with herbs and medicines. She requested a follow-up visit and is returning for that now, two weeks after taking the misoprostol. She had very heavy bleeding the day she used misoprostol, but the bleeding steadily declined after that. She resumed her normal activities the day after using misoprostol. She feels that she is no longer pregnant but complains of intermittent cramping. When you perform a pelvic examination, the uterus is non-pregnant size and non-tender. Her bleeding is like a light menstrual period. You look at her cervix and see that her os is open and there appears to be a rubbery clot or piece of tissue in the os.

Ask participants: *What is the diagnosis?*

Answer should be: Tissue trapped in the cervical os.

Ask: *What would you do to treat this?*

Ensure the following points are included in the discussion:

- Try to draw the tissue out of the cervix using ring forceps or similar grasping instrument.
- If the tissue breaks up and cannot be pulled out, vigorous uterine massage may help dispel the clot.
- If uterine massage does not dispel the tissue lodged in the cervix, the woman can be managed either by:
 - 1) giving a repeat dose of misoprostol to soften the cervix and cause uterine contractions to dispel the clot or:
 - 2) vacuum aspiration. Either treatment is acceptable. Ask the woman which treatment she prefers.
- If the provider gives her a repeat dose of misoprostol, as long as the cramping subsides within a day of the misoprostol and she feels fine, it is not necessary to schedule additional follow-up care.

Other points to mention: Occasionally a large clot or rubbery tissue can get trapped in the cervical os. This can be painful, sometimes very painful, and can result in persistent cramping. By the two-week follow-up visit, women are normally not experiencing cramping.

Scenario 3 (PAC)

A 19-year-old woman who was approximately seven weeks pregnant, tried to terminate the pregnancy on her own. She comes to the clinic for help because she had mild but consistent bleeding and she suspected that she never fully expelled the pregnancy. She was eligible for misoprostol to treat incomplete abortion. She contacts the clinic 12 days after taking the pills because she continues to have vaginal bleeding. She had heavy cramping and bleeding the day she took misoprostol and diminished bleeding with some spotting thereafter, but is worried because she is now using three pads every day. Her bleeding alternates between a light to moderate period, but the pads are not saturated. The bleeding is gradually growing lighter over time. She is not feeling lightheaded or dizzy.

Ask participants: *What is the diagnosis?*

Answer should be: Prolonged bleeding

Ask: *What would you do to treat this?*

Ensure the following points are included in the discussion:

- Reassure the woman that she is having variable bleeding that is a normal part of her treatment. She has no signs of hypovolemia. As long as the general pattern of bleeding is that it is diminishing over time, this is normal.
- Inform the woman of three choices to manage problematic prolonged bleeding:
 1. Wait and watch (reassurance).
 2. A second dose of misoprostol to assist with uterine contractility and expel residual tissue (if any). Although a second dose of misoprostol is widely used for this purpose, its efficacy has not been specifically studied. If she is given a second dose of misoprostol for prolonged bleeding, she should be contacted or assessed again about a week later to determine if bleeding has diminished.
 3. Vacuum aspiration

- Encourage iron-rich foods and provide iron tablets if available.

Other points to mention: Many clinicians (and sometimes the women themselves) are concerned about prolonged bleeding, especially if it was not anticipated. Bleeding time is variable with misoprostol for first-trimester incomplete abortion, but can continue for as long as 14 days.

Complications: Comprehensive Abortion Care

Note: If you are using Woman-Centered, Comprehensive Abortion Care: Reference Manual, you will use this module. The Complications: Postabortion Care module contains more information on presenting complications.



Purpose

This module prepares participants to identify and manage complications that may occur during or after vacuum aspiration and uterine evacuation with medical methods.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered, comprehensive abortion care, which includes postabortion care
- ☐ Describe a woman's rights in the abortion-care setting
- ☐ Describe methods for evacuating the uterus
- ☐ Implement infection-prevention techniques
- ☐ Perform a complete clinical assessment
- ☐ Diagnose and manage life-threatening gynecological conditions



Objectives

By the end of this module, participants should be able to:

1. Identify signs, symptoms and causes of abortion-related complications
2. Identify steps to diagnosis, manage or refer complications
3. Describe after-care for women with complications
4. Explain learning from adverse events



Materials

- ☐ Serious Adverse Events Skits scripts
- ☐ Case Study Role Play Scenarios for Complications: Comprehensive Abortion Care
- ☐ Case Studies worksheet and answer key for Complications: Comprehensive Abortion Care
- ☐ Management of Complications (CAC) Skills Checklist
- ☐ Knowledge Test and Test Key



Advance preparation

- ☐ Be familiar with local referral processes.
- ☐ Be familiar with the three techniques for root cause analysis.
- ☐ Duplicate case study role plays, handout, worksheet and skills checklist.
- ☐ Duplicate Knowledge Test.

Time: 1 hour, 45 minutes

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module prepares participants to identify and manage complications that may occur during or after vacuum aspiration and uterine evacuation with medical methods.

Say: We will look first at the types, signs, symptoms and causes of complications and then at steps for managing them.

Show slide: *Objectives*

1. Identify signs, symptoms and causes of abortion-related complications
2. Identify steps to diagnosis, manage or refer complications
3. Describe after-care for women with complications
4. Explain learning from adverse events

Say: This module addresses complications that may occur during or after vacuum aspiration and uterine evacuation with medical methods. Pain management is an essential part of management of complications.

Show slide: *Abortion Is a Safe Procedure*

“When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure.” – WHO, 2012

As long as effective methods are used, abortion is usually safe. However, even in the most skilled hands, procedural complications can occur.

2. Types of complications

Show and discuss slide: *Types of Complications*

- Presenting
- Procedural

- Pregnancy-related
- Ensure that the following information is covered:
 - Complications may develop individually or several at the same time.
 - Presenting complications are those that a woman has prior to the uterine evacuation procedure.
 - Procedural complications can occur during provision of uterine evacuation, during the recovery period or later and are rare when uterine evacuation is performed using effective methods.
 - Pregnancy-related or gynecological complications may require specific clinical consideration and management.
 - Pregnancy-related conditions may be discovered during the clinical assessment or may not become evident until during or after the uterine evacuation.
- Refer participants to the Clinical Assessment module for more information on assessing presenting and pregnancy-related complications.

Show and discuss slide: *Frequency of Adverse Events*

Table 14A-1: Adverse events	
Adverse events	Frequency
Failed abortion for first-trimester with misoprostol only (needing vacuum aspiration for any reason)	15%
Failed abortion for first-trimester with mifepristone + misoprostol (needing vacuum aspiration for any reason)	5%
Infection in first-trimester medical abortion	0.3%
Any adverse event after first-trimester vacuum aspiration abortion	<1%
Serious adverse event after first-trimester vacuum aspiration abortion	<0.1%
Second-trimester medical abortion needing surgical evacuation	8%
Serious complications from second-trimester medical abortion	1%

- Discuss the chart, noting that complications do occur, but they are rare. These numbers come from large case series in experienced facilities, so complication rates may be higher in facilities with less experienced providers or lower case volume.
 - Failed abortion—that is, needing vacuum aspiration for any reason including retained products, incomplete, ongoing or bleeding—for first-trimester misoprostol only is around 15 percent. The ongoing pregnancy rate is around five percent. For first-trimester mifepristone-misoprostol using the recommended regimen, failed abortion is four to five percent and ongoing pregnancy rate is less than one percent.
 - Infection in first-trimester medical abortion is 0.3 percent.

- Any adverse event after first-trimester vacuum aspiration is less than one percent (8.46/1000).
- Serious adverse events after first-trimester vacuum aspiration are less than 0.1 percent (0.71/1000).
- Second-trimester medical abortion needing surgical evacuation (for any indication including retained placenta, bleeding, failure to pass products) is about eight percent.
- Second-trimester medical abortion serious complications (transfusion, hemorrhage, laparotomy) are about one percent.
- Second-trimester D&E serious complications are about two percent.

Show and discuss slide: *Frequency of Death*

Table 14A-2: Frequency of death	
First-trimester vacuum aspiration abortion	1/1,000,000 (0.0001%)
First-trimester medical abortion	1/100,000 (0.001%)
Second-trimester D&E	3.3/100,000 (0.0033%)

Discuss the chart, noting that the frequency of death is very low.

Show slide: *Assessment and Management of Complications*

The provider needs to:

- Do rapid initial assessment and management of shock if woman is presenting for postabortion care
- Continually assess the woman for complications
- Manage complications by providing pain management, then treating immediately or stabilizing and referring

Say: Now we will discuss how to identify and manage complications.

3. Complications of vacuum aspiration or medical abortion

Say: Several types of complications may infrequently occur with either vacuum aspiration or medical abortion. These include: incomplete abortion, infection, continuing pregnancy, hemorrhage and ectopic pregnancy.

First we will discuss incomplete abortion.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

Show slide: *Signs and Symptoms of Incomplete Abortion: Immediate*

- Heavy vaginal bleeding

- Less tissue than expected
- Sometimes severe abdominal pain

Show slide: *Signs and Symptoms of Incomplete Abortion: Delayed*

- Uterine tenderness
- Fever, pain, infection
- Elevated white blood cell count

Ask the learner to describe the cause of that woman's condition.

Show slide: *Causes of These Signs and Symptoms*

- Retained pregnancy tissue after uterine evacuation
- Uterine infection (endometritis), especially likely if RTI present

Show and discuss slide: *Treatment of Incomplete Abortion*

- Usually treat with vacuum aspiration
- May use misoprostol or expectant management with close monitoring
- If woman has heavy bleeding or signs and symptoms of infection, use immediate vacuum aspiration
- Note that treatment of incomplete abortion is usually vacuum aspiration, whether the initial uterine evacuation method was vacuum aspiration or medical methods.

Say: Another possible complication of vacuum aspiration or medical methods is infection.

Show slide: *Signs and Symptoms of Uterine Infection*

- Lower pelvic or abdominal pain
- Bleeding
- Fever and chills
- Uterine or lower abdominal tenderness on exam
- Cervical motion tenderness

Say: If a woman has signs of infection, what should the provider do?

- Make sure the answers include: Establish antibiotic coverage and then perform/re-perform vacuum aspiration for retained tissue if indicated.

Say: The next complication we'll discuss is continuing pregnancy. This is rare after uterine evacuation with vacuum aspiration or medical methods when performed by a trained provider. If any of you has seen a woman experiencing a continuing pregnancy, please tell us about her signs and symptoms.

Show slide: *Signs and Symptoms of Continuing Pregnancy*

- On vacuum aspiration, smaller amount of POC than expected
- Persistent pregnancy symptoms
- Less vaginal bleeding than expected
- Uterine size increasing after uterine evacuation

Ask participants to describe the cause of that woman's signs and symptoms.

Show slide: *Continuing Pregnancy*

- Also known as "failed abortion"
- Pregnancy continues due to:
 - Ineffective uterine evacuation
 - Failure to evacuate gestational sac
 - Extrauterine pregnancy
- Early gestational age (less than six weeks), operator inexperience and uterine anomalies may make it more difficult to evacuate gestational sac using vacuum aspiration

Say: Examining the aspirate immediately after uterine evacuation can decrease the risk of failed vacuum aspiration. Vacuum aspiration is the recommended treatment for continuing pregnancy, although a second dose of misoprostol is an option where vacuum aspiration is not available and the woman initially had medical abortion with mifepristone and misoprostol.

Now let's look at hemorrhage.

Show slide: *Hemorrhage*

- Rare after safe abortion
- May occur because of incomplete abortion, infection or uterine atony

Say: Uterine atony is one cause of hemorrhage.

Ask for a participant who has treated a woman with this complication to describe the woman's signs and symptoms.

Show slide: *Signs and Symptoms of Uterine Atony*

- Copious vaginal bleeding
- Large, boggy, softened uterus

Ask the participant to describe the factors contributing to that woman's condition.

Show slide: *Factors Contributing to Uterine Atony*

- Uterus loses muscle tone, cannot stop bleeding
- More common in multiparous and later pregnancies

Say: What are some methods for managing hemorrhage?

- Responses should include: vacuum aspiration, fluid and blood replacement and oxygen administration; uterotonics or intrauterine tamponade may also be used; when uterine atony is the cause of hemorrhage, bimanual uterine massage may be effective.

Show slide: *Steps for Management of Hemorrhage*

- Conduct bimanual massage
- Give uterotonics therapies
- Proceed with uterine aspiration
- Perform intrauterine tamponade
- Perform hysterectomy if bleeding cannot be stopped by other measures

Say: Management should be done step by step to control bleeding. Providers should move quickly to the next step if bleeding is not controlled. Hysterectomy should be done only as a last resort.

Show and discuss slide: *Uterotonics for Bleeding or Stabilization*

After uterine aspiration:

- Methylergonovine 0.2mg intramuscularly or intracervically, not for women with hypertension
- Misoprostol 200-800mcg orally, rectally or sublingually
- Oxytocin 20 units in 1L IV at a rate of 60 drops per minute
- Intrauterine tamponade

These therapies may be given for bleeding or to stabilize a patient for transfer after vacuum aspiration or postpartum hemorrhage. They may also be effective after a medical abortion. More details on dosage and method are in the Reference Manual.

Say: Let's now discuss undiagnosed ectopic pregnancy. Again, this is not a complication of the uterine evacuation, but rather a condition that was in place before it. Women should be screened for ectopic pregnancy before uterine evacuation with medical methods or vacuum aspiration but sometimes it is not detected. How does ectopic pregnancy complicate abortion-related care?

Show slide: *Ectopic Pregnancy*

- Usually detected during clinical assessment
- Can go undiagnosed, even after UE with medical methods, as POC not examined

- Medications used in UE with medical methods will not treat an ectopic pregnancy
- Life-threatening condition – refer or treat immediately

Show slide: *Possible Signs and Symptoms of Ectopic Pregnancy*

After VA: no villi or decidua are seen when POC are examined

After medical methods:

- Minimal vaginal bleeding
- Uterine size that is smaller than expected
- Sudden, intense and persistent lower abdominal pain or cramping, sometimes with:
 - Irregular vaginal bleeding or spotting
 - Palpable adnexal mass
- Fainting, shoulder pain, rapid heartbeat or lightheadedness (from internal bleeding). Internal bleeding is not necessarily accompanied by vaginal bleeding.

Say: A ruptured ectopic pregnancy is a gynecologic emergency that can be life threatening and requires immediate surgical intervention. A woman with suspected ectopic pregnancy should be treated or transferred as soon as possible to a facility that can confirm diagnosis and begin treatment.

Now we'll talk about complications specific to vacuum aspiration.

4. Complications of vacuum aspiration

Say: Cervical, uterine or abdominal injuries may occur during vacuum aspiration procedures, although they are rare.

Please read through the information on cervical, uterine and abdominal injuries in the Reference Manual.

What are the signs and symptoms of these kinds of injuries during a vacuum aspiration procedure?

- Take some answers, then show slide, making sure to highlight anything that participants did not mention.

Show slide: *Signs and Symptoms of Cervical, Uterine or Abdominal Injury*

During procedure:

- Excessive vaginal bleeding
- Sudden excessive pain
- Instrument passes further than expected
- Aspirator vacuum decreases

- Fat or bowel in aspirate

P Say: *What are the signs and symptoms post-procedure?*

Show slide: *Signs and Symptoms of Cervical, Uterine or Abdominal Injury (cont.)*

Post-procedure:

- Persistent abdominal pain
- Rapid heart rate
- Falling blood pressure
- Pelvic tenderness
- Fever, elevated white blood cell count

Say: *What might cause such injuries?*

Show slide: *Causes of Cervical, Uterine and Abdominal Injury*

- Minor cervical lacerations from tenaculum or dilator, or anything inserted in the vagina during an unsafe abortion
- Uterine perforation caused by:
 - Excessive force used to dilate (such as with stenotic cervix)
 - Unusual uterine position (for example, very retroverted)
 - Actual uterine size different than expected

Show slide: *Management of Cervical or Vaginal Laceration*

- Ensure adequate pain control and proper positioning and lighting.
- Apply antiseptic solution to the cervix and vagina.
- Check for more than one laceration.
- Stop the bleeding by:
 - Clamping a ring forceps over the tear
 - Applying silver nitrate, or
 - Suturing with continuous absorbable suture
- Repair with laparotomy any deep tears or sutured lacerations that continue bleeding.
- Vaginal packing may be used for emergent treatment of bleeding.

Show slide: *Management of Uterine Perforation*

If:

- Perforation occurred during aspiration

- Woman is stable
- No other signs of intra-abdominal injury, and
- Evacuation is complete

Then you may admit her and closely observe for signs and symptoms of intra-abdominal injury or hemorrhage.

Say: This is appropriate only if the perforation occurred during the uterine aspiration and the provider feels confident that there were no other injuries. Management of presenting uterine perforation is discussed in the Complications: Postabortion Care module.

If laparotomy or laparoscopy is not possible, transfer the woman to a higher-level facility.

Show slide: *Medication-Related Complications*

Say: During vacuum-aspiration procedures, women will occasionally experience medication-related complications.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

Show slide: *Signs and Symptoms of Medication-Related Complications*

- Dizziness
- Muscular twitching or seizures
- Loss of consciousness
- Drop in blood pressure or pulse
- Respiratory depression

Ask the same participant to describe the cause of the medication-related complication that they had seen.

Show slide: *Factors Contributing to Medication-Related Complications*

- Overdose
- Intravascular injection
- Hypersensitivity reaction
- General anesthesia

Show slide: *Management of Medication-Related Complications*

- Reversal agents
- Treating respiratory and cardiac depression
- Stabilizing convulsions

Say: Hematometra is another complication of vacuum aspiration. It refers

to the accumulation of blood clots in the uterine cavity.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

Show slide: *Signs and Symptoms of Hematometra*

- Enlarged, firm, tender uterus
- Pelvic pressure
- Intense cramps and pain
- Lightheadedness
- Mild fever
- Scant vaginal bleeding

Say: Re-evacuation with vacuum aspiration will usually resolve the condition.

Now we're going to discuss vasovagal reaction.

Explain that fainting can occasionally occur during vacuum aspiration.

- This is a vagal reaction to stimulation during the procedure.
- Typically it lasts about 10 seconds and does not require intervention.

Ask for a participant who has treated a woman with this complication to describe the woman's signs and symptoms.

Show slide: *Signs and Symptoms of a Vasovagal Reaction*

- Fainting, loss of consciousness
- Cold or damp skin
- Dizziness
- Nausea
- Moderate drop in blood pressure, pulse

Ask the same participant to describe the cause of the vasovagal reaction in the woman mentioned.

Show slide: *Cause of Vasovagal Reactions*

- Result of vagal nerve stimulation during vacuum aspiration.
- Explain that a vagal reaction is not a true complication, but rather a side effect.
- Point out that it can be very distressing when a woman experiences a vagal reaction if the staff are not aware of what is going on.

Say: How is a vasovagal reaction treated?

- Make sure the following points are made: most symptoms pass quickly as the woman regains consciousness and no further treatment is necessary; occasionally, smelling salts will be needed to revive the woman; in very rare cases, atropine injection will be necessary if the reaction is prolonged.

Note to trainer: Many participants may be confused about vagal reaction and may mistake it for a more serious condition. Ensure that participants understand that a vagal reaction is not shock and is usually self-limiting without requiring intervention. Vagal reaction may occur with IV insertion, intramuscular injection, vacuum aspiration or the sight of blood. It is fainting and is self-limited rather than a seizure that might require intervention.

Say: How would you describe Asherman's Syndrome?

Take one or two responses. Ensure that the following points are covered: a rare complication of vacuum aspiration in which the inside of the uterus becomes scarred; more commonly associated with postpartum curettage than with VA; signs and symptoms are amenorrhea, cyclical cramping and infertility.

Ask for questions about any of the vacuum aspiration complications discussed thus far.

5. Complications of medical abortion

Say: Now we will move on to discuss possible complications of uterine evacuation with medical methods.

P *First we'll talk about failure of medical abortion, which is defined as situations requiring an intervention to empty the uterus due to a continuing pregnancy or unacceptable symptoms such as hemorrhage. Based on the table of adverse events we reviewed during the introduction to this module, which recommended regimen has a lower failure frequency: mifepristone and misoprostol or misoprostol only?*

- Answer should be mifepristone and misoprostol

What is the failure frequency for each regimen?

- Answers should include: 15 percent with misoprostol only, 5 percent with mifepristone and misoprostol.
- Note that misoprostol for incomplete abortion fails in approximately 10 percent of cases.

Say: We discussed continuing pregnancy, which is one kind of failure of medical abortion, back in the section on possible complications of both VA and medical methods. A continuing pregnancy occurs in less than one percent of women who take mifepristone and misoprostol and approximately four to six percent of women who use misoprostol only for gestations up to nine weeks.

Another possible complication of uterine evacuation with medical

methods is persistent pain.

Ask for a participant who has treated a woman with persistent pain to describe the woman's symptoms.

Show slide: *Persistent Pain*

- Intense pain that persists for longer than four to six hours after taking misoprostol, or
- Intense pain unrelieved with ibuprofen and mild narcotics

Ask the same participant to describe the cause of the persistent pain in the woman mentioned.

Show slide: *Possible Causes of Persistent Pain*

- Pregnancy tissue trapped in the os
- Ectopic pregnancy
- Upper reproductive tract infection

Say: If there is pregnancy tissue in the os, it can sometimes be grasped with an instrument such as ring forceps and gently removed. If none of the listed causes, consider low pain tolerance and manage with counseling, reassurance and pain medications.

Next we'll look at allergic reactions to mifepristone or misoprostol.

Show slide: *Allergic Reactions*

- Symptoms may include swelling of hands or feet, rashes or wheezing.
- Manage conventionally, such as with an antihistamine.
- Severe allergic reactions (very rare) should receive emergency treatment.

Women who experience sudden shortness of breath, swelling of the airway or any other severe or unusual reaction should receive emergency treatment.

Explain that women often want to know about any long-term effects or complications of abortion.

- Ask several participants to give their ideas about the long-term effects or complications of abortion.

Show slide: *Abortion Not Linked to Long-Term Problems*

Research shows no association between safely-induced first-trimester abortion and:

- Breast cancer
- Future infertility
- Severe psychological reactions

6. Complications in women who present for postabortion care

Note to trainers: More details on signs, symptoms and treatment of postabortion complications are covered in the Complications: Postabortion Care module.

Say: Now we're going to look at complications that may be present when a woman comes to the clinic for postabortion care.

- Ask participants to turn to the overview of complications in women who present for postabortion care in section 8.0 of the *Woman-Centered, Comprehensive Abortion Care: Reference Manual* and read the information describing this potentially urgent care.
- After five minutes, begin the question and answer discussion.

Say: Do the majority of women presenting for postabortion care require emergency treatment? What signs and symptoms are they most likely to have? What treatment is required in this case?

- Ensure that participants understand that most women have light to moderate bleeding and no complications, and uterine evacuation may be the only treatment required.

Say: What are the causes of the complications that women may present with in postabortion care?

Show slide: *Causes of Complications in Postabortion Care*

- Injury from the abortion procedure
- Incomplete uterine evacuation
- Infection

Say: How should informed consent be handled if the woman needs emergency care?

- Ensure that responses include: when a woman presents with a life-threatening emergency, complete clinical assessment and voluntary informed consent may be deferred until actions have been taken to save the woman's life.

Say: What is the first step in providing care to a woman presenting for postabortion care?

- Ensure that responses include: perform a rapid initial assessment and obtain voluntary informed consent if possible.
- Note that a clinical assessment should be done as the provider begins to treat the complications.

Say: With which severe complications may women present?

Show slide: *Possible Presenting Severe Complications*

- Shock
- Hemorrhage
- Sepsis
- Intra-abdominal injury

Say: Shock can develop in any patient at any time during postabortion care and requires immediate action.

What is usually a key part of treatment for women presenting with signs and symptoms of pelvic infection, sepsis or hemorrhage due to incomplete abortion?

- Ensure that response is: prompt uterine evacuation, usually with vacuum aspiration.

Ask if there are any questions about complications in postabortion care. If there are detailed questions, refer to the Complications module of Ipas's *Woman-Centered Postabortion Care: Reference Manual*, which is on the CD-ROM.

7. Emergency response

Say: Now we're going to talk about emergency plans and referring women to other facilities.

Show and discuss slide: *In Case of Emergency*

- Complete assessment and informed consent may be deferred until after life-saving treatment.

Ask participants if their facilities have an emergency plan, and if so, what it includes.

- Facilities should have a plan for emergencies which may include:
 - On-call provider
 - Referral
 - Information sharing
 - Practicing for emergencies
 - Supplies
 - Engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications
- Ask participants to read section 9.0 on emergency response in the Reference Manual. Facilitate a brief group discussion about each element of an emergency plan and participants' ideas for developing or improving their facilities' emergency plans.

Show slide: *On-Call Provider*

A clinically-knowledgeable person should be available 24 hours a day to:

- Answer women's questions and provide reassurance
- Provide or refer for care

Advise participants that not all facilities have to treat all complications that arise. Stabilizing the woman and referring her for treatment is also appropriate. Referral systems are important so facilities can quickly refer women for more care when necessary.

- Discuss characteristics of a proper referral system.

Show slide: *Qualities of a Proper Referral System*

- Staff and transport ready 24 hours a day
- Referral plans and protocols established within and between facilities
- Share information about woman's situation and treatment with referral hospital, and then hospital reports back on her care

Ask participants to turn to Appendix D in the Uterine Evacuation Procedure With Ipas MVA Plus module of the Reference Manual for a sample referral form.

How does this form compare with the one used at your facility?

- Discuss responses.
- Discuss important components of a referral form.
- Suggest that participants might want to modify their facility's referral form to include these components.

Show slide: *How Communities Can Assist With Referral*

- Consider all resources available for help.
- Police cars, religious or agency vehicles, and taxis can provide transport.
- Plan ahead.
- Local contacts can act as referral agents.

Show slide: *Transport to Medical Facility*

Show slide: *Information Sharing*

Providers should call the referral hospital to tell them:

- That the woman is being transported
- Why she is being referred
- Her history
- What measures have already been taken

- Her current condition

Show slide: *Practicing for Emergencies*

On a routine basis, facility staff should review and practice how to:

- Treat hemorrhage and shock
- Start intravenous fluids
- Give oxygen (if available)
- Provide cardiopulmonary resuscitation

Say: Facility staff need to know their roles and protocols in an emergency.

Show slide: *Supplies for Emergencies*

- Facility should have a container with emergency medicines and supplies
- Check stock and expirations on a monthly basis

Say: The container or cart should only be used in emergencies, so that supplies are there when an emergency arises.

Show slide: *Links to Communities*

Providers and facilities can work with community members and groups to:

- Recognize signs and symptoms of abortion complications
- Know how and where to receive emergency care
- Prevent delays in transporting women to emergency health services
- Refer women to emergency services, follow up after care and link women to other reproductive health services

Say: Now we're going to talk briefly about care after treatment for abortion complications.

8. Post-procedure care

Show and discuss slide: *Care After Treatment for Abortion Complications*

The woman must be:

- Physically monitored
- Emotionally supported
- Provided verbal and printed information about:
 - Her condition, including long-term changes
 - Use of medications
 - Contraceptive methods

- Follow-up care
- What to expect, and what to do if emergency care is needed

Say: Information on her condition should include counseling about any long-term changes resulting from the complications, such as hysterectomy or bowel perforation repair.

Printed information may be written or illustrated depending on her needs.

Ask if participants have any questions about post-procedure care following complications.

Say: Now we're going to discuss monitoring serious adverse events and how to learn from them when they occur.

9. Serious adverse event monitoring

Show slide: *Adverse Events*

- Complications that a patient suffers during treatment that are not a result of her presenting condition
- Estimated one in 10 patients in the hospital for any reason suffers some adverse event
- Rare in routine abortion-related and contraceptive care
- Serious adverse events result in life-threatening injury or death

Show slide: *Types of Adverse Events*

- Adverse event (AE)/complication – problem requiring intervention or management beyond what is normally necessary for a procedure or anesthesia
- Serious adverse event (SAE) – results in death, life-threatening injury, permanent impairment, or requires medical or surgical intervention to prevent permanent impairment
- Near miss – has potential to harm a patient but does not due to chance, prevention or mitigation

As you discuss each type, ask a participant to briefly share an abortion-related experience they had with each one.

Show slide: *Examples of Adverse Events*

Table 14A-3: Examples of complications/Serious Adverse Events (SAEs)	
Vacuum aspiration	Medical abortion
Perforation treated conservatively or requiring surgery	Unplanned aspiration (for example, for heavy bleeding or pain)
Anesthesia-related complication requiring hospitalization or causing seizures	Reactions to medications requiring emergency treatment
Bleeding requiring a blood transfusion	Bleeding requiring a blood transfusion
Infection requiring intravenous antibiotics and/or hospital admission	Infection requiring intravenous antibiotics and/or hospital admission
Unintended intra-abdominal surgery	Unintended intra-abdominal surgery
Ongoing pregnancy	Ongoing pregnancy
Ectopic pregnancy unrecognized at time of procedure	Ectopic pregnancy unrecognized when medical abortion given
Death	Death

Show and discuss slide: *Why Adverse Events Occur*

- Rarely due to a single person or event
- Rather, usually result from a combination of:
 - Client factors
 - Human error
 - Institutional error

Ask participants to provide examples of client factors and human and institutional errors.

Take a few responses. Make sure that client factors include:

- High gestational age
- Obesity
- Altered uterine anatomy
- Complex medical problems.

Institutional error may include:

- Any time institutions do not adequately protect patient safety
- Lack of appropriate medications and supplies

Now we'll watch two skits and talk about how to establish a workplace culture that is conducive to reporting and learning from adverse events to maintain safety.

Have participants perform the two serious adverse events skits and then, in a large group, discuss the differences between a “blame culture” and a “safety culture” in relation to serious adverse events.

Show slide: *Safety Depends On*



- Just culture: human actions are judged fairly and viewed within the complexity of the system factors
- Reporting culture: staff feel safe from retribution and report information about safety concerns even when it involves human error
- Learning culture: when active improvement efforts are directed at system redesign

Show slide: *Adverse Event Reporting*

Once the woman has been cared for, the event should be:

- Documented – complete information in the woman’s chart and facility logbook
- Reported – to local authorities according to established guidelines
- Analyzed – so that the experience can be used to improve care

Open dialogue should be encouraged by all people involved in the adverse event including the providers, other health workers, administrators, clients and their family (with clients’ consent). When adverse events occur, facility staff can hold discussions with family and community members to prevent misunderstandings and even potential threats. This must be done in ways that respect women’s right to confidentiality and privacy. The goal is to see where the system failed and to improve the system so that in the future, the same adverse event does not recur.

Show slide: *Root Cause Analysis*

Root cause analysis is a technique for learning from AEs

- Team discussion with all relevant staff members

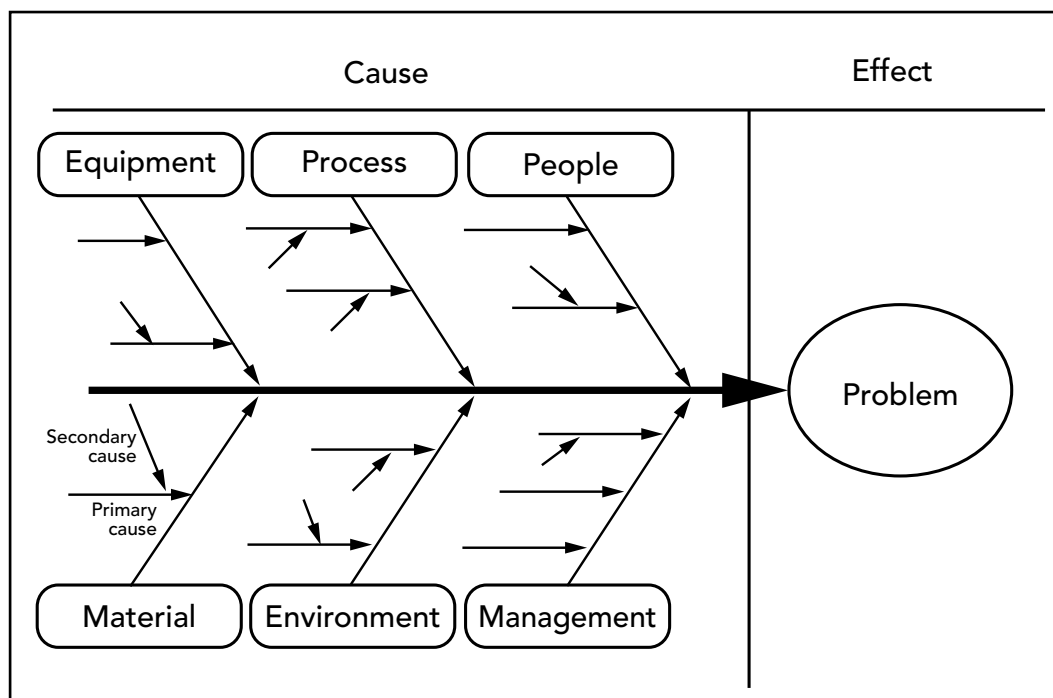
- Non-punitive discussion conducted in a spirit of learning

Ask:

- What happened?
- Why did it happen?
- What can be changed to prevent similar events in the future?

There are different techniques for conducting a root cause analysis. Three techniques we will briefly discuss here include: Fishbone Diagram, The Five Whys and Problem Tree Analysis.

Show and discuss slide: *Fishbone Diagram*



- Include the following points in your discussion:
 - Write the problem in a box on the right-hand side of the page.
 - Draw a horizontal line to the left of the problem.
 - Decide on the categories of causes for the problem. Useful categories of causes in a classic fishbone diagram include People, Processes, Equipment and Materials, Environment and Management. Another way to think of categories is in terms of causes at each major step in the process.
 - Draw diagonal lines above and below the horizontal line (these are the “fishbones”), and label with the categories you have chosen.
 - Generate a list of causes for each category.
 - List the causes on each fishbone, drawing branch bones to show relationships among the causes.

- Develop the causes by asking “Why?” until you have reached a useful level of detail—that is, when the cause is specific enough to be able to test a change and measure its effects.

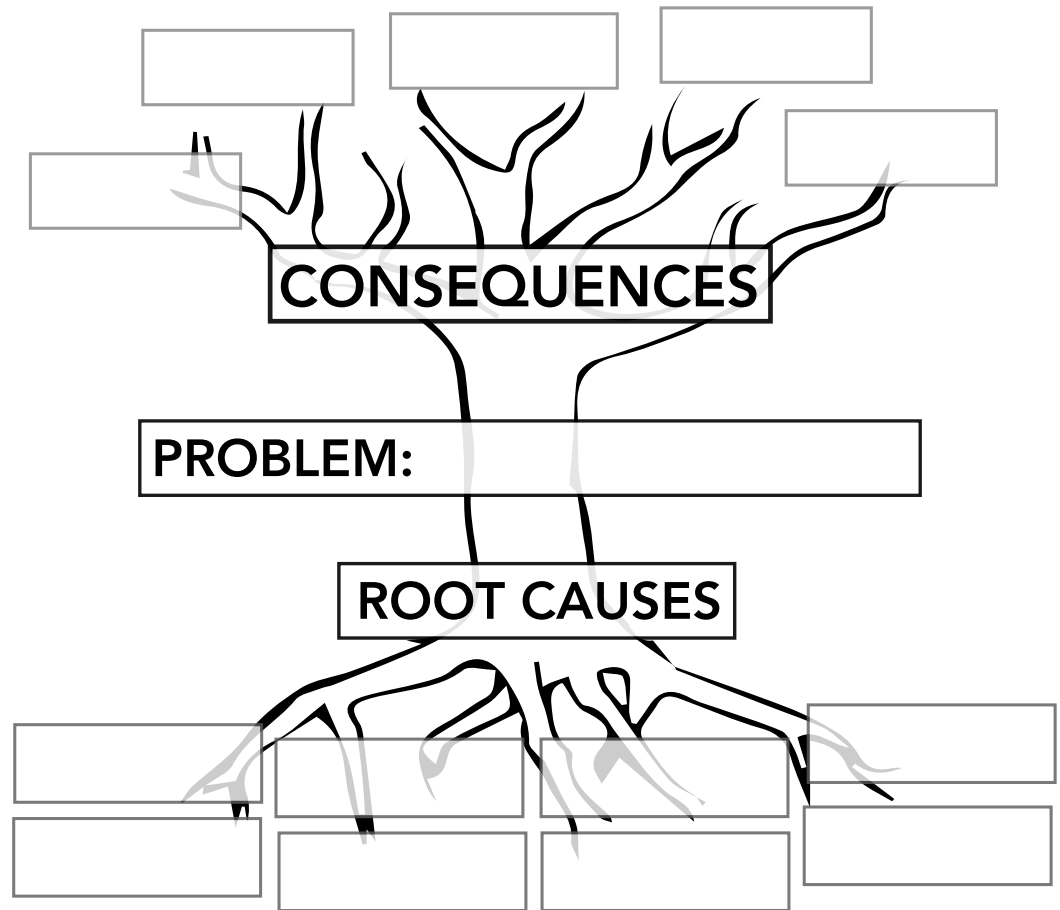
Show and discuss slide: *The Five Whys*



- Include the following points in your discussion:
 - By repeatedly asking the question “Why?” (use five as an average), we can peel away the layers of a problem, just like the layers of an onion, which can lead us to the root cause of a problem.
 - We need to avoid assumptions and logic traps (errors in our thinking) that can lead us astray, and instead continue to drill down to the real root causes.
 - Steps to use the Five Whys:
 1. Write down the specific problem. Writing it down helps you formalize the problem and describe it accurately. It also helps a team focus on the same problem
 2. Use brainstorming to consider why the problem might be occurring. Some basic rules of brainstorming include:
 - All ideas are acceptable; judgment is ruled out until the process is complete.
 - Freewheeling is welcome: the wilder the better. Humor triggers the right brain and helps get original ideas flowing.
 - Quantity counts at this stage, not quality.
 - Build on the ideas put forward by others.
 - Every person and every idea has equal worth.
 3. Select the most likely reason for the problem and write it down.
 4. If this doesn't identify the root cause of the problem, ask “Why?” again and write that answer down.

5. Continue to ask and answer “Why?” until the team agrees that they have identified the problem’s root cause. This may take less or more than five “Whys?”

Show and discuss slide: *Problem Tree Analysis*



- Include the following points in your discussion:
 - Problem tree analysis is best carried out in a small focus group of about six to eight people using flip chart paper or an overhead transparency.
 - The first step is to discuss and agree on the problem or issue to be analyzed. Do not worry if it seems like a broad topic because the problem tree will help break it down. The problem or issue is written in the center of the flip chart and becomes the trunk of the tree.
 - Next, the group identifies the causes of the problem, which are drawn as the roots, and then identifies the consequences, which become the branches. These causes and consequences can be created on post-it notes or cards, perhaps individually or in pairs, so that they can be arranged in a cause-and-effect logic.
 - The heart of the exercise is the discussion, debate and dialogue that is generated as factors are arranged and re-arranged, often

forming sub-dividing roots and branches. Take time to allow people to explain their feelings and reasoning, and record related ideas and points that come up on separate flip chart paper under titles such as solutions, concerns and decisions.

- Discuss this example of Root Cause Analysis:
 - Why did perforation occur? The doctor perforated the uterus.
 - Why did the doctor perforate the uterus? The doctor used a cannula that was too small.
 - Why did the doctor use the cannula that was too small? All of the larger cannula had been used the day before and had not been cleaned and sterilized.
 - Why hadn't the cannula been cleaned and sterilized? The one staff member trained and responsible for instrument processing was away on family leave.
 - Action to prevent this from happening in the future: Cross-train other staff on instrument processing and assign instrument processing duty based on staffing schedule.

For more information on root cause analysis, please refer to Additional Resources.

10. Diagnosis and management of complications case study role plays

Say: We have discussed the signs, symptoms, causes and management of complications seen in abortion-related care. Now we will practice recognizing and managing these conditions, either by providing definitive treatment or making a referral.

Note to Trainer: Do not move to the next slide yet, as it reveals the diagnosis for Case Study #1.

Provide activity instructions and then divide participants into small groups.

- Give each group the case study role play scenarios, worksheet and a Management of Complications Skills Checklist.
- Assign each group a case study.
- Ask groups to role play—with one participant playing the role of client and one playing the role of provider—the diagnosis of the complications described in their assigned case studies. In some case studies, additional information is given by a third person at some point in the scene. The person playing the role of the provider should state what steps are being taken to diagnose and treat the complication, such as “I perform a pelvic exam” or “I apply silver nitrate.”
- Tell groups to have one person look at the appropriate section of

the Management of Complications Skills Checklist for each of their diagnoses to ensure that the provider takes the necessary steps to manage the complication. They should provide feedback to the provider after the role play.

- After each role play, participants should respond to questions on the worksheet about identifying aspects of emergency response that are important to handling this complication well, whether an adverse event occurred and what steps can be taken to prevent such events in the future.
- They will have 25 minutes to complete this activity.
- Have groups choose a reporter who will present their case, diagnosis and, if relevant, steps to prevent future similar adverse events and emergency response to the larger group.
- Advise participants to refer to the Reference Manual if needed.

After 25 minutes have passed, ask groups to begin the report-back and discussion.

- Use the Complications Management skills checklist as a key, and the worksheet as a guide.
- Starting with the first case study, each group reporter should:
 - Read aloud the case study and diagnosis.
 - Read the group's completed worksheet responses.
 - Discuss emergency response plan aspects that would improve the management of this complication.
 - Identify any adverse events and how to prevent future reoccurrences.
- Ask the reporter with Case Study #1 to report back to the large group.

Show slide: *Case Study #1: Treatment for Incomplete Abortion With Infection*

- Administer course of broad spectrum antibiotics. Dosage and route of administration vary depending on the severity of the infection.
- Evacuate or re-evacuate uterus.

Ask the reporter with Case Study #2 to report.

Show slide: *Case Study #2: Management of Uterine Atony*

- Perform uterine massage
- Administer uterotonics
- Perform vacuum aspiration
- Further intervention as required

Ask the reporter with Case Study #3 to report.

Show slide: *Case Study #3: Management of Hemorrhage*

- Provide supportive therapies as needed (oxygen, fluids and/or transfusion).
- Perform vacuum aspiration.
- Provide referral and transportation for treatment, if necessary.

Ask the reporter with Case Study #4 to report.

Show slide: *Case Study #4: Management of Infection From Likely Retained Tissue in the Uterus*

- Start antibiotics.
- Perform vacuum aspiration if there are signs or symptoms of retained tissue.

Ask the reporter with Case Study #5 to report.

Show slide: *Case Study #5: Ectopic Pregnancy*

- For suspected ectopic pregnancy, treat or transfer as soon as possible to a facility that can confirm diagnosis and begin treatment.
- For ruptured ectopic pregnancy, provide or arrange for immediate surgical intervention.

Say: What questions do you have concerning the management of any of the complications that we have discussed?

- Answer questions and discuss.
- Give each participant a copy of the Complications Management skills checklist.
 - Tell them that these can be used when practicing the management of complications.
 - It also can be used for developing facility protocols for managing complications.

Say: What after-care needs to be offered for women who have experienced complications?

- Answers should reflect the following slide.

Show slide: *After-Care for Women With Complications*

- Physically and emotionally support and monitor the woman.
- Advise her about her condition and about medications, contraception and follow-up.
- Counsel her about any resulting long-term changes.
- Explain what to expect and what to do and not do in an emergency.
- Offer to give her written materials concerning her condition.

Advise the group that, to enhance their ability to effectively manage these complications, they can supplement this training with more in-depth

learning that may be available to them locally. Refer them to the Ipas Woman-Centered Postabortion Care: Reference Manual for more details on managing complications.

11. Summary and test

Ask participants for key points covered in this module. Use the objectives as a reference.

What questions do you have about anything discussed in this module?

- Answer questions.

Note to trainer: If participants have many questions, they may benefit from further training in the Complications: Postabortion Care module.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.
- Thank the participants for their participation.

References

- Achilles, S. L., & Reeves, M. F. (2011). Prevention of infection after induced abortion: Release date October 2010: SFP guideline 20102. *Contraception*, 83(4), 295-309.
- Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science*, 248(4951), 41-44.
- American Psychological Association, Task Force on Mental Health and Abortion. (2008). Report of the Task Force on Mental Health and Abortion. Washington, DC: Author. Retrieved from <http://www.apa.org/pi/wpo/mental-health-abortion-report.pdf>
- Atrash, H. K., Cheek, T. G., & Hogue, C. J. (1988). Legal abortion mortality and general anesthesia. *American Journal of Obstetrics and Gynecology*, 158(2), 420-424.
- Chen, B. A., & Creinin, M. D. (2007). Contemporary management of early pregnancy failure. *Clinical Obstetrics and Gynecology*, 50(1), 67-88.
- Cleland, K., Creinin, M. D., Nucatola, D., Nshom, M., & Trussell, J. (2013). Significant adverse events and outcomes after medical abortion. *Obstetrics and Gynecology*, 121(1), 166-171.
- Committee on Gynecologic Practice. (2009). ACOG Committee Opinion No. 434: Induced abortion and breast cancer risk. *Obstetrics and Gynecology*, 113(6), 1417-1418.
- Copeland, L. J., Jarrell, J. F., & Dodson, R. (2000). *Textbook of gynecology* (Second ed.). Philadelphia: W. B. Saunders.
- Creinin, M.D., Schwartz, J. L., Guido, R.S., & Pymar, H.C. (2001). Early pregnancy failure: Current management concepts. *Obstetrical and Gynecological Survey*, 56(2), 105-113.
- Davey, A. (2006). Mifepristone and prostaglandin for termination of pregnancy: Contraindications for use, reasons and rationale. *Contraception*, 74(1), 16-20.
- Goldstone, P., Michelson, J., & Williamson, E. (2012). Early medical abortion using low-dose mifepristone followed by buccal misoprostol: A large Australian observational study. *Medical Journal Australia*, 197(5), 282-286.
- Hakim-Elahi, E., Tovell, H. M., & Burnhill, M. S. (1990). Complications of first-trimester abortion: A report of 170,000 cases. *Obstetrics and Gynecology*, 76(1), 129-135.
- Ipas. (2009). *Uterine evacuation with manual vacuum aspiration (MVA): A training manual for conducting short courses*. Chapel Hill: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Kaunitz, A. M., Rovira, E. Z., Grimes, D. A., & Schulz, K. F. (1985). Abortions that fail. *Obstetrics and Gynecology*, 66(4), 533-537.
- Lichtenberg, E. S. & Grimes, D. A. (2009). Surgical complications: Prevention and management. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield & M. D. Creinin (Eds.), *Management of unintended and abnormal pregnancy: Comprehensive abortion care*. Oxford: Wiley-Blackwell.
- March, C. M. (2011). Asherman's syndrome. *Seminars in Reproductive Medicine*, 29(2), 83-94.
- National Cancer Institute. (2010). *Summary report: Early reproductive events and breast cancer workshop*.
- Policar, M. S., Pollack, A. E., Nicholas, C., & Dudley, S. (1999). *Principles of abortion care: A curriculum for physician assistants and advanced practice nurses*. Washington, DC: National Abortion Federation.

Royal College of Obstetrics and Gynecology. (2011). *The care of women requesting induced abortion: Evidence-based guideline no. 7*. London: RCOG Press.

Solter, C., Miller, S., & Gutierrez, M. (2000). Module 11: Manual Vacuum Aspiration (MVA) For Treatment of Incomplete Abortion *Comprehensive Reproductive Health and Family Planning Curriculum*. Watertown, MA: Pathfinder International.

Stewart, F. H., Wells, E. S., Flinn, S. K., & Weitz, T. A. (2001). *Early Medical Abortion: Issues for Practice*. San Francisco, California: UCSF Center for Reproductive Health Research & Policy.

Thonneau, P., Fougereyrollas, B., Ducot, B., Boubilley, D., Dif, J., Lalande, M., et al. (1998). Complications of abortion performed under local anesthesia. *European Journal Obstetrics Gynecology Reproductive Biology*, 81(1), 59-63.

Von Hertzen, H., Piaggio, G., Huong, N. T., Arustamyan, K., Cabezas, E., Gomez, M., & Peregoudov, A. (2007). Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: A randomised controlled equivalence trial. *Lancet*, 369(9577), 1938-1946.

World Health Organization. (1994). *Clinical management of abortion complications: A practical guide*. Geneva, Switzerland: World Health Organization.

World Health Organization. (1995). *Complications of abortion: Technical and managerial guidelines for prevention and treatment*

World Health Organization. (2007). *Integrated management of pregnancy and childbirth (IMPAC). Managing complications in pregnancy and childbirth: A guide for midwives and doctors*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2009). *World Health Organization's guidelines for the management of postpartum hemorrhage and retained placenta*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems* (Second ed.). Geneva, Switzerland: World Health Organization.

World Health Organization. (2012). *World Health Organization's recommendations for the prevention and treatment of postpartum hemorrhage*. Geneva, Switzerland: World Health Organization.

Knowledge Test Key

1. a
2. d
3. d
4. c
5. c
6. d
7. a
8. b
9. a
10. d

Complications Knowledge Test

Circle the correct response.

1. Uterine evacuation procedures result in immediate and long-term complications when performed by trained providers:
 - a. Rarely, but complications can include infection and/or retained POC
 - b. Quite often
 - c. Such as breast cancer and infertility
 - d. b & c

2. Managing complications does not entail:
 - a. Staff knowing how to recognize a complication
 - b. Staff knowing how to treat a complication
 - c. Referral for conditions that cannot be fully treated onsite
 - d. Fully treating onsite all complications that occur

3. Incomplete abortion:
 - a. Is indicated by vaginal bleeding and pain
 - b. Can lead to infection
 - c. Is treatable by vacuum aspiration
 - d. All of the above

4. Continuing pregnancy:
 - a. Is suggested by a lack of vaginal bleeding, persistent pregnancy symptoms and/or increasing uterine size after medical abortion
 - b. Risk after vacuum aspiration can be decreased by examining the aspirate immediately after the procedure
 - c. Both a & b
 - d. Is caused by dilatation and curettage (D&C)

5. A condition that occurs when the uterus cannot contract to stop bleeding is:
 - a. Disseminated intravascular coagulopathy (DIC)
 - b. Asherman Syndrome
 - c. Uterine atony
 - d. Hematometra

6. The causes of medication-related complications can include:

- a. Overdosage
- b. Incorrect injection into a vessel
- c. Hypersensitivity
- d. All of the above

7. Complications of uterine evacuation with medical methods include:

- a. Severe and prolonged bleeding, continuing pregnancy
- b. Severe headaches, dizziness
- c. Brief fainting spells
- d. Hematometra

8. A vasovagal reaction:

- a. Is the same as physiological shock
- b. Usually resolves itself and is not life-threatening
- c. Indicates uterine perforation
- d. Must be treated surgically

9. Facilities should refer women with complications to another facility if:

- a. They cannot fully treat her onsite
- b. She cannot pay at the current facility
- c. She has a high fever
- d. She has injury to the uterus, vagina or bowel

10. After-care for women with complications includes providing:

- a. Close monitoring
- b. Information about follow-up
- c. Counseling on medical and emotional consequences
- d. All of the above

Serious Adverse Events Skits

Have participants perform the two skits below and then, in a large group, discuss the differences between a “blame culture” and a “safety culture” in relation to serious adverse events.

Clinic #1

Supervisor (looking around the room in an alarmed manner): What happened here?

Staff (pointing at the provider): S/he caused the perforation!

Supervisor (speaking in an accusing tone of voice): Why did you perforate that woman's uterus? Why weren't you more careful? Didn't you learn anything at that training we sent you to? I hope you haven't reported it yet. This will make us look really bad at our annual review!

Provider: Well, I am feeling really terrible about this. I was doing what I was trained to do...

Supervisor (sharply interrupting the provider): I don't want to hear your excuses. Never mind... you're clearly incompetent. We'll just have to transfer you to some little town where we won't have to worry about you.

Clinic #2

Supervisor (looking directly at the provider and speaking in a calm tone of voice): I understand there was a uterine perforation during your procedure this morning. How is the woman doing?

Provider: Yes, there was. Thankfully, it seems to be a minor perforation, and the woman is doing well. We think it should heal fine on its own without any further procedures.

Supervisor: I'm glad to hear that the woman is improving. Please tell me what happened and what may have contributed to the perforation.

Provider: Well, I had already started the procedure when I realized that I was going to need a larger cannula size. When I asked for the larger size, my assistant informed me that we only had one of each size, and unfortunately, the larger sizes had been used earlier and had not yet been cleaned and high-level disinfected. So I proceeded to use the smaller size, but of course, I had to make many more passes with the smaller cannula to complete the procedure. I tried to be careful, but I guess I was not careful enough.

Supervisor: I see. Well, we've heard of this happening before. It sounds like there may be a variety of causes for this adverse event, including instrument supply, processing schedules, preparation before the procedure, etc. Let's gather the whole clinic team and think together about some ideas that may help prevent this from happening again. We can also begin the reporting process for your facility.

Supervisor: That sounds good. I really appreciate this support and the chance to think about ways that the team and I can improve the quality of our services.

Mentor: Good. And when we're finished with the team meeting, I would like to talk privately with you more about how you're feeling about this.

Case Study Role Play Scenarios for Complications: Comprehensive Abortion Care

Note: The person playing the provider should not see the case study.

Case Study #1

A young woman had a vacuum aspiration two days ago. She returned to the clinic because she has heavy vaginal bleeding, some abdominal pain and a fever. The nurse remembers that when her MVA procedure was performed, the amount of tissue evacuated seemed less than expected, but didn't say anything at the time because the provider performing the MVA seemed to think that the procedure went smoothly. In addition, tissue inspection is not routinely done at this facility.

Case Study #2

An older woman who has four children came to the clinic for a uterine evacuation at 11 weeks LMP. Immediately following the vacuum aspiration procedure, she has copious vaginal bleeding. Her uterus is found upon exam to be large and soft.

Case Study #3

A young woman who had a uterine evacuation with medical methods has returned urgently to the facility a few weeks later. She has experienced heavy bleeding for the last week. Today her bleeding is abnormally heavy and she is feeling weak and dizzy. She reports no pain and no fever.

Case Study #4

A week after taking misoprostol for uterine evacuation, a woman returned to the clinic feeling very sick, with fever, persistent abdominal pain and vaginal bleeding. It is noted upon exam that her uterus is tender and there is no tissue visible at the os.

Case Study #5

A 35-year-old woman, approximately eight weeks pregnant as indicated by LMP, was having some spotting. On pelvic exam, the provider found a retroverted uterus approximately six-to-eight-week size and speculum exam showed a closed cervical os with no blood. She had no uterine or pelvic tenderness. She does not want to keep the pregnancy and so went home with the medications and instructions for a medical abortion. She returned to the clinic after three days, having had very little bleeding after taking the medicines, continuing to feel pregnant, and having some sharp left lower abdominal pain, but not like menstrual pain. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at the facility.

Case Studies for Complications: Comprehensive Abortion Care

Instructions: Discuss your assigned case study and complete the following worksheet questions.

1. Diagnosis

2. Steps to manage

3. Important emergency response aspects

4. Is this an adverse event?

5. If this is an adverse event:

a. What happened?

b. Why did it happen?

c. What might be changed to prevent similar events in the future?

Complications Case Studies Comprehensive Abortion Care Answer Key

Case Study #1

1. Case info - A young woman had a vacuum aspiration two days ago. She returned to the clinic because she has heavy vaginal bleeding, some abdominal pain and a fever. The nurse remembers that when her MVA procedure was performed, the amount of tissue evacuated seemed less than expected, but didn't say anything at the time because the provider performing the MVA seemed to think that the procedure went smoothly. In addition, tissue inspection is not routinely done at this facility.
2. Diagnosis - Incomplete abortion with infection
3. Steps to manage - Administer course of broad spectrum antibiotics (dosage and route of administration vary depending on the severity of the infection). Then evacuate or re-evacuate uterus.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? – Yes
6. If yes...
 - a. What happened? - The procedure was incomplete, which led to an infection.
 - b. Why did it happen? - The nurse didn't speak up when she had concerns, and no tissue inspection was performed which would have identified the issue.
7. What might be changed to prevent similar events in the future? - Changes could be that this is discussed and all team members are encouraged to speak up with concerns about any procedure at the time it is happening, and clinic protocol should be reviewed to be sure tissue inspection is part of every procedure, equipment is available, and all are aware of it and how to do it.

Case Study #2

1. Case info - an older woman who has four children came to the clinic for a uterine evacuation at 11 weeks LMP. Immediately following the vacuum aspiration procedure, she has copious vaginal bleeding. Her uterus is found upon exam to be large and soft.
2. Diagnosis - Uterine atony
3. Steps to manage - Perform uterine massage. Administer uterotonics. Perform vacuum aspiration. Perform or refer for further intervention (intrauterine tamponade or hysterectomy) as required.

4. Important emergency response aspects - Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? – No, as nothing in the procedure contributed to the uterine atony.

Case Study #3

1. Case info – A young woman who had a uterine evacuation with medical methods has returned urgently to the facility a few weeks later. She has experienced heavy bleeding for the last week. Today her bleeding is abnormally heavy and she is feeling weak and dizzy. She reports no pain and no fever.
2. Diagnosis – Hemorrhage
3. Steps to manage - Provide supportive therapies as needed (oxygen, fluids and/or transfusion). Perform vacuum aspiration. Provide referral and transportation for treatment, if necessary.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? – Yes, since “unplanned aspiration” after MA and “bleeding requiring transfusion” are considered complications.
6. If yes...
 - a. What happened? – The medical abortion regimen given to her failed.
 - b. Why did it happen? – This is uncertain, but medical abortion does not work for a small percentage of women who take it. Or there may have been an error in dosage or the information provided to the woman.
7. What might be changed to prevent similar events in the future? - The team could review the information provided to women after MA to be sure the guidance on warning signs and when to call or return to the clinic with concerns or complications is clear; additionally, they could talk with the woman to better understand if there were any other barriers to her returning sooner that are related to the facility and their services that they could address. The team may also want to verify that the regimen being used is correct and MA medications are not expired and are stored as recommended.

Case Study #4

1. Case info – A week after taking misoprostol for uterine evacuation, a woman returned to the clinic feeling very sick, with fever, persistent abdominal pain and vaginal bleeding. It is noted upon exam that her uterus is tender and there is no tissue visible at the os.
2. Diagnosis - Infection from likely retained tissue in the uterus
3. Steps to manage - Start antibiotics. Perform vacuum aspiration if there are signs or symptoms of retained tissue.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? – Yes, since an unplanned aspiration was required.
6. If yes...
 - a. What happened? – The medical abortion regimen given to her failed, leading to retained tissue and infection.
 - b. Why did it happen? – This is uncertain, but medical abortion does not work for a small percentage of women who take it. Or there may have been an error in dosage or the information provided to the woman.
7. What might be changed to prevent similar events in the future? - Team might want to review the MA regimen to be sure it is being given correctly and the information provided to women to be sure it is understandable. This could be an event without any “error” or barrier that leads to the AE, but can be used as an opportunity to review information, systems and processes to be sure that all are as good as they can be.

Case Study #5

1. Case info - A 35-year-old woman, approximately eight weeks pregnant as indicated by LMP, was having some spotting. On pelvic exam, the provider found a retroverted uterus approximately six-to-eight-week size and speculum exam showed a closed cervical os with no blood. She had no uterine or pelvic tenderness. She does not want to keep the pregnancy and so went home with the medications and instructions for a medical abortion. She returned to the clinic after three days, having had very little bleeding after taking the medicines, continuing to feel pregnant, and having some sharp left lower abdominal pain, but not like menstrual pain. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at your facility.

2. Diagnosis – Ectopic pregnancy
3. Steps to manage – For suspected ectopic pregnancy, treat or transfer as soon as possible to a facility that can confirm diagnosis and begin treatment. For ruptured ectopic pregnancy, provide or arrange for immediate surgical intervention.
4. Important emergency response aspects - Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? – Yes, unrecognized ectopic pregnancy when MA is given is considered an adverse event.
6. If yes...
 - a. What happened? – The provider failed to diagnose an ectopic pregnancy.
 - b. Why did it happen? - The woman's retroverted uterus made it more difficult to assess the uterine size. This in addition to the slight discrepancy between LMP (eight weeks) and uterine size (six to eight weeks) should have triggered some uncertainty and suggested assistance in diagnosis.
7. What might be changed to prevent similar events in the future? - Clinic protocol could be amended to provide for a routine assessment by a second provider and/or ultrasound (where available) in all cases with such uncertainty.

Management of Complications (CAC) Skills Checklist

Skill	Yes	No	Comments
Incomplete abortion or infection			
Administers antibiotics as indicated			
Performs uterine evacuation as indicated			
Continuing pregnancy			
Performs uterine evacuation with vacuum aspiration			
Hemorrhage			
Gives supportive therapy including oxygen, IV fluid and blood transfusion as indicated			
Evaluates for presence of incomplete abortion, uterine atony, laceration or perforation			
Provides appropriate therapy (see steps below)			
Uterine atony			
Begins with bimanual massage			
Gives uterotonics			
Performs uterine aspiration			
Performs intrauterine tamponade			
Performs or refers for hysterectomy if bleeding cannot be stopped by other measures			
Ectopic pregnancy			
Recognizes and treats or refers suspected ectopic pregnancy			
Cervical or vaginal lacerations			
Applies silver nitrate or applies pressure by clamping ring forceps for minor lacerations			
Applies sutures as needed			

(continued on pages 359 - 360)

Management of Complications (CAC) Skills Checklist

Skill (continued)	Yes	No	Comments
Uterine perforation			
Admit and observe if perforation occurred during the UE, woman is stable and there are no other injuries			
Laparotomy or laparoscopy to diagnose and manage if the woman is unstable and/or there are signs of intra-abdominal injury			
Stabilize and transfer if facility cannot manage the complication			
Medication-related complication			
Treats as indicated for allergic reactions or overdose			
Hematometra			
Performs uterine aspiration			
Vasovagal reaction			
Treats with positioning			
Atropine injection if prolonged			
Failed medical abortion			
Performs uterine aspiration as indicated			
Persistent pain			
Performs evaluation for retained products, ectopic pregnancy or infection			
Removes tissue trapped at the cervical os			
Offers adequate pain management or refers for further evaluation			
Postabortion care			
Perform rapid initial assessment for shock			
Shock management			
Performs secondary assessment (bimanual and speculum exam) for underlying causes of shock, e.g., incomplete abortion, cervical or vaginal laceration, uterine perforation, uterine atony, infection or sepsis			
Treat underlying causes of shock			

Management of (CAC) Complications Skills Checklist

Skill (continued)	Yes	No	Comments
Emergency response			
Has a 24-hour emergency response plan in place			
Has a referral plan for complicated patients			
Gives adequate post-procedure care			
Has a plan for monitoring and evaluating adverse events			

Complications: Postabortion Care

Note: If you are using Woman-Centered Postabortion Care: Reference Manual or require training on diagnosis and management of presenting complications, use this module. The Complications: Comprehensive Abortion Care module contains more information on the diagnosis and management of procedural complications related to vacuum aspiration and uterine evacuation with medical methods. If participants are using the Woman-Centered, Comprehensive Abortion Care: Reference Manual, please give them copies of the Complications module of Woman-Centered Postabortion Care: Reference Manual.



Purpose

This module prepares participants to identify and manage presenting severe complications seen in women who require postabortion care.



Prerequisites

Participants should already be able to:

- ☐ Describe the key concepts of woman-centered postabortion care
- ☐ Describe a woman's rights in the abortion-care setting
- ☐ Describe methods for evacuating the uterus
- ☐ Implement infection-prevention techniques
- ☐ Perform a complete clinical assessment
- ☐ Diagnose and manage life-threatening gynecological conditions

Objectives



By the end of this module, participants should be able to:

1. Identify signs and symptoms of severe abortion-related complications
2. Identify signs and symptoms of shock and manage appropriately
3. Identify steps to diagnosis, manage or refer complications
4. Describe after-care for women with complications
5. Explain learning from adverse events



Materials

- ☐ Serious Adverse Events Skits scripts
- ☐ Case Studies Role Play Scenarios for Complications: Postabortion Care
- ☐ Case Studies for Complications: Postabortion Care Worksheet

- ☐ Complications Case Studies (PAC) Answer Key
- ☐ Management of Complications (PAC) Skills Checklist
- ☐ Knowledge Test and Test Key



Advance preparation

- ☐ Be familiar with local referral processes.
- ☐ Duplicate case study role plays, handout, worksheet and skills checklist.
- ☐ Duplicate Knowledge Test.

Time: 1 hour, 45 minutes

1. Introduction

Greet the participants. Introduce yourself and the module.

Show slide: *Purpose*

This module prepares participants to identify and manage presenting severe complications seen in women who require postabortion care.

Say: We will look first at the signs, symptoms and causes of severe complications, and then at steps for managing them.

Show slide: *Objectives*

1. Identify signs and symptoms of severe abortion-related complications
2. Identify signs and symptoms of shock and manage appropriately
3. Identify steps to diagnose, manage or refer complications
4. Describe after-care for women with complications
5. Explain learning from adverse events

Say: This module addresses severe complications that may occur before, during or after uterine evacuation. When a woman presents for postabortion care, it is essential to assess her health and condition immediately. Pain management is an essential part of management of complications.

Show and discuss slide: *Causes of Complications in Postabortion Care*

- Abortion-related injury
- Incomplete uterine evacuation
- Infection

Say: How should informed consent be handled if the woman needs emergency care?

- Ensure that responses include: when a woman presents with a life-threatening emergency, complete clinical assessment and voluntary informed consent may be deferred until actions have been taken to

save the woman's life.

Say: With which severe complications may women present?

- Ensure that responses include: shock, hemorrhage, sepsis and intra-abdominal injury.

Show slide: *Possible Presenting Severe Complications*

- Shock
- Hemorrhage
- Sepsis
- Intra-abdominal injury

Say: Shock can develop in any patient at any time during postabortion care and requires immediate action.

2. Types of complications

Show and discuss slide: *Types of Complications*

- Presenting
- Procedural
- Pregnancy-related
- Ensure that the following information is covered:
 - Complications may develop individually or several at the same time.
 - Presenting complications exist when the woman arrives at the clinic.
 - Procedural complications occur during provision of uterine evacuation, during the recovery period or later and are rare when uterine evacuation is performed by a trained provider.
 - Pregnancy-related or gynecological complications may require specific clinical consideration and management.
 - Pregnancy-related conditions may be discovered during the clinical assessment or may not become evident until during or after the uterine evacuation.
 - Most women who present for postabortion care are stable and need routine management, but some may present in distress and need urgent treatment.
- Refer participants to the Clinical Assessment module for more information on assessing presenting and pregnancy-related complications.

Show and discuss slide: *Assessment and Management of Complications*

The provider offering postabortion care needs to:

- Do rapid initial assessment and management of shock
- Continually assess the woman for complications
- Manage complications by providing pain management, then treating immediately or stabilizing and referring

Say: What is the first step in providing care to a woman presenting for postabortion care?

- Ensure that responses include: perform a rapid initial assessment and obtain voluntary informed consent if possible.
- Note that a clinical assessment should be done as the provider begins to treat the complications.

Say: Now we will discuss how to identify and manage complications.

3. Rapid initial assessment and management of shock

Say: Recognizing shock is the first step in providing care to a woman who has told you or who you believe requires postabortion care. Although most women presenting for postabortion care are ambulatory and do not need emergency treatment, some require emergency care and shock must be addressed immediately.

To check for shock, use your ABCs.

Show and discuss slide: *The “ABC” Signs*

Any member of the facility staff can quickly check:

- Airway
- Breathing
- Circulation
- Consciousness
- Convulsions (whether she’s having them)

to identify if she needs urgent care.

- Ask participants to identify some signs of shock. Take a few answers and then show slide.

Show and discuss slide: *Signs of Shock*

- Low blood pressure (SBP <90mm HG)
- Fast pulse
- Pallor or cold extremities
- Decreased capillary refill
- Dizziness or inability to stand
- Low urine output (<30ml per hour)
- Difficulty breathing

- Impaired consciousness, lethargy, agitation, confusion

Say: Shock can develop at any time during postabortion care, especially if underlying injuries were not detected during the initial assessment. Once shock is stabilized, it will be necessary to determine the underlying cause of shock. Shock in postabortion care patients is usually either hemorrhagic or septic.

- Ask participants how to stabilize for shock. (*Note to Trainers: this is not covered in depth in Woman-Centered, Comprehensive Abortion Care: Reference Manual but is in Woman-Centered Postabortion Care: Reference Manual. Participants may be relying on other clinical training for these responses*).
 - Answers should include: Ensure that airway is open; Elevate the legs; Give oxygen; Give rapid bolus crystalloid (LR or NS); Give second liter if vital signs remain abnormal; Transfuse if vital signs remain unstable; Keep warm; Place urinary catheter; Monitor fluid intake and output including ongoing blood loss; Get laboratory tests including blood type and crossmatch, hematocrit and hemoglobin, blood cultures and chemistry tests if available; Monitor and record vital signs every 15 minutes; Prepare for emergency transfer if woman cannot be treated in the facility.

Show and discuss slide: *Stabilization for Shock*

- Ensure that airway is open - turn head to side to prevent aspiration
- Elevate the legs - to increase return of blood to the heart
- Give oxygen - five L/minute by mask or nasal cannula
- Give rapid bolus crystalloid (LR or NS) – by one or two large bore IVs, one liter then reassess
- Give second liter - if vital signs remain abnormal
- Transfuse - if vital signs remain unstable after two liters IV fluid

Show and discuss slide: *Stabilization for Shock (cont.)*

- Keep warm
- Place urinary catheter
- Monitor fluid intake and output - including ongoing blood loss
- Get laboratory tests - blood type and crossmatch, hematocrit and hemoglobin, blood cultures and chemistry tests if available
- Monitor and record vital signs - every 15 minutes
- Prepare for emergency transfer if woman cannot be treated in the facility

Say: Once shock is stabilized, identify and treat the underlying cause immediately. Now we will discuss how to do this.

4. Secondary assessment for underlying causes of shock

Say: In order to determine the underlying cause of shock, and identify other complications, the provider must now do a more complete but urgent clinical assessment.

Show and discuss slide: *Assessing Underlying Cause*

- Take history
 - From the woman if she is conscious, otherwise from anyone accompanying her
 - If possible determine: gestational age, type of abortion procedure
- Perform physical exam: vital signs, heart, lung, abdominal, pelvic exam
 - Abdominal distension, rigidity, guarding and rebound
 - Sources of bleeding during speculum exam
 - Size and consistency of uterus, cervical motion tenderness, uterine tenderness during bimanual exam

Show and discuss slide: *Physical Exam Considerations*

- Pelvic exam
 - Good positioning and lighting to identify and treat bleeding
 - Any instruments or anesthetics that may be needed are prepared and available
- Pain medication for women who are uncomfortable or may need a procedure
- Speculum exam
 - Repair any lacerations during the exam
 - Inspect cervical os and remove any visible products of conception with ring forceps

What are the usual causes of shock in postabortion care patients?

- Take two or three answers. Ensure that participants know that hemorrhage and infection/sepsis are the usual causes of shock in postabortion care patients

Show and discuss slide: *Hemorrhagic Shock*

Hemorrhagic shock is the result of severe blood loss, caused by:

- Incomplete abortion
- Uterine atony, or

- Laceration and/or perforation (intra-abdominal injury)

Show and discuss slide: *Septic Shock*

Septic shock is the end result of infection, caused by:

- Incomplete abortion
- Intra-uterine infection, or
- Intra-abdominal injury

Say: Now we will look at how to identify and treat specific complications.

5. Diagnosis and management of specific complications

Say: First we will discuss incomplete abortion.

Show and discuss slide: *Signs and Symptoms of Incomplete Abortion in PAC*

- Open os with products of conception visible and/or heavy bleeding
- The uterus may be enlarged, with or without tenderness

Say: After uterine evacuation, some tissue may remain in the uterus. Large amounts of retained tissue can result in heavy bleeding and infection if untreated.

Show and discuss slide: *Management of Incomplete Abortion*

- Manage shock as indicated.
- Make sure the woman has adequate pain control.
- Give prophylactic or therapeutic antibiotics as indicated.
- Provide uterine evacuation by one of these methods:
 - Vacuum aspiration if she has signs or symptoms of infection, heavy bleeding or shock
 - Misoprostol if no contraindications
 - Close monitoring until retained products are expelled if no contraindications

Say: Adequate pain control may include paracervical block and oral or IV pain medication as needed if uterine aspiration is indicated. Small amounts of retained tissue may pass spontaneously without requiring further intervention.

Ask for a participant who has treated a woman with cervical or vaginal lacerations to describe the woman's signs and symptoms.

Show and discuss slide: *Signs and Symptoms of Cervical or Vaginal Lacerations in PAC*

Presenting:

- Vaginal bleeding
- Lacerations visible on speculum exam

Ask the same participant to describe the treatment given to the woman mentioned.

Show and discuss slide: *Management of Lacerations*

- Ensure adequate pain control so extent of injury can be seen and repair is adequate.
- For minor lacerations:
 - Apply pressure over tear with ring forceps.
 - Apply silver nitrate.

Show and discuss slide: *Management of Lacerations (cont.)*

- For lacerations requiring repair by suturing:
 - Apply local anesthetic to repair site; sedation may assist with ease of repair.
 - Ensure proper positioning and lighting.
 - Apply antiseptic solution to cervix and vagina.
 - Grasp cervix gently with sponge or ring forceps.
 - Carefully inspect the entire cervix for more than one laceration.
 - Start at apex of tear, close tear with continuous absorbable suture.
 - Use ring forceps to gently bring apex down if exposure is difficult.
 - Repair with laparotomy any tear that has extended deeply beyond vaginal vault or continues bleeding after suturing.
 - Vaginal packing may be used for emergent treatment of bleeding.

Show and discuss slide: *Signs and Symptoms of Uterine Perforation in PAC*

Presenting:

- Woman reports a history of abortion with instrumentation
- Distended and/or rigid abdomen with rebound and/or guarding
- Signs or symptoms of sepsis and/or shock

During the aspiration procedure:

- Instruments pass further than expected
- Fat or bowel noted in the aspirate
- Aspirator vacuum decreases

- Woman has severe abdominal pain during or after procedure
- Sudden increase in bleeding or pain

Say: Uterine perforation can be life-threatening and prompt management is indicated because there is a high risk of infection and damage to other abdominal and pelvic organs (bowel, bladder and vessels). Bleeding may not be evident on pelvic exam but significant hemorrhage may be masked with intra-abdominal bleeding.

Show and discuss slide: *Management of Uterine Perforation in PAC*

- In all cases, shock management as indicated
- If the perforation occurred during an aspiration performed at this facility, the woman is stable, there are no signs of intra-abdominal injury and the evacuation is complete:
 - Admit woman and closely observe for signs and symptoms of intra-abdominal injury or hemorrhage. This is appropriate only if the perforation occurred during a uterine aspiration and the provider feels confident that there were no other injuries.

Show and discuss slide: *Management of Uterine Perforation in PAC (cont.)*

- If woman is unstable or has signs of intra-abdominal injury:
 - Laparotomy or laparoscopy to diagnose and manage, or
 - Stabilize and transfer her
- If evacuation is not complete:
 - Complete evacuation with laparotomy or laparoscopy and repair any damage, then inspect abdominal cavity carefully for injuries, or
 - If laparotomy/laparoscopy not available, prepare to transfer to higher-level facility

Say: If the uterus or cervix is beyond repair or bleeding cannot be controlled, a hysterectomy may be necessary.

Now we're going to discuss uterine atony.

Ask for a participant who has treated a woman with uterine atony to describe the woman's signs and symptoms.

Show and discuss slide: *Signs and Symptoms of Uterine Atony*

- Enlarged, soft boggy uterus
- Heavy bleeding
- May be secondary to incomplete abortion

Say: Uterine atony is a condition in which the uterus loses muscle tone and does not stop bleeding. Women with atony will bleed heavily. This complication is more common in women who have had several children or who are later in pregnancy. Atony may be secondary to incomplete abortion or intrauterine clots (hematometra).

Ask the same participant to describe the treatment given to the woman mentioned.

Show and discuss slide: *Management of Uterine Atony*

Follow step by step and move quickly to the next step if bleeding is not controlled:

- Conduct bimanual massage.
- Give uterotonics therapies.
- Proceed with uterine aspiration.
- Perform intrauterine tamponade.
- Perform hysterectomy only if bleeding cannot be stopped by other measures.

Say: Hysterectomy should only be performed as a last resort.

Show and discuss slide: *Uterotonics for Bleeding or Stabilization*

After uterine aspiration:

- Methylergonovine 0.2mg intramuscularly or intracervically, not for women with hypertension
- Misoprostol 200-800mcg orally, rectally or sublingually
- Oxytocin 20 units in 1L IV at a rate of 60 drops per minute
- Intrauterine tamponade

Say: More details on dosage and method are in the Reference Manual.

Now we're going to look at sepsis.

Infection may occur after a uterine evacuation procedure if the abortion was incomplete, infection prevention was not followed, or if a woman had a pelvic infection at the time of uterine evacuation. Intrauterine infection (also called endometritis) can become a more generalized infection (sepsis or septic shock) if it is untreated. A woman with sepsis should be hospitalized.

First, let's review the signs and symptoms of an intrauterine infection.

Show slide: *Signs and Symptoms of Intrauterine Infection (Endometritis)*

- Lower pelvic or abdominal pain
- Fever and chills
- Uterine or lower abdominal tenderness on bimanual exam
- Cervical motion tenderness
- Unusual or bad smelling vaginal or cervical discharge

Show slide: *Diagnosis of Sepsis*

Suspected infection *plus*:

- Hypotension (SBP <90mmHg) *plus*
- One or more of the following:
 - Pulse >100 per minute
 - Respiratory rate >24 breaths per minute
 - Abnormal temperature (<36°C or >38°C)

Ask participants how they have treated women with sepsis.

Take some answers, then show slide, making sure to discuss anything on the slide that wasn't mentioned by participants.

Show and discuss slide: *Management of Sepsis*

- Shock management as indicated
- Broad-spectrum IV or IM antibiotics until afebrile for 48 hours
- Then oral antibiotics for a total of at least seven days of treatment
- Tetanus toxoid and tetanus antitoxin if there was unsafe abortion and vaccination history unknown
- For incomplete abortion - immediate uterine evacuation
- For suspected intra-abdominal injury - laparotomy with injury repair
- For women not responding to treatment - hysterectomy may be necessary

Say: The recommended broad-spectrum antibiotics are Ampicillin 2g IV every six hours, plus either gentamicin 5mg/kg body weight IV every 24 hours or metronidazole 500mg IV every eight hours.

Hematometra is another possible complication of uterine aspiration. It refers to the accumulation of blood clots in the uterine cavity. In such cases, the uterus cannot properly contract.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

Show slide: *Signs and Symptoms of Hematometra*

- Enlarged, firm, tender uterus
- Pelvic pressure
- Intense cramps and pain
- Lightheadedness
- Mild fever

- Scant vaginal bleeding

Say: Re-evacuation with vacuum aspiration will usually resolve the condition.

Now we're going to discuss vasovagal reaction.

Explain that fainting can occasionally occur during vacuum aspiration.

- This is a vagal reaction to stimulation during the procedure.
- Typically it lasts about 10 seconds and does not require intervention.

Show slide: *Signs and Symptoms of a Vasovagal Reaction*

- Fainting, loss of consciousness
- Cold or damp skin
- Dizziness
- Nausea
- Moderate drop in blood pressure, pulse

Show slide: *Cause of Vasovagal Reactions*

- Result of vagal nerve stimulation during vacuum aspiration

Say: A vagal reaction is not a true complication, but rather a side effect. Vagal reaction may occur with IV insertion, intramuscular injection, vacuum aspiration or the sight of blood. It is fainting and is self-limited, rather than a seizure that might require intervention.

- Point out that it can be very distressing when a woman experiences a vagal reaction if the staff are not aware of what is going on.

Say: How is a vasovagal reaction treated?

- Make sure the following points are made:
 - Most symptoms pass quickly as the woman regains consciousness and no further treatment is necessary.
 - Lie the woman down and raise her legs up.
 - Smelling salts may be used to revive the woman.
 - In very rare cases, atropine injection will be necessary if the reaction is prolonged: 0.5mg IV.

Note to trainer: Many participants may be confused about vagal reaction and may mistake it for a more serious condition. Ensure that participants understand that a vagal reaction is not shock and is usually self-limiting without requiring intervention.

Say: Another complication women may experience is persistent pain after taking misoprostol.

Ask for a participant who has treated a woman with persistent pain after

taking misoprostol to describe the woman's symptoms.

Show and discuss slide: *Persistent Pain*

- Intense pain that persists for longer than four to six hours after taking misoprostol, or
- Intense pain unrelieved with ibuprofen and mild narcotics

Ask the same participant to describe the cause of the persistent pain in the woman mentioned.

Show and discuss slide: *Possible Causes of Persistent Pain*

- Pregnancy tissue trapped in the os
- Ectopic pregnancy
- Upper reproductive tract infection

Say: If there is pregnancy tissue in the os, it can sometimes be grasped with an instrument such as ring forceps and gently removed. For other causes, manage the cause as indicated (treat infection; assess for ectopic pregnancy). If none of the listed causes, consider low pain tolerance and manage with counseling, reassurance and pain management.

Next we'll look at allergic reactions to mifepristone or misoprostol.

Show slide: *Allergic Reactions*

- Symptoms may include swelling of hands or feet, rashes or wheezing.
- Manage conventionally, such as with an antihistamine.
- Severe allergic reactions (very rare) should receive emergency treatment.

Say: Women who experience sudden shortness of breath, swelling of the airway or any other severe or unusual reaction should receive emergency treatment.

Let's now discuss undiagnosed ectopic pregnancy. This is not a complication of the uterine evacuation, but rather a condition that was in place before it. Women should be screened for ectopic pregnancy during the clinical assessment, and providers should suspect ectopic pregnancy in a woman who presents with ongoing bleeding and abdominal pain even if she has had a previous uterine evacuation procedure.

Show and discuss slide: *Ectopic Pregnancy*

- Usually detected during clinical assessment
- Cannot be treated by vacuum aspiration or medical methods
- Is a life-threatening condition – refer or treat immediately

Show slide: *Possible Signs and Symptoms of Ectopic Pregnancy*

- Persistent vaginal bleeding and pelvic pain

- Minimal vaginal bleeding after taking medications for abortion
- Uterine size smaller than expected
- Sudden, intense and persistent lower abdominal pain or cramping
- Palpable adnexal mass
- Fainting, shoulder pain, rapid heartbeat or lightheadedness

Say: The abdominal pain or cramping is often initially one-sided, then generalized.

Fainting, shoulder pain, rapid heartbeat or lightheadedness may be due to ruptured ectopic with internal bleeding. Internal bleeding is not necessarily accompanied by vaginal bleeding.

A ruptured ectopic pregnancy is a gynecologic emergency that can be life threatening and requires immediate surgical intervention. A woman with suspected ectopic pregnancy should be treated or transferred as soon as possible to a facility that can confirm diagnosis and begin treatment.

6. Emergency response

Say: Now we're going to talk about emergency plans and referring women to other facilities.

Show and discuss slide: *In Case of Emergency*

- Complete assessment and informed consent may be deferred until after life-saving treatment
- Facilities should have a plan for emergencies which may include:
 - On-call provider
 - Referral
 - Information sharing
 - Practicing for emergencies
 - Supplies
 - Engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications
- Ask participants if their facilities have an emergency plan, and which of these options it includes. Instruct participants to read section 9.0 on emergency response of the Reference Manual. After five minutes, have a group discussion about how each option may be helpful. Ask participants to write in their notebooks their ideas for developing and improving their facilities' emergency plans.

Show slide: *On-Call Provider*

A clinically-knowledgeable person should be available 24 hours a day to:

- Answer women's questions and provide reassurance
- Provide or refer for care

Advise participants that not all facilities offering abortion-related care have to treat all complications that arise. Stabilizing the woman and referring her to a nearby facility for treatment is also appropriate. At a decentralized level, referral systems are important so facilities can quickly refer women for more care when necessary.

- Discuss some of the characteristics of a proper referral system.

Show slide: *Qualities of a Proper Referral System*

- Staff and transport ready 24 hours a day.
- Referral plans and protocols established within and between facilities.
- Share information about woman's situation and treatment with referral hospital, and hospital reports back on her care there.

Say: Ask the participants to turn to Appendix D in the Uterine Evacuation Procedure With Ipas MVA Plus® module of the Reference Manual for a sample referral form.

Say: How does this form differ from the one used at your facility?

- Discuss answers.
- Discuss the important components of a referral form.

Suggest that participants might want to modify their facility's referral form to include these components.

Show slide: *How Communities Can Assist With Referral*

- Consider all resources available for help.
- Police cars, religious or agency vehicles, and taxis can provide transport.
- Plan ahead.
- Local contacts can act as referral agents.

Show slide: *Transport to Medical Facility*

Show slide: *Information Sharing*

Providers should call the referral hospital to tell them:

- That the woman is being transported
- Why she is being referred
- Her history
- What measures have already been taken

- Her current condition

Show slide: *Practicing for Emergencies*

On a routine basis, facility staff should review and practice how to:

- Treat hemorrhage and shock
- Start intravenous fluids
- Give oxygen (if available)
- Provide cardiopulmonary resuscitation

Facility staff need to know their roles and protocols in an emergency.

Show slide: *Supplies for Emergencies*

- Facility should have a container with all medicines and supplies for an emergency.
- Check stock and expirations on a monthly basis.

Say: The container or cart should only be used in emergencies, so that supplies are there when an emergency arises.

Show slide: *Links to Communities*

Providers and facilities can work with community members and groups to:

- Recognize signs and symptoms of abortion complications
- Know how and where to receive emergency care
- Prevent delays in transporting women to emergency health services
- Refer women to emergency services, follow up after care and link women to other reproductive health services

Say: Now we're going to talk briefly about post-procedure care following abortion complications.

7. Post-procedure care

Show and discuss slide: *Care After Treatment for Abortion Complications*

The woman must be:

- Physically monitored
- Emotionally supported
- Provided verbal and printed information about:
 - Her condition, including long-term changes
 - Use of medications
 - Contraceptive methods

- follow-up care
- What to expect, and what to do if emergency care is needed

Say: Information on her condition should include counseling about any long-term changes resulting from the complications, such as hysterectomy or bowel perforation repair.

Printed information may be written or illustrated depending on her needs.

Show and discuss slide: *Tetanus Immunization After Unsafe Abortion*

If the woman has had an unsafe abortion and:

- Is immunized against tetanus, give a booster injection of tetanus toxoid 0.5mL intramuscular
- Is not immunized against tetanus:
 - Give anti-tetanus serum 1,500 units intramuscular, and
 - A booster injection of 0.5mL intramuscular after four weeks

Ask if participants have any questions about post-procedure care following complications.

Say: Now we're going to discuss monitoring serious adverse events and how to learn from them when they occur.

8. Serious adverse event monitoring

Show slide: *Adverse Events*

- Complications that a patient suffers during treatment that are not a result of her presenting condition
- One in 10 patients in the hospital for any reason suffers some adverse event
- Rare in routine abortion-related and contraceptive care
- Serious adverse events result in life-threatening injury or death

Say: Do any of you have experience with serious adverse events?

If yes, ask one to share an example.

Show slide: *Types of Adverse Events*

- Adverse event (AE)/complication – problem requiring intervention or management beyond what is normally necessary for a procedure or anesthesia
- Serious adverse event (SAE) – results in death, life-threatening injury, permanent impairment, or requires medical or surgical intervention to prevent permanent impairment

- Near miss – has potential to harm a patient but does not due to chance, prevention or mitigation
- As you discuss each type, ask a participant to briefly share an abortion-related experience they had with each one

Show slide: *Examples of Adverse Events*

Table 14B-1: Examples of complications/Serious Adverse Events (SAEs)	
Vacuum aspiration	Medical abortion
Perforation treated conservatively or requiring surgery	Unplanned aspiration (for example, for heavy bleeding or pain)
Anesthesia-related complication requiring hospitalization or causing seizures	Reactions to medications requiring emergency treatment
Bleeding requiring a blood transfusion	Bleeding requiring a blood transfusion
Infection requiring intravenous antibiotics and/or hospital admission	Infection requiring intravenous antibiotics and/or hospital admission
Unintended intra-abdominal surgery	Unintended intra-abdominal surgery
Ongoing pregnancy	Ongoing pregnancy
Ectopic pregnancy unrecognized at time of procedure	Ectopic pregnancy unrecognized when medical abortion given
Death	Death

Say: It is estimated that one in every 10 patients in the hospital for any reason suffers some adverse event.

Show and discuss slide: *Why Adverse Events Occur*

- Rarely due to a single person or event
- Rather, usually result from a combination of:
 - Client factors
 - Human error
 - Institutional error

Say: Do you agree with these causes? Why or why not? Can you think of examples of client factors and institutional errors?

Take a few responses. Make sure that client factors include:

- High gestational age
- Obesity
- Altered uterine anatomy
- Complex medical problems

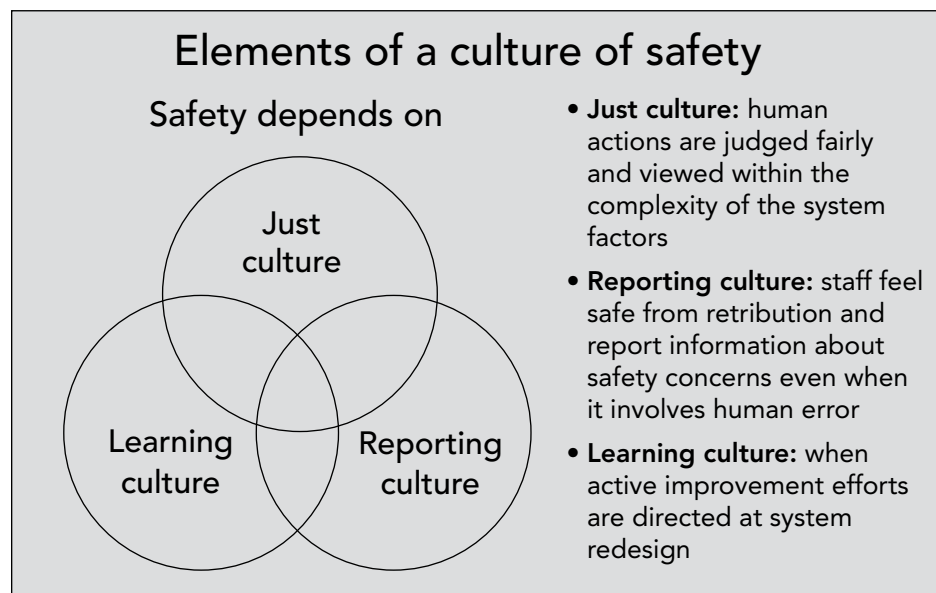
Institutional error may include:

- Any time institutions do not adequately protect patient safety
- Lack of appropriate medications and supplies in order to save money

Say: Now we'll watch two skits and talk about how to establish a workplace culture that is conducive to reporting and learning from adverse events to maintain safety.

Have participants perform the two serious adverse events skits and then, in a large group, discuss the differences between a "blame culture" and a "safety culture" in relation to serious adverse events.

Show slide: *Safety Depends On*



- Just culture: human actions are judged fairly and viewed within the complexity of the system factors
- Reporting culture: staff feel safe from retribution and report information about safety concerns even when it involves human error
- Learning culture: when active improvement efforts are directed at system redesign

Show slide: *Adverse Event Reporting*

Once the woman has been cared for, the event should be:

- Documented – complete information in the woman's chart and facility logbook
- Reported – to local authorities according to established guidelines
- Analyzed - so that the experience can be used to improve care

Open dialogue should be encouraged by all the people involved in the adverse event including the providers, assistants, administrators, the

patients and their family (if appropriate). When adverse events occur, facility staff can hold discussions with family and community members to prevent misunderstandings and even potential threats, while respecting the woman's privacy. The goal is to see where the system failed and to improve the system so that in future, the same adverse event does not happen again.

Show slide: *Root Cause Analysis*

Root cause analysis is a technique for learning from AEs

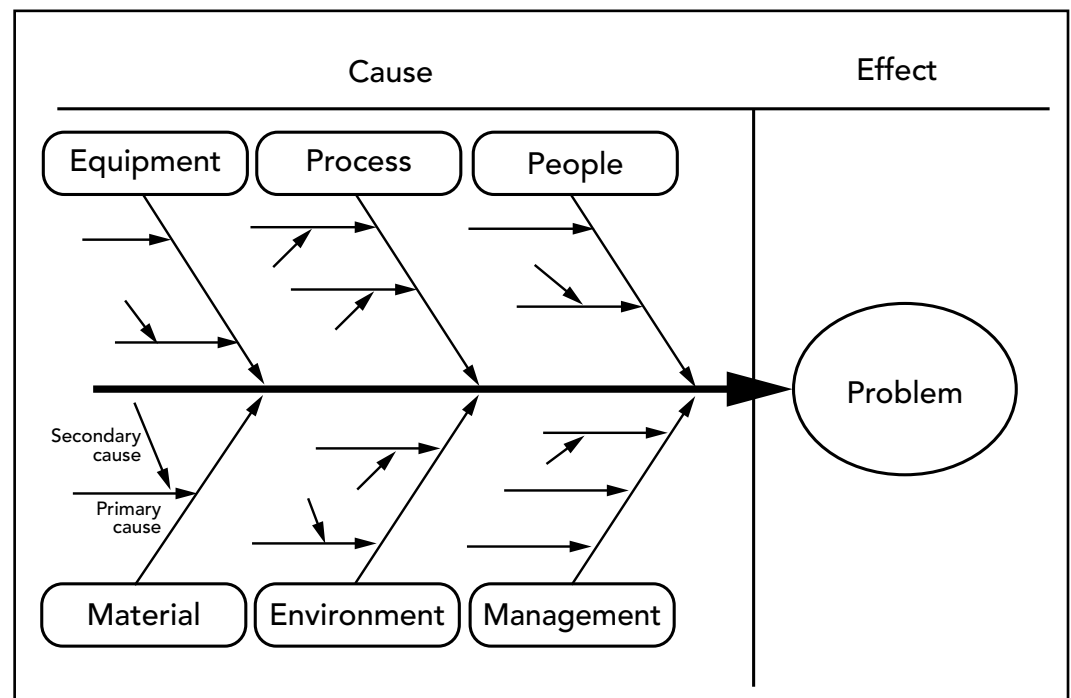
- Team discussion with all relevant staff members
- Non-punitive discussion conducted in a spirit of learning

Ask:

- What happened?
- Why did it happen?
- What can be changed to prevent similar events in the future?

There are different techniques for conducting a root cause analysis. Three techniques we will briefly discuss here include: Fishbone Diagram, The 5 Whys and Problem Tree Analysis.

Show and discuss slide: *Fishbone Diagram*

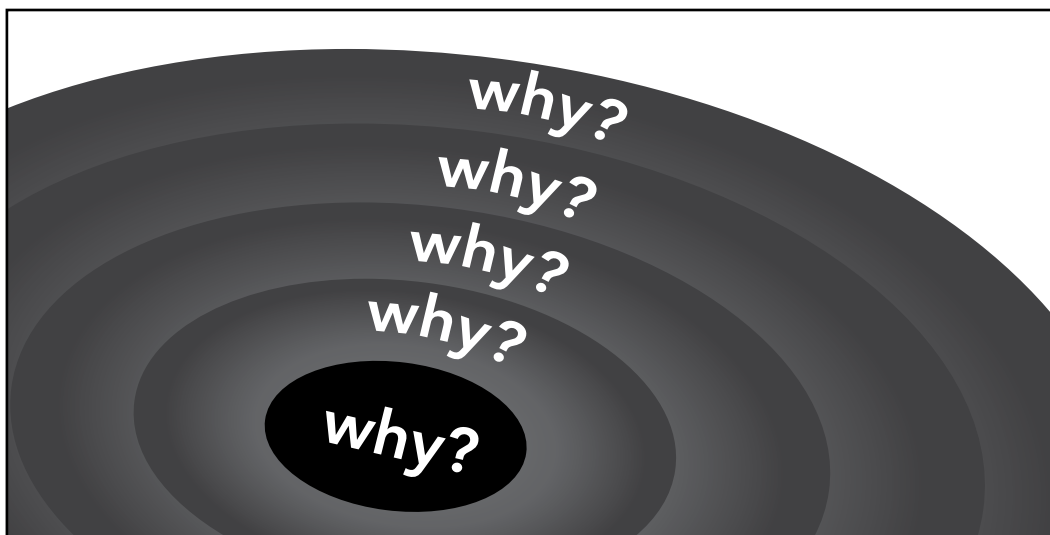


- Include the following points in your discussion:
 - Write the problem in a box on the right-hand side of the page.
 - Draw a horizontal line to the left of the problem.
 - Decide on the categories of causes for the problem. Useful categories of causes in a classic fishbone diagram include

People, Processes, Equipment and Materials, Environment and Management. Another way to think of categories is in terms of causes at each major step in the process.

- Draw diagonal lines above and below the horizontal line (these are the “fishbones”), and label with the categories you have chosen.
- Generate a list of causes for each category.
- List the causes on each fishbone, drawing branch bones to show relationships among the causes.
- Develop the causes by asking “Why?” until you have reached a useful level of detail—that is, when the cause is specific enough to be able to test a change and measure its effects.

Show and discuss slide: *The Five Whys*



Include the following points in your discussion:

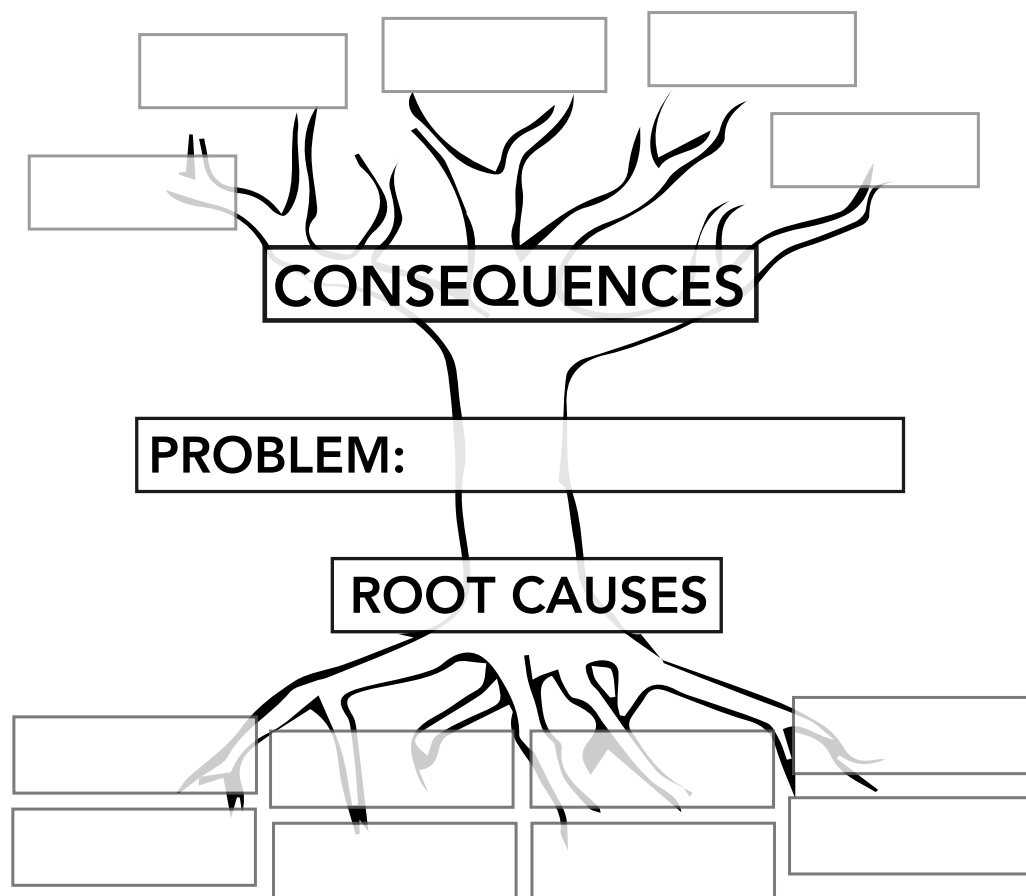
- By repeatedly asking the question “Why?” (use five as an average), we can peel away the layers of a problem, just like the layers of an onion, which can lead us to the root cause of a problem.
- We need to avoid assumptions and logic traps (errors in our thinking) that can lead us astray and instead, continue to drill down to the real root causes.

Steps to use the Five Whys:

1. Write down the specific problem. Writing it down helps you formalize the problem and describe it accurately. It also helps a team focus on the same problem.
2. Use brainstorming to consider why the problem might be occurring. Some basic rules of brainstorming include:
 - All ideas are acceptable; judgment is ruled out until the process is complete.

- Freewheeling is welcome: the wilder the better. Humor triggers the right brain and helps get original ideas flowing
 - Quantity counts at this stage, not quality
 - Build on the ideas put forward by others
 - Every person and every idea has equal worth
3. Select the most likely reason for the problem and write it down.
 4. If this doesn't identify the root cause of the problem, ask "Why?" again and write that answer down.
 5. Continue to ask and answer "Why?" until the team agrees that they have identified the problem's root cause. This may take less or more than five "Whys?"

Show and discuss slide: *Problem Tree Analysis*



- Include the following points in your discussion:
 - Problem tree analysis is best carried out in a small focus group of about six to eight people using flip chart paper or an overhead transparency.

- The first step is to discuss and agree on the problem or issue to be analyzed. Do not worry if it seems like a broad topic because the problem tree will help break it down. The problem or issue is written in the center of the flip chart and becomes the trunk of the tree.
- Next, the group identifies the causes of the problem, which are drawn as the roots, and then identifies the consequences, which become the branches. These causes and consequences can be created on post-it notes or cards, perhaps individually or in pairs, so that they can be arranged in a cause-and-effect logic.
- The heart of the exercise is the discussion, debate and dialogue that is generated as factors are arranged and re-arranged, often forming sub-dividing roots and branches. Take time to allow people to explain their feelings and reasoning, and record related ideas and points that come up on separate flip chart paper under titles such as solutions, concerns and decisions.
- Relate this example of Root Cause Analysis:
 - Why did perforation occur? The doctor perforated the uterus.
 - Why did doctor perforate uterus? The doctor used a cannula that was too small.
 - Why did the doctor use the cannula that was too small? All of the larger cannula had been used the day before and had not been cleaned and sterilized.
 - Why hadn't the cannula been cleaned and sterilized? The one staff member trained and responsible for instrument processing was away on family leave.
 - Action to prevent this from happening in the future: Cross-train other staff on instrument processing and assign instrument processing duty based on staffing schedule.

For more information on root cause analysis, please refer to Additional Resources.

9. Diagnosis and management of complications case study role plays

Say: We have discussed the signs, symptoms, causes and management of complications seen in postabortion care. Now we will practice recognizing and managing these conditions, either by providing definitive treatment or making a referral.

Note to Trainer: Do not move to the next slide yet, as it reveals the diagnosis for Case Study Role Play #1.

Break participants into small groups.

- Give each group the Case Study Role Play Scenarios Worksheet and a Management of Complications Skills (PAC) Checklist.

- Assign each group one to two case studies.
- Ask the groups to role play—with one participant as client and one as provider—diagnosis of the complications described in their assigned case studies. In some case studies, additional information is given by a third person at some point in the scene. The “provider” should state what steps are being taken to diagnose and treat the complication, such as “I perform a pelvic exam” or “I apply silver nitrate.”
- Tell groups to have one person look at the appropriate section of the Management of Complications Skills Checklist for each of their diagnoses to ensure that the “provider” takes the necessary steps to manage the complication.
- After each role play, they should use the worksheet to identify any aspects of emergency response that are important to handling this complication well, whether an adverse event occurred and what steps can be taken to prevent such events in the future. They will have 25 minutes to complete this activity.
- Have groups choose a “reporter” who will present their case, diagnosis and, if relevant, steps to prevent future similar adverse events and improve emergency response to the larger group.
- Advise participants to use the Reference Manual.

After 25 minutes have passed, begin the report-back and discussion.

- Use the Management of Complications Skills Checklist as a key, and the worksheet as a guide.
- Starting with the first case study, each group reporter should:
 - Read aloud the case study and diagnosis.
 - Read the group’s completed Case Studies for Complications worksheet.
 - Discuss emergency response plan aspects that improved or would improve the management of this complication.
 - Identify any adverse events and how to prevent future reoccurrences.
- Ask the reporter with Case Study #1 to report back to the large group.

Show slide: *Case Study #1: Management of Incomplete Abortion, Shock*

- Stabilize for shock
- Continue broad-spectrum antibiotics
- Transfuse or prepare for immediate transport to another facility for transfusion

Ask the reporter with Case Study #2 to report.

Show slide: *Case Study #2: Management of Sepsis, With Likely Uterine or Abdominal Injury*

- Shock management as indicated
- Begin broad spectrum antibiotics
- Laparotomy for repair of possible uterine or abdominal injury
- Evacuate uterus under direct visualization
- Stabilize and transfer if facility cannot manage the complication

Ask the reporter with Case Study #3 to report.

Show slide: *Case Study #3: Management of Incomplete Abortion With Likely Perforation*

- Admit and observe
- Surgical intervention to diagnose and manage if the woman becomes unstable or there are signs of intra-abdominal injury
- Stabilize and transfer if facility cannot manage the complication
- Because this case involves an adverse event, review the case according to the facility protocol.

Ask the reporter with Case Study #4 to report.

Show slide: *Case Study #4: Management of Persistent Pain Due to Tissue Trapped In Cervical Os*

- Grasp tissue with ring forceps and gently remove.

Say: Are there any questions concerning the management of any of the complications that we have discussed?

- Answer questions and discuss.
- Give each participant a copy of the Management of Complications Skills Checklist.
 - Tell them that these can be used when practicing the management of women with complications.
 - It also can be used for developing site protocols for managing women with complications.

Say: What after care needs to be offered for women who have experienced complications?

- Answers should reflect the following slide.

Advise the group that, to enhance their ability to effectively manage these complications, they can supplement this training with more in-depth learning that may be available to them locally. Refer them to the *Ipas Woman-Centered Postabortion Care: Reference Manual* for more details on managing complications.

10. Summary and test

Ask participants for key points covered in this module. Use the objectives as a reference.

What questions do you have about anything discussed in this module?

- Answer questions.

Distribute the knowledge test.

- Ask participants to complete the knowledge test.
- Collect tests.
- Review correct answers from the test key.
- Thank the participants for their participation.

References

- Achilles, S. L., & Reeves, M. F. (2011). Prevention of infection after induced abortion: Release date October 2010: SFP guideline 20102. *Contraception*, 83(4), 295-309.
- Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science*, 248(4951), 41-44.
- American Psychological Association (APA) Task Force on Mental Health and Abortion. (2008). Report of the APA task force on mental health and abortion. Washington DC.
- Chen, B. A., & Creinin, M. D. (2007). Contemporary management of early pregnancy failure. *Clinical Obstetrics and Gynecology*, 50(1), 67-88.
- Cleland, K., Creinin, M. D., Nucatola, D., Nshom, M., & Trussell, J. (2013). Significant adverse events and outcomes after medical abortion. *Obstetrics and Gynecology*, 121(1), 166-171.
- Copeland, L. J., Jarrell, J. F., & Dodson, R. (2000). *Textbook of gynecology*, (Second ed.). Philadelphia: W. B. Saunders.
- Creinin, M. D., Schwartz, J. L., Guido, R. S., & Pymar, H. C. (2001). Early pregnancy failure: Current management concepts. *Obstetrical and Gynecological Survey*, 56(2), 105-113.
- Hakim-Elahi, E., Tovell, H. M., & Burnhill, M. S. (1990). Complications of first-trimester abortion: A report of 170,000 cases. *Obstetrics and Gynecology*, 76(1), 129-135.
- Ipas. (2009). *Uterine evacuation with manual vacuum aspiration (MVA): A training manual for conducting short courses*. Chapel Hill, NC: Ipas.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual*, (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Kaunitz, A. M., Rovira, E. Z., Grimes, D. A., & Schulz, K. F. (1985). Abortions that fail. *Obstetrics and Gynecology*, 66(4), 533-537.
- Lichtenberg, E. S., & Grimes, D. A. (2009). Surgical complications: Prevention and management. In M. Paul, E. S. Lichtenberg, L. Borgatta, D. A. Grimes, P. G. Stubblefield & M. D. Creinin (Eds.), *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* (pp. 224-251). West Sussex, UK: Wiley-Blackwell.
- March, C. M. (2011). Asherman's syndrome. *Seminars in Reproductive Medicine*, 29(2), 83-94.
- National Cancer Institute. (2010). *Summary report: Early reproductive events and breast cancer workshop* (Second ed.) Retrieved from <http://www.cancer.gov/cancertopics/causes/ere/workshop-report>.
- Committee on Gynecologic Practice. (2009, reaffirmed in 2011). ACOG Committee Opinion No. 434: Induced abortion and breast cancer risk. *Obstetrics and Gynecology*, 113(6), 1417-1418.
- Solter, C., Miller, S., & Gutierrez, M. (2000). Module 11: Manual Vacuum Aspiration (MVA) For Treatment of Incomplete Abortion. *Comprehensive Reproductive Health and Family Planning Curriculum*. Watertown, MA: Pathfinder International.
- Thonneau, P., Fougereyrollas, B., Ducot, B., Boubilley, D., Dif, J., Lalande, M., & Soulat, C. (1998).

Complications of abortion performed under local anesthesia. *European Journal Obstetrics Gynecology Reproductive Biology*, 81(1), 59-63.

Von Hertzen, H., Piaggio, G., Huong, N. T., Arustamyan, K., Cabezas, E., Gomez, M., & Peregoudov, A. (2007). Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: A randomised controlled equivalence trial. *Lancet*, 369(9577), 1938-1946.

World Health Organization. (1994). *Clinical management of abortion complications: A practical guide*. Geneva, Switzerland: World Health Organization.

World Health Organization. (1995). *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2007). *Managing complications in pregnancy and childbirth: A guide for midwives and doctors: Integrated management of pregnancy and childbirth (IMPAC)* (Second ed.). Geneva, Switzerland: World Health Organization.

World Health Organization. (2009). World Health Organization's guidelines for the management of postpartum hemorrhage and retained placenta. Geneva, Switzerland: World Health Organization.

World Health Organization (WHO). (2011). *IMAI district clinician manual: hospital care for adolescents and adults: Guidelines for the management of common illnesses with limited resources* (Vol. 1). Geneva, Switzerland, Switzerland: World Health Organization.

World Health Organization. (2012a). *Safe abortion: Technical and policy guidance for health systems*, (Second ed.). Geneva, Switzerland: World Health Organization.

World Health Organization. (2012b). World Health Organization's recommendations for the prevention and treatment of postpartum hemorrhage. Geneva, Switzerland: World Health Organization.

Knowledge Test Key

1. b
2. d
3. d
4. a
5. c
6. d
7. c
8. b
9. a
10. d

Complications Knowledge Test

Circle the correct response.

1. Most women who present for postabortion care:
 - a. Have a uterine perforation
 - b. Are stable
 - c. Are in shock
 - d. a & c
2. Managing complications does NOT include:
 - a. Staff knowing how to recognize a complication
 - b. Staff knowing how to treat a complication
 - c. Referral for conditions that cannot be fully treated onsite
 - d. Fully treating onsite all complications that occur
3. Incomplete abortion:
 - a. May result in vaginal bleeding and pain
 - b. Can lead to infection
 - c. Is treatable by vacuum aspiration
 - d. All of the above
4. The first step in treating a woman presenting with postabortion complications is:
 - a. Perform a rapid initial assessment for shock
 - b. Check for pregnancy-related complications
 - c. Perform a physical exam
 - d. Get voluntary informed consent
5. A condition that occurs when the uterus cannot contract to stop bleeding is:
 - a. Disseminated intravascular coagulopathy (DIC)
 - b. Asherman Syndrome
 - c. Uterine atony
 - d. Hematometra

6. In postabortion care, suspect ectopic pregnancy in a woman who presents with the following:
 - a. Ongoing bleeding and abdominal pain after a UE procedure
 - b. Uterine size smaller than expected
 - c. Minimal vaginal bleeding after taking medications for abortion
 - d. All of the above
7. Signs and symptoms of an intrauterine infection include:
 - a. Severe and prolonged bleeding
 - b. Severe headaches, dizziness
 - c. Cervical motion tenderness
 - d. Brief fainting spells
8. A vasovagal reaction:
 - a. Is the same as physiological shock
 - b. Usually resolves itself and is not life-threatening
 - c. Indicates uterine perforation
 - d. Must be treated surgically
9. Sites should refer women with complications to another facility if:
 - a. They cannot fully treat her onsite
 - b. She cannot pay at the current site
 - c. She has a high fever
 - d. She has injury to the uterus, vagina or bowel
10. After-care for women with complications includes providing:
 - a. Close monitoring
 - b. Information about follow-up
 - c. Counseling on medical and emotional consequences
 - d. All of the above

Serious Adverse Events Skits

Have participants perform the two skits below and then, in a large group, discuss the differences between a “blame culture” and a “safety culture” in relation to serious adverse events.

Clinic #1

Supervisor (looking around the room in an alarmed manner): What happened here?

Staff (pointing at the provider): S/he caused the perforation!

Supervisor (speaking in an accusing tone of voice): Why did you perforate that woman's uterus? Why weren't you more careful? Didn't you learn anything at that training we sent you to? I hope you haven't reported it yet. This will make us look really bad at our annual review!

Provider: Well, I am feeling really terrible about this. I was doing what I was trained to do...

Supervisor (sharply interrupting the provider): I don't want to hear your excuses. Never mind... you're clearly incompetent. We'll just have to transfer you to some little town where we won't have to worry about you.

Clinic #2

Supervisor (looking directly at the provider and speaking in a calm tone of voice): I understand there was a uterine perforation during your procedure this morning. How is the woman doing?

Provider: Yes, there was. Thankfully, it seems to be a minor perforation, and the woman is doing well. We think it should heal fine on its own without any further procedures.

Supervisor: I'm glad to hear that the woman is improving. Please tell me what happened and what may have contributed to the perforation.

Provider: Well, I had already started the procedure when I realized that I was going to need a larger cannula size. When I asked for the larger size, my assistant informed me that we only had one of each size, and unfortunately, the larger sizes had been used earlier and had not yet been cleaned and high-level disinfected. So I proceeded to use the smaller size, but of course, I had to make many more passes with the smaller cannula to complete the procedure. I tried to be careful, but I guess I was not careful enough.

Supervisor: I see. Well, we've heard of this happening before. It sounds like there may be a variety of causes for this adverse event, including instrument supply, processing schedules, preparation before the procedure, etc. Let's gather the whole clinic team and think together about some ideas that may help prevent this from happening again. We can also begin the reporting process for your facility.

Provider: That sounds good. I really appreciate this support and the chance to think about ways that the team and I can improve the quality of our services.

Mentor: Good. And when we're finished with the team meeting, I would like to talk privately with you more about how you're feeling about this.

Case Study Role Play Scenarios for Complications: Postabortion Care

Note: The person playing the provider role should not see the case study.

Case Study #1:

A woman comes to the clinic after having aborted at home after four months of pregnancy. She is wearing blood-soaked clothes, is pale and very anxious. She is febrile on exam and has a 12-week size uterus with an open os. IV antibiotics are started and she has an MVA procedure for incomplete abortion. One hour after the MVA, she has continued bleeding, has a rapid pulse and low blood pressure. She appears very ill.

Case Study #2

A 23-year-old woman comes to the rural health center with vaginal bleeding and a fever. On exam, she is in distress with a high fever of 104°F (39°C) and a tender lower abdomen with rebound and guarding. Although LMP is 10 weeks ago, her uterus size is about six weeks. Additionally, she reports that three days ago she went to a local woman for an abortion who pushed something inside her uterus.

Case Study #3

A 26-year-old woman reporting an LMP from eight weeks ago comes in with vaginal bleeding and a fever. On exam, her temperature is 100.6°F (38.1°C). There is a moderate amount of dark blood in her vagina; the uterus is slightly tender and at eight week size. There are no adnexal masses and the cervix appears open. She is diagnosed with incomplete abortion and treated with uterine evacuation with MVA after establishing antibiotic coverage. During the procedure, the cannula goes in too far without meeting any resistance. The woman complains of severe abdominal pain after the procedure. However, her vital signs are stable and there is minimal bleeding.

Case Study #4

The client is a 17-year-old woman who was provided misoprostol in this clinic two weeks ago for bleeding after inducing an abortion at eight weeks with herbs. She returns today complaining of intermittent cramping. Her bleeding was initially heavy like a period but now is just light spotting. Other than the intermittent pain, she is feeling well and does not think that she is still pregnant. A pelvic exam shows that the uterus is a non-pregnant size and not tender, and she has a small amount of dark blood in the vagina. At the os, there appears to be a rubbery clot or piece of tissue.

Case Studies for Complications: Postabortion Care

1. Diagnosis

2. Steps to manage

3. Important emergency response aspects

4. Is this an adverse event?

5. If this is an adverse event:

a. What happened?

b. Why did it happen?

c. What might be changed to prevent similar events in the future?

Complications Case Studies (PAC) answer key

Case Study #1:

1. Case info – A woman comes to the clinic after having aborted at home after four months of pregnancy. She is wearing blood-soaked clothes, is pale and very anxious. She is febrile on exam and has a 12-week size uterus with an open os. IV antibiotics are started and she has an emergent MVA for incomplete abortion. One hour after the MVA, she has continued bleeding, a rapid pulse and low blood pressure. She appears very ill.
2. Diagnosis - Incomplete abortion and shock
3. Steps to manage - Stabilize for shock. Continue broad-spectrum antibiotics. Transfuse or prepare for immediate transport to another facility for transfusion.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? No, the complications were presenting and not caused or worsened by anything that occurred at the clinic.

Case Study #2

1. Case info – A 23-year-old woman comes to the rural health center with vaginal bleeding and a fever. On exam, she is in distress with a high fever. Examination finds a temperature of 104°F (39°C) and a tender lower abdomen with rebound and guarding. Although LMP is 10 weeks ago, her uterus size is about six weeks. Additionally, she reports that three days ago she went to a local woman for an abortion who pushed something inside her uterus.
2. Diagnosis – Sepsis with likely uterine or abdominal injury
3. Steps to manage - Shock management as indicated. Begin broad spectrum antibiotics. Laparotomy for repair of possible uterine or abdominal injury. Evacuate uterus under direct visualization. Stabilize and transfer if facility cannot manage the complication.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.

5. Is this an adverse event? No, the complications were presenting and not caused or worsened by anything that occurred at the clinic.

Case Study #3

1. Case info – A woman reporting an LMP eight weeks ago came in with bleeding and a fever, which was diagnosed as incomplete abortion and treated with MVA. During the procedure, the cannula goes in too far without meeting any resistance. The woman complains of severe abdominal pain after the procedure. However, her vital signs are stable and there is minimal bleeding.
2. Diagnosis – Incomplete abortion with likely perforation
3. Steps to manage - Admit and observe. Surgical intervention to diagnose and manage if the woman becomes unstable or there are signs of intra-abdominal injury. Stabilize and transfer if facility cannot manage the complication.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? Yes, as the perforation occurred during a procedure at the clinic.
6. If yes...
 - a. What happened? – The provider perforated the woman's uterus during an MVA procedure.
 - b. Why did it happen? – Many factors should be considered. The provider may not have taken enough time during the bimanual exam to be certain of the size, shape and position of the uterus. The correct size cannula may not have been used or available. Technique may not have been gentle enough. Also, there may have been factors that made the provider feel rushed during the procedure.
7. What might be changed to prevent similar events in the future? Depends on the root cause analysis, but possibilities include: Ensure that providers know how to perform a thorough bimanual exam and understand the importance of discovering the size, shape and position of the uterus and cervix before a vacuum aspiration procedure in order to perform it safely. Changes in clinic flow to be sure procedures are unrushed. Changes to insure appropriate instrument availability.

Case Study #4

1. Case info – The client is a 17-year-old woman who was provided misoprostol in this clinic two weeks ago for bleeding after inducing an abortion at eight weeks with herbs. She returns today complaining of intermittent cramping. Her bleeding was initially heavy like a period but now is just light spotting. Other than the intermittent pain, she is feeling well. A pelvic exam shows that the uterus is a non-pregnant size and not tender, and she has a small amount of dark blood in the vagina. At the os, there appears to be a rubbery clot or piece of tissue.
2. Diagnosis – Persistent pain due to tissue trapped in cervical os
3. Steps to manage – Grasp tissue with ring forceps and gently remove.
4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
5. Is this an adverse event? No, the complications were presenting and not caused or worsened by anything that occurred at the clinic.

Management of Complications (PAC) Skills Checklist

Skill	Yes	No	Comments
Performs rapid initial assessment for shock			
Calls for help, activates emergency procedures			
Performs initial management of shock			
Ensures open airway			
Turns head to the side			
Elevates legs			
Gives oxygen, five L/minute by mask or nasal cannula			
Inserts one or two large bore IVs, gives one liter crystalloid bolus			
Transfuse if vital signs remain unstable			
Keeps woman warm			
Places urinary catheter			
Monitors and records vital signs every 15 minutes			
Monitors intake and output			
Send laboratory evaluations			
Prepares for emergency transfer if adequate treatment is not available			
Performs secondary assessment for underlying causes of shock			
Performs bimanual and speculum exam for signs and symptoms of incomplete abortion, cervical or vaginal laceration, uterine perforation, uterine atony, infection or sepsis			
Incomplete abortion			
Administers antibiotics as indicated			
Performs uterine evacuation as indicated			
Cervical or vaginal lacerations			
Applies silver nitrate or applies pressure by clamping ring forceps for minor lacerations			
Applies sutures as needed			

(continued on pages 399 - 400)

Management of Complications (PAC) Skills Checklist

Skill (continued)	Yes	No	Comments
Uterine perforation			
Admit and observe if perforation occurred during the UE, woman is stable, there are no other injuries			
Laparotomy or laparoscopy to diagnose and manage if the woman is unstable and/or there are signs of intra-abdominal injury			
Stabilize and transfer if facility cannot manage the complication			
Uterine atony			
Begins with bimanual massage			
Gives uterotonics			
Performs uterine aspiration			
Performs intrauterine tamponade			
Performs or refers for hysterectomy if bleeding can't be stopped by other measures			
Infection or sepsis			
Shock management as indicated			
Begin broad spectrum antibiotics			
Uterine evacuation or surgical management as indicated			
Manages other complications			
Hematometra			
Performs uterine aspiration			
Vasovagal reaction			
Treats with positioning			
Atropine injection if prolonged			

Management of Complications (PAC) Skills Checklist

Skill (continued)	Yes	No	Comments
Persistent pain			
Performs evaluation for retained products, ectopic pregnancy or infection			
Removes tissue trapped at the cervical os			
Offers adequate pain management or refers for further evaluation			
Allergic reactions			
Treats as indicated for allergic reactions			
Ectopic pregnancy			
Recognizes and treats or refers suspected ectopic pregnancy			
Emergency response			
Has a 24-hour emergency response plan in place			
Has a referral plan for complicated patients			
Gives adequate post-procedure care			
Has a plan for monitoring and evaluating adverse events			

Clinical Practicum



Purpose

This module presents a clinical practicum for participants to achieve competency in the skills necessary for providing woman-centered, comprehensive abortion care, including postabortion care: counseling and contraceptive services; clinical assessment; uterine evacuation with Ipas MVA Plus® (including processing Ipas MVA Plus instruments); uterine evacuation with medical methods; and management of complications.



Prerequisites

Participants should already be able to:

- Describe the key concepts of woman-centered, comprehensive abortion care, including postabortion care
- Describe a woman's rights in the abortion-care setting
- During simulated practice, proficiently perform the skills for providing woman-centered, abortion-related care as outlined in the training curriculum modules: counseling; contraceptive services; clinical assessment; uterine evacuation with Ipas MVA Plus (including processing Ipas MVA Plus instruments); uterine evacuation with medical methods; Optional: Post-evacuation IUD insertion and implant insertion (if previously trained on these skills); and management of complications



Objectives

By the end of this module, participants should be able to:

1. Competently perform the clinical skills necessary for providing woman-centered, abortion-related care: counseling; contraceptive services; clinical assessment; uterine evacuation with Ipas MVA Plus (including processing Ipas MVA Plus instruments); uterine evacuation with medical methods; and management of complications
2. Identify areas in the above skills that may need further practice



Materials

- ☐ Items from the Clinical Practicum Supplies and Equipment list
- ☐ Skills checklists from each clinical module

- ☐ Abortion-Related Care Clinical Skills Evaluation form
- ☐ End-of-Course Evaluation form (found in How to Use This Manual)
- ☐ Plain paper for the Skills Improvement Follow-Up activity
- ☐ Flipchart paper
- ☐ Have IUD/IUSs and contraceptive implants available to insert postabortion during simulated practice, for those already trained.
- ☐ Certificates of Attendance and Competency (found on CD-ROM)



Advance preparation

Note to trainer: This module may need to be adapted for your setting. Consider the length of time needed and available for practice, the order of topics, the need for additional trainers, the amount of review required at the start of each topic and other logistics when adapting the module. See How to Use this Manual for more information.

- ☐ Ensure that all participants have reached competency in simulated skills practice prior to participating in the clinical practicum.
- ☐ Obtain approval for facilities where training will take place.
- ☐ Plan the design of the practicum.
- ☐ Organize trainers and discuss their roles, emphasizing teamwork.
- ☐ Determine how to involve staff from the facilities where practicum will be held.
- ☐ Determine what each participant's role will be during the practicum.
- ☐ Determine how to configure teams of participants and trainers.
- ☐ Arrange for participants to observe or assist with care for women with complications.
- ☐ Prepare and duplicate materials (flipcharts, checklists, evaluation forms).
- ☐ Ensure readiness of equipment and supplies needed for the practicum (see Clinical Practicum Supplies and Equipment list).
- ☐ Have alternative activities ready for participants to do when client caseload is slow.
- ☐ Copy Certificates of Attendance for those who complete the clinical practicum and Certificates of Competency for those who achieve competency in all skills.
- ☐ Review the Additional Training Resources listed at the end of this module.
- ☐ Review Conducting This Clinical Practicum (below).

Conducting this clinical practicum

Time required

The time required for this clinical practicum can vary significantly depending on the practicum design, the needs and skills of participants, facility caseloads and the amount of time available.

Format

This practicum module is divided into sessions by skill set. The content of each session reflects the module of the same name in the theoretical part of this training.

Each session should begin with a short content review — a mini-lecture using flipcharts and a review of the checklist(s) for that skill. Participants should then be briefed on the details of the session and released to their assignments. At the end of each practice session, participants should regroup to debrief and discuss.

Designing the practicum

- ❑ The design of the practicum depends on the needs of the participants and realities of the practicum facilities. Trainers will need to determine whether the practicum can be held with several participants and trainers at one time at the same facility or at several facilities at the same time. A modular or other adapted approach can be used, staggering place, times, participants, trainers and/or skills.
 - Consider designing the practicum so that participants practice skills that logically go together (such as counseling and contraceptive services or uterine evacuation and post-evacuation IUD insertion).
 - Use time well. For example, have some participants practice counseling all day one day while other participants practice clinical assessment, then have the participants switch skill practice the next day. Meanwhile, participants who will only be practicing instrument processing can do so on both days. Another option is for participants to be “on call” for a week, conducting their clinical practice when women present for care.

Note that many skills are similar for induced abortion and postabortion care. The practicum could include treatment of women in either circumstance.

- ❑ Schedule the practicum to meet participants' needs and circumstances. For example, hold it in the mornings or on weekends, or in smaller sections over a longer period of time, in order to maximize participants' practice time.
- ❑ If the participants will be divided into groups or will practice at different facilities, arrange for additional trainers. Each participant must be directly supervised by a trainer.

- ❑ Employ principles of adult learning and maintain a positive learning environment.

Before the practicum

- ❑ Identify the times at the practicum facility when women are most likely to present for care. To ensure enough women are available during scheduled times for clinical practicum, consider asking local facilities to refer women coming for abortion-related services to the practicum facility during the training period. Alternatively, to practice vacuum aspiration, schedule women for endometrial biopsy during the practicum and allow participants to perform the procedure, as the skill is similar to uterine evacuation.
- ❑ Ensure that practicum-facility protocols, equipment and supplies are consistent with skills to be taught. Decide how to handle any noted discrepancies.
 - If necessary, adapt training activities to reflect practicum-facility practices or create additional activities.
 - Determine where review and debrief discussions can take place before and after practice. This may be a private room on- or off-site.
- ❑ Determine how to keep track of participants who have successfully achieved competency and those who need more practice, as well as how the latter will receive additional practice.

During the practicum

- Refer to the Reference Manual during review, debriefing and other discussions with participants.
- Assign participants to practice procedures according to their skill level.
- Assign a few participants and a trainer to work together in “practice groups.” Pair strong participants with weaker ones and ask them to help each other. Participants who have reached competency can help those who have not. Ensure participants understand their roles, other participants’ roles and how to provide assistance.
- Limit the number of participants and observers for each procedure to respect women’s privacy.
- Obtain the woman’s permission for participants to perform the procedure, ensuring she understands that the trainer will be present and that she has the right to refuse without being denied care.
- Always respect the woman’s right to confidentiality and privacy, not only in direct care but also when discussing her care with participants.
- Only give corrective feedback to participants in the presence of a woman when the mistake could endanger her or cause her discomfort, in order to limit the anxiety of the woman as well as the participant.

- Carefully monitor the practicum to ensure that other trainers are following agreed-upon protocols and using the checklists to problem-solve issues, to ensure that practice groups are working well and to make certain that every participant is getting opportunities to participate.
- Consider seeking feedback from participants after each session using the Session Evaluation form found in How to Use This Manual.
- When no practice opportunities are available, use this time for supervised pelvic model practice, role plays, case studies and discussion.
- Use the Clinical Skills Evaluation form in this module for evaluating participants to determine if they can be certified as competent in abortion-related skills.

After the practicum

- Provide the End-of-Course Evaluation for participants to complete. An example can be found in How to Use This Manual.
- Debrief with facility staff and other trainers about what worked well and how the clinical practicum could be improved. Thank everyone for their participation.
- Provide each participant with specific recommendations for implementing and improving their skills when they return to their facilities.
- Provide feedback on each participant's skills to their facility supervisor, if appropriate.
- Arrange follow-up visits with the participants to support them in establishing the use of their skills and to help them problem-solve. Follow-up should occur as soon as possible after the training, preferably within a month.
- Provide opportunities for refresher courses and facility-visit exchanges between participants.
- Ask the participants what they see as their most important next steps and how you might assist them.

Time: Variable

1. Introduction

Greet the participants. Introduce yourself and any other trainers. Introduce the clinical practicum.

Show flipchart: Clinical Practicum: Purpose

- This module presents a clinical practicum for participants to achieve competency in the clinical skills necessary for providing woman-centered, comprehensive abortion care, including postabortion care: counseling and contraceptive services; clinical assessment; uterine evacuation with Ipas MVA Plus (including processing Ipas MVA Plus instruments); uterine evacuation with medical methods; and management of complications.

Show flipchart: Clinical Practicum: Objectives

- By the end of this module, participants should be able to:
 1. Competently perform the clinical skills necessary for providing woman-centered, abortion-related care
 2. Identify areas in the above skills that may need further practice

Explain the skill competency process.

- Competency is based on the participant's ability to properly perform the skills according to standardized protocols. Those protocols are defined in the skill checklists.
- Hand out copies of skill checklists for each session.
 - Explain that both participants and trainers will use the checklists.
 - Participants can use the checklists to provide feedback to their peers as well as to reinforce their own understanding of the skills.
 - Trainers will use them to measure the participants' competency.
 - Each skill checklist will be reviewed before the start of each practicum session.

Say: The aim in this practicum is for you to achieve skill competency. Your overall proficiency with these skills will come over time as you gain more experience.

Brief participants on the overall instructions for the clinical practicum.

- Explain that in the clinical practicum, they will be applying what they have learned from the didactic modules of this training.
- Advise participants that they should conduct the practice according to the checklists. The trainer will observe, taking notes as needed.
- Let participants know that this is an opportunity to acquire new skills and to practice the woman-centered approach they have learned throughout the course.

Say: Can someone list a few ways to be "woman-centered" when providing abortion-related services?

- Providing thorough counseling and ensuring informed consent; offering a choice of uterine evacuation and contraceptive methods; actively listening to the woman throughout the encounter; maintaining privacy by keeping the woman covered as much as possible; keeping the woman informed of your actions while providing care.

Describe the schedule for the practicum and participants' assignments.

- If participants will be divided into practice groups, instruct them on how their groups will operate.
- Explain when and where the trainers will give feedback. Individual feedback should ideally come immediately after each skill practice.
- Remind participants that they should follow the ground rules for giving feedback.
- Review the ground rules listed on Page 89 of the *Effective Training in Reproductive Health: Course Design and Delivery Trainer's Manual*.
- Tell participants that there are alternative activities available for times when there is no opportunity to practice procedures.

Tour the practicum facility with the group.

- Describe practicum-relevant aspects of the facility, including staffing, locations of restrooms and phones.

Before we move into the actual skill-practice sessions, what further questions or concerns are there?

- Answer any questions.
- Release the participants to their assignments.

2. Informed consent, information, counseling and contraceptive services

Say: Let's quickly review the key concepts from the Informed Consent, Information and Counseling and Contraceptive Services modules.

What three topics should be offered to the woman for discussion before a uterine evacuation?

Show flipchart: Before a Uterine Evacuation...

- Discuss pregnancy options if the woman has not already made a decision and desires counseling.
- Obtain voluntary informed consent.
- Explain procedure options and answer any questions she may have.

Say: What are the primary roles of an abortion-care counselor?

Take a few responses.

Show flipchart: Primary Roles of the Abortion-Care Counselor

- Solicit and affirm the woman's feelings.
- Elicit circumstances surrounding the pregnancy that have implications for her clinical care and referrals to other services she might need.
- Help the woman clarify her thoughts and decisions about her pregnancy, choices and her future sexual and reproductive health.
- Allow the woman to explore her feelings about abortion.
- Ensure that the woman receives appropriate answers to her questions and concerns, in language that she understands.
- Provide referrals to additional services if necessary.
- Help the woman determine who she might go to for social support, if she wants that.

Say: There are many techniques used to effectively communicate; let's brainstorm a few of them.

Label a flipchart: Ways to Effectively Communicate

- Write participants' answers on the flipchart.
- Be sure the following answers are covered: stay attentive; ask open-ended questions; use encouraging words; use non-verbal cues to show interest in what she is saying; let her talk before providing more information; ensure that she understands the information; use age-appropriate language and terms; use active listening.

Say: Now let's review the important points for provision of contraception at the time of abortion-related care.

In general, women (including young women) can use all modern contraceptive methods immediately following a uterine evacuation if:

- There are no severe complications requiring further treatment
- The woman receives adequate counseling and gives informed consent
- The provider screens for any precautions for using a particular contraceptive method

Label a flipchart: Considerations for Medical Eligibility for Contraceptives

- Write participants' answers on the flipchart.

Refer to section 8.0 of the Reference Manual to ensure that all the key points are mentioned.

Ask participants what concerns or questions they have about practicing abortion-related counseling and contraceptive services.

- Lead a discussion about the issues raised.
- If participants do not raise particular issues, review critical areas that may challenge them.

- Review the Informed Consent, Information and Counseling and Contraceptive Services checklists.
- Point out that this session uses two skill checklists: Informed Consent, Information and Counseling and Contraceptive Services.
- Allow participants to raise questions or ask for clarification.
- Brief participants with instructions for the Counseling and Contraceptive Services practicum.
- Explain any details of the session practicum that have not already been covered.
- Assure participants that they will have an opportunity to practice providing information, pregnancy options and abortion-related counseling, obtaining informed consent (if the woman desires), and contraceptive-services counseling.
- Advise them about any factors or protocols that may impact their practice.

Begin practicum: Informed Consent, Information and Counseling and Contraceptive Services

- Release the participants to their assignments.

When the practice is finished, lead participants in a debrief discussion on counseling and contraceptive services.

Note to Trainer: Use the following steps to debrief a clinical practicum session.

- Ask participants what they thought about their practice:
 - What was easiest? Most difficult?
 - What surprised them?
 - What were their strongest skills?
 - What skills do they need to improve the most?
 - What did they learn about providing appropriate care for young women?
 - What did they learn about caring for women in general?
- Share your and other trainers' feedback about the practicum.
- Ask the participants for a session evaluation or other feedback.
- Summarize lessons learned.
- Ask the participants what they see as their most important next steps toward gaining skills mastery.
- Ask how you might assist them, either in this practicum or at another time.

3. Clinical Assessment

Say: Let's do a quick review of some of the key issues from the Clinical Assessment module. What are the key issues a health worker should consider when assessing a woman for a uterine evacuation?

Show flipchart: Assessing a Woman for Abortion-Related Care

- Is she pregnant?
- What is the length of the pregnancy?
- What is the uterine size?
- Are there any medical conditions that could affect her care?
- Does she have any special needs?

Say: Answers to these questions are obtained during the clinical assessment. Let's review the elements of a clinical assessment.

Show flipchart: Complete Clinical Assessment

- Woman's history
- Physical examination
- Collection of specimens and ordering of any lab tests, only if needed

Refer to the flipchart as you review the details of clinical assessment.

- Ask participants to turn to the Clinical Assessment module in the Reference Manual.
- Allow participants to raise questions and ask for clarification as you review it.
- Use your judgment to determine which areas to cover in more depth.

Ask participants what outstanding concerns or questions they have about practicing the clinical assessment.

Review the Clinical Assessment checklist.

- Allow participants to raise questions or ask for clarification.

Brief participants with instructions for the Clinical Assessment practicum.

- Explain any details of the session that have not already been discussed.
- Advise them about any factors or protocols that may impact their practice.

Begin practicum: Clinical Assessment

- Release the participants to their assignments.

After the practice, lead participants in a debriefing discussion on the clinical assessment.

4. Ipas MVA instrument processing

Say: Now let's do a quick review of some of the key MVA instrument-processing issues we learned in the Reference Manual. Which standard precaution techniques must be followed when processing instruments?

- Consider all blood and body fluids from every person to be infectious; use personal protective barriers such as gowns and face protection when exposure to those areas of the body might occur; guard against skin punctures from sharp instruments; always wear gloves when handling blood or other body fluids; wash hands immediately before and after contact with contaminated items, even if gloves were worn.

What are the four basic steps for processing Ipas MVA Plus aspirators and Ipas EasyGrip® cannulae?

Label flipchart: Four Steps for Processing Ipas MVA Plus

- Write participants' answers on the flipchart.
- 1. Decontamination soak, 2. Cleaning, 3. Sterilization or high-level disinfection, 4. Storage

Say: What are the common options for processing the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae?

Label flipchart: Processing Options for Ipas MVA Plus

- Write participants' answers on the flipchart.
- Steam autoclave at 121°C (250°F) with 106 KPa pressure (15lbs/in²); glutaraldehyde (Cidex); 0.5 percent chlorine solution; boiling

Say: When steam autoclaving the instruments, why is it important to pay attention to the temperature specified?

- Using a different temperature or other settings may damage the instruments.

Say: Is it necessary to sterilize or high-level disinfect the aspirator?

- Yes. The aspirator must be sterilized or HLD after use but can be stored clean before using it another time.

Say: What is the purpose of a decontamination soak?

- Following the procedure, all instruments to be reused should be kept wet until they can be cleaned. Soaking instruments immediately after use removes some material and makes them easier to clean by preventing material from drying on them. Soaking in a disinfectant, however, does not make items safe to handle with bare hands. It is essential to wear gloves and face protection.

Review the Instrument Processing Skills Checklist.

- Allow participants to raise questions or ask for clarification.
- Ask them if they have any outstanding concerns or questions about processing Ipas MVA instruments.

- Lead a discussion about the issues raised.

5. Uterine evacuation procedure with Ipas MVA Plus

Say: Let's review some of the key issues from the Uterine Evacuation Procedure With Ipas MVA Plus module. What are the factors to consider when developing a pain-management plan?

Label flipchart: Pain Management: Factors

- Write participants' answers on the flipchart.
- Be sure that answers include: what the woman wants and needs; medical history; physical and psychological status; anxiety; nature of the procedure; resources available; facility protocols.

Say: An appropriate pain-management plan should take into consideration the types of pain medication for uterine evacuation.

- Anxiolytics for anxiety
- Anesthetic: paracervical block using lidocaine
- Nonsteroidal analgesics (ibuprofen or naproxen)
- Conscious sedation

Say: Let's review how to develop a pain management plan with the woman:

- Explain the procedure.
- Discuss options available to reduce pain and their potential side effects.
- Ask about her preferred support measures: companion, silence, distraction, information, environment and others.
- Non-pharmacologic measures can be used in addition to but are not a replacement for pain medication.
- Decide on a pain-management plan.

In general, pain can be reduced with a combination of verbal support, oral medications, paracervical block, skilled and gentle clinical technique and calming environment.

Advise participants about practicum-facility protocols for pain management and what medications are available.

Say: Now let's talk about the MVA procedure itself: What are some important considerations to remember during the MVA procedure?

- Ensure that the following answers are included in the discussion: ensure the aspirator can maintain a vacuum; take care when attaching or detaching the cannula from the aspirator; check the products of conception (POC) when finished; support the woman and protect her

privacy; and monitor for complications.

Show flipchart: Steps for Performing MVA

1. Prepare instruments.
2. Prepare the woman.
3. Perform cervical antiseptic preparation.
4. Perform paracervical block.
5. Dilate cervix.
6. Insert cannula.
7. Suction uterine contents.
8. Inspect tissue.
9. Perform any concurrent procedures.
10. Take immediate post-procedure steps, including instrument processing.

Say: Let's do a quick review of some key issues of post-procedure care. What kind of physical monitoring do you need to do?

- Check vital signs; evaluate bleeding and cramping at least twice; ensure that she's resting comfortably; ensure recovery from procedure and medications; review chart for condition, history and baseline vitals.

Say: What post-procedure symptoms might lead you to further evaluate the woman?

- Significant physical decline; dizziness, shortness of breath, fainting; severe vaginal bleeding; severe abdominal pain or cramps.

Briefly discuss practicum-facility protocols for pain management, provision of antibiotics and other aspects of post-procedure care.

- Review practicum-facility options for scheduling a follow-up appointment, if desired.

Lead a short review discussion on monitoring a woman's emotional state, providing support and counseling her on contraception after the procedure.

Ask participants to turn to the Post-Procedure Care section of the Reference Manual.

- Ask a participant to read aloud the discharge instructions and list of danger signs a woman should be prepared to monitor after she leaves the facility.

Ask participants what concerns or questions they have about practicing post-procedure care.

- Lead a discussion about the issues raised.

- If they do not raise particular issues, review critical areas that may challenge them.

Say: Let's do a quick review of some of the key follow-up care issues. What is the purpose of follow-up care?

- To ensure that the uterine evacuation is complete following misoprostol-only abortions; to follow up on concerns, complications, contraceptive services and emotional issues; to provide preventive care and referrals for other services.
- There is no medical need for a routine follow-up visit following an uncomplicated uterine evacuation, except for a misoprostol-only medical abortion (not treatment of incomplete abortion with misoprostol). However, all women should be advised that additional services are available to them if needed or desired.

Label flipchart: Elements of Follow-Up Care

- Ask participants to name the elements of a follow-up care visit.
- Write their answers on the flipchart.
- Physical elements: review medical record; ask how the woman has been feeling since the procedure; assess physical status; review any laboratory tests results; stabilize, treat or refer for any acute problems and ensure that any earlier complications have been resolved; if evacuation is incomplete, perform VA again.
- Information and referrals: inform her what to expect following completion or continued treatment, ask about contraceptive needs, determine other social needs, refer for other services where indicated.

Many participants have experience with the physical-examination elements of follow-up care, but may not have as much experience with the information provision and referrals aspects. Participants should keep this in mind when practicing.

Review the Uterine Evacuation Procedure With Ipas MVA Plus Checklist.

- Allow participants to raise questions or ask for clarification.
- Ask them if they have any outstanding concerns or questions about the MVA procedure.
- Lead a discussion about the issues raised.

Brief participants with instructions for the uterine evacuation with MVA practicum.

- Explain details of the practicum that have not already been covered.
- Explain the protocol to be used in case of adverse events.
- Remind participants to address the emotional elements of care.
- Advise them about any facility factors or protocols that may impact

their practice.

- Discuss practicum-facility referral protocols and options.
- Discuss practicum-facility protocols for processing instruments, addressing any variance with protocols taught in this training course.
 - Ensure that they have an opportunity to practice with the instrument-processing method(s) used at their home facilities.
- If participants are going to different locations to practice different units of this section, explain each of their assignments.

Begin practicum: Uterine Evacuation Procedure With Ipas MVA Plus

- Release participants to their assignments.
- Ideally, a trainer should perform the first MVA procedure while the participants observe. However, this may not be practical depending on the number of observers allowed and the caseload at the practicum facility.
- Advise participants that they should perform instrument processing at the practicum facility even if this is not a role they usually fill at their home facilities. The skills they gain can be used later when supervising others who process instruments.
 - Participants can be paired with staff who usually process instruments or matched with a trainer who is proficient at instrument processing.

When participants have finished their practice, lead a debrief discussion on performing uterine evacuation with the Ipas MVA Plus.

Practicum: IUD insertion, for those with previous training on the procedure

What are the eligibility criteria for IUD insertion after uterine aspiration?

- A woman is eligible for IUD insertion if she has an uncomplicated uterine aspiration. She cannot have an IUD placed after a septic abortion. She is eligible for an IUD if she has been counseled about the method and chooses it for contraception.
- Review the post-MVA IUD insertion sections of Contraceptive Services skills checklist.

6. Uterine evacuation with medical methods

Say: Let's quickly review some of the key issues from the Medical Methods module. What are the eligibility criteria for uterine evacuation with mifepristone and misoprostol or misoprostol only?

- A confirmed pregnancy of up to 13 weeks since the last menstrual period (LMP)
- For treatment of incomplete abortion: uterine size up to 13 weeks,

open cervical os and vaginal bleeding or history of vaginal bleeding during this pregnancy

Say: Let's look at some contraindications to uterine evacuation with medical methods.

Show flipchart: Contraindications to UE With Medical Methods

- Ectopic pregnancy (confirmed or suspected)
- Allergy to mifepristone, misoprostol, prostaglandins
- Chronic adrenal failure (only for mifepristone with misoprostol)
- Inherited porphyria (only for mifepristone with misoprostol)
- For incomplete abortion: signs of pelvic infection or sepsis, hemodynamic instability or shock

Show flipchart: Precautions for UE With Medical Methods

- IUD in place: Evaluate for the presence of ectopic pregnancy; if none, remove the IUD
- Severe uncontrolled asthma or long-term corticosteroid therapy (only for mifepristone with misoprostol)
- Severe/unstable health problems
- For incomplete abortion: uterine size 13 weeks or larger

Review the Uterine Evacuation with Medical Methods Skills Checklist.

- Allow participants to raise questions or ask for clarification as you review it.

Ask participants what outstanding concerns or questions they have about practicing UE with medical methods.

- Lead a discussion about the issues raised.

Brief participants with instructions for the Uterine Evacuation With Medical Methods practicum.

- Explain details of the practicum that have not already been covered.
- Explain the protocol in case of adverse events.
- Remind them to provide full information to the woman.
- Advise them about any practicum-facility factors or protocols that may impact their practice.
- Discuss practicum-facility referral protocols and options.
- Begin practicum: Uterine Evacuation With Medical Methods
- Release participants to their assignments.
- Ideally, a trainer should begin the first UE with medical methods

session while the participants observe. However, this may not be practical depending on the number of observers allowed and the caseload at the practicum facility.

- Participants should practice both initial administration and follow-up or confirmation for uterine evacuation with medical methods.

When participants have finished the practicum, lead a debriefing discussion.

7. Complications

Note to trainer: If the clinical practicum facility treats women with complications of abortion, arrange for the participants to observe (in pairs, for example) the management of these complications. It may even be appropriate for some participants, depending on their skills and facility protocols, to actually assist with the woman's care. In no way should the practicum interfere with the woman's treatment – but it is possible to use the situation as a learning opportunity.

Review the most common types of complications and their management.

- This review will most likely need to be adapted to whether the training is primarily on comprehensive abortion care or postabortion care, and the types of UE methods that are available locally.

Review the Management of Complications Checklist.

- This checklist review will likely need to be adapted to fit the circumstances.
- Ask participants what concerns they have about practicing complications management.
- Brief participants with instructions for the complications practicum.
- Whether attending to a woman with complications or only observing, participants should be monitored using the checklists, as in any other session.
- Explain any details of the practicum that have not been covered.
- Advise them about any facility factors or protocols that may impact their practice.

Begin practicum: Management of Complications

Note to trainer: Complications may not occur during the practicum. If they do not, ensure that participants have opportunity to practice through role play diagnosis and treatment of complications.

- Release participants to their assignments.

When their practice is finished, lead participants in a debrief discussion on management of complications.

8. Summary and evaluation

Conduct a debrief of the practicum.

- Ask participants for key points covered in the practicum. Use the objectives as a reference.
- Ask participants what comments they have regarding the clinical practicum experience.
- Have participants complete the End-of-Course Evaluation form and collect the forms.
- Ask participants what worked well and what did not in the clinical practicum.
 - Referring to the session evaluations or other feedback given by participants, brainstorm ideas for improving the practicum for future participants.

Give instructions for the Skills Improvement Follow-Up activity.

- Hand out a piece of blank paper to each participant.
- Instruct participants to tear the piece of paper into two halves.
- Ask them to write their name and three specific skills they want to improve on one half of the paper and then copy the same information onto the other half.
- Have them pass one half to you and keep the other half themselves. Tell them that the half they kept is a reminder—or small “action plan”—of skills they can improve and seek additional training or supervision for during the coming months.
- In one to two months, send the other half to each participant with a note asking them how their progress is going.

Ask the participants what they see as their most important next steps and how you might assist them.

Thank the participants for their participation and tell them how you may be reached for more information or support.

Conduct closing ceremony.

- At the completion of an entire training course, a ceremony is often held to present certificates and acknowledge participants, staff and trainers. Arrange the closing ceremony according to local practices.
- Hand out Certificates of Attendance and Competency.

References

Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual (second ed.)*. (K. L. Turner & A. Huber Eds.). Chapel Hill, NC: Ipas.

Ipas. (2014). *Woman-centered postabortion care: Reference manual (second edition)*, (K. L. Turner & A. Huber Eds.). Chapel Hill, NC: Ipas.

World Health Organization (2012). *Safe abortion: Technical and policy guidance for health systems, (second ed.)*. Geneva: World Health Organization.

Clinical Practicum Supplies and Equipment

Informed Consent, Information and Counseling and Contraceptive Services

- ☐ Private area
- ☐ Samples of available contraceptive methods, including IUD/IUS and implants
- ☐ Pamphlets, educational materials (for adult and younger women)
- ☐ Referral forms and logbook
- ☐ Consent forms
- ☐ Anatomic models including arm models for implant insertion practice

Clinical Assessment

- ☐ Clock
- ☐ Blood pressure cuff
- ☐ Thermometer
- ☐ Stethoscope
- ☐ Speculum
- ☐ Table with stirrups
- ☐ Gloves
- ☐ Lamp
- ☐ Cover for perineum
- ☐ Laboratory supplies
- ☐ Antibiotics
- ☐ Pain medication

Uterine Evacuation Procedure With Ipas MVA Plus

- ☐ Personal protective barriers (gloves, face protection, gown)
- ☐ Sink, soap, towels
- ☐ Lamp
- ☐ Speculum
- ☐ Tenaculum
- ☐ Betadine®, cup, clamp with gauze
- ☐ 10cc syringe, 23 gauge 1.5" needle
- ☐ Xylocaine 1.0% or 0.5%

- ☐ Pain medication
- ☐ Cervical dilators or misoprostol
- ☐ Ipas MVA Plus aspirator
- ☐ Ipas EasyGrip cannulae
- ☐ Container for POC, lamp, glass dish, sieve
- ☐ Bucket with soak fluid
- ☐ Pelvic model (for practice)
- ☐ Intrauterine device for post-evacuation IUD placement practice

Post-Procedure Care

- ☐ Clock
- ☐ Blood pressure cuff
- ☐ Stethoscope
- ☐ Thermometer
- ☐ Samples of contraceptive methods
- ☐ Referral forms and logbook

Follow-Up Care

- ☐ Clock
- ☐ Blood pressure cuff
- ☐ Stethoscope
- ☐ Thermometer
- ☐ Gloves
- ☐ Speculum
- ☐ Lamp
- ☐ Cover for perineum
- ☐ Samples of contraceptive methods
- ☐ Referral forms and logbook

Uterine Evacuation With Medical Methods

- ☐ Supplies listed above for Counseling and Contraceptive Services, Clinical Assessment
- ☐ Private waiting room
- ☐ Drinking water and cups

- ☐ Instructions and/or information sheet for women
- ☐ Analgesics
- ☐ Mifepristone and misoprostol, or misoprostol only depending on method being trained
- ☐ Side-effect medications (e.g. anti-nausea medicine)
- ☐ Equipment and medications for emergencies
- ☐ Sanitary pads
- ☐ Toilets
- ☐ (optional) Ultrasound and its accessories
- ☐ (optional) Urine β -hCG tests and urine cups

Complications

- ☐ Blanket
- ☐ Clock
- ☐ Blood pressure cuff
- ☐ Stethoscope
- ☐ Thermometer
- ☐ Oxygen tank
- ☐ Gloves
- ☐ IV fluids/set
- ☐ Antibiotics
- ☐ Pain medication
- ☐ Uterotonics

Note: Restrooms with toilets should be easily accessible to all women receiving abortion-related care.

Abortion-Related Care Clinical Skills Evaluation

Instructions: This is a checklist for the essential skills described throughout the training curriculum for abortion-related service delivery. It is brief and can be used to evaluate the participant's competence in abortion-care skills for training certification. The trainer evaluates the competence of each participant based on direct observation of the participant's provision of abortion-related care, including manual vacuum aspiration (MVA) and/or uterine evacuation with medical methods.

Certification in MVA service delivery requires demonstrating competency on all items in Part I. Certification in uterine evacuation with medical methods service delivery requires demonstrating competency on all items in Part II. If a participant does not demonstrate competency in Part I or II or cannot be observed, refer to Part III where recommendations can be made as to how performance might be improved to achieve competency.

Mark a check in the box next to each step that is competently demonstrated by the participant. After completing the form, discuss the results with the participant.

I. MVA Clinical Skills

- ☐ 1. Establishes rapport with the woman, helps her feel comfortable, ensures privacy
- ☐ 2. Assesses the woman's health: medical history including date of last menstrual period (LMP); physical examination; collection of specimens and ordering of any lab tests, only if needed
- ☐ 3. Provides counseling, or confirms that the woman received counseling, and obtains her informed consent
- ☐ 4. Provides contraceptive counseling, or confirms that the woman received contraceptive counseling, and prepares to provide her with her method of choice
- ☐ 5. Evaluates need for and administers pain management based on the woman's condition and her desires
- ☐ 6. Administers prophylactic antibiotics
- ☐ 7. Uses infection-prevention practices: handwashing, gloves, face protection
- ☐ 8. Assesses size and position of uterus
- ☐ 9. Identifies possible reproductive tract infection (RTI) and administers or prescribes therapeutic antibiotics if indicated
- ☐ 10. Ensures that the cannulae are high-level disinfected (HLD) or sterile, rinsed and ready for use
- ☐ 11. Prepares aspirator and checks vacuum
- ☐ 12. Selects cannula based on uterine size and dilatation needed; inspects cannula and aspirator
- ☐ 13. Swabs cervix, and vagina if desired, with antiseptic solution
- ☐ 14. Administers paracervical block and any other necessary medications
- ☐ 15. Dilates cervix, inserts cannula and attaches aspirator

- ☐ 16. Uses No-Touch Technique
- ☐ 17. Moves cannula effectively to empty the uterus
- ☐ 18. Stops evacuation when signs of completion are present
- ☐ 19. Examines the aspirate to confirm completion and to ensure it is consistent with the woman's length of pregnancy
- ☐ 20. Performs any concurrent procedures, such as IUD insertion, contraceptive implant insertion, contraceptive injection and sterilization; repair of cervical tear
- ☐ 21. Ensures post-procedure care is provided; monitors the woman's status
- ☐ 22. Ensures she was provided contraceptive counseling and her preferred method, if desired
- ☐ 23. Provides referrals as needed
- ☐ 24. Ensures follow-up care is scheduled, if the woman requests it

II. Uterine Evacuation With Medical Methods Clinical Skills

- ☐ 1. Establishes rapport with the woman, helps her feel comfortable, ensures privacy
- ☐ 2. Assesses the woman's health: medical history, date of last menstrual period (LMP), uterine size, emotional state
- ☐ 3. Provides counseling, or confirms that the woman received counseling, and obtains her informed consent
- ☐ 4. Provides detailed information about expected effects, side effects, warning signs, required visits and protocol in the event of failure of the procedure
- ☐ 5. Explains all aspects of the mifepristone and/or misoprostol administration regimen, including pain management
- ☐ 6. Provides emergency contact information in case the woman has questions or needs care
- ☐ 7. Ensures all the woman's questions have been answered
- ☐ 8. Ensures contraceptive counseling and a method are provided, if the woman desires one. Pills, patches, rings, implants, and injections may be started during the clinic visit
- ☐ 9. Discusses warning signs with the woman and signs of successful uterine evacuation with medical methods
- ☐ 10. Schedules follow-up visit if the woman requests it, or if a misoprostol-only regimen is used for medical abortion
- ☐ 11. If evaluating a woman who has returned for follow-up care after UE with medical methods, confirms completion of the uterine evacuation or provides back-up care or referral if needed

(PLEASE PRINT)

Evaluator

Participant

Name _____

Name _____

Title _____

Title _____

Date _____

Date _____

Signature _____

Signature _____

Name of Medical Facility _____

III. Recommendations

For skills that were not observed or were not performed to competency, make recommendations for improvement. For example: "needs to continue practice under supervision" or "repeat clinical training."

Item

Recommendation

Comments

Please add any comments you may have about the participant's ability to perform MVA or uterine evacuation with medical methods.

Additional Resources

Overview and guiding principles

Ipas online clinical and service delivery updates and courses

Clinical Updates in Reproductive Health provide up-to-date, evidence-based recommendations and clinical protocols. Available at Ipas's website, www.ipas.org/clinical updates.

Ipas University (IpasU) offers free, online, on-demand courses for reproductive health professionals on safe abortion care and postabortion care. These courses can be used for self-guided learning or as the online component of a blended learning model. Trainers may also want to use videos or other embedded materials during their training courses. For the IpasUniversity course catalog, see www.ipas.org; to register and take courses, please go to www.IpasU.org.

Medical Abortion Matters is a biannual newsletter, created to share global perspectives on medical abortion access, news and research. Subscribe online at: www.ipas.org/newsletters.

Service Delivery Matters is a biannual newsletter sharing technical news and updates – including training and service delivery strategies and tools, clinical recommendations, programmatic interventions and research results. It is for health-care providers, trainers, administrators, technical specialists and others who can positively influence how comprehensive abortion care is delivered. Subscribe online at: www.ipas.org/newsletters

Alan Guttmacher Institute. (2013). Guttmacher Institute: Advancing sexual and reproductive health worldwide through research, policy analysis and public education. From <http://www.guttmacher.org/>

Alan Guttmacher Institute & World Health Organization. (2012). *Facts on Induced Abortion Worldwide*. New York, NY: Alan Guttmacher Institute.

Burns, A. A., Ronnie Lovich, Jane Maxwell and Katharine Shapiro.(2012). *Where Women Have No Doctor*. Berkeley, CA: The Hesperian Foundation.

Center for Reproductive Law and Policy website. Retrieved from <http://reproductiverights.org/>

Center for Study of Adolescents, Pacific Institute for Women's Health, & ACE Communications. *The great betrayal* [Videocassette]: CSA PIWH ACE Communications.

Cook, R. J., & Dickens, B. M. (2000). *Considerations for formulating reproductive health laws, second edition*. Geneva: World Health Organization.

Cook, R. J., Dickens, B. M., & Fathalla, M. F. (2003). *Reproductive health and human rights: Integrating medicine, ethics, and law*. Oxford, UK: Oxford University Press.

Corbett, M. R., & Turner, K. L. (2003). Essential elements of postabortion care: origins, evolution and future directions. *International Family Planning Perspectives*, 29 (3), 106-111.

Creinin, M. D., Schwartz, J. L., Guido, R. S., & Pymar, H. C. (2001).Early pregnancy failure--current management concepts. *Obstetrical Gynecological Survey*, 56(2), 105-113.

Family Care International. (2001). *Advancing commitments: Sexual and reproductive health presentation Tools*. New York, NY: Family Care International (FCI).

- Family Health International. (1999). Client-provider interaction: Family planning counseling. *Contraceptive Technology and Reproductive Health Series*. Retrieved from <http://www.fhi360.org/sites/default/files/webpages/Modules/CPI/s1pg1.htm>
- Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., & Shah, I. H. (2006). Unsafe abortion: the preventable pandemic. *Lancet*, 368(9550), 1908-1919.
- Hall, J. A., Roter, D. L., & Katz, N. R. (1988). Meta-analysis of correlates of provider behavior in medical encounters. *Medical Care*, 26(7), 657-675.
- Hord, C. E. (2002). *Making safe abortion accessible: A practical guide for advocates*. Chapel Hill, NC: Ipas.
- International Planned Parenthood Federation. (1996). *The IPPF Charter on Sexual and Reproductive Rights*. London, UK: International Planned Parenthood Federation.
- Ipas. (2013). *Woman-centered, comprehensive abortion care: Reference manual* (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Ipas. (2014). *Woman-centered postabortion care: Reference manual* (second ed.). K. L. Turner & A. Huber (Eds.). Chapel Hill, NC: Ipas.
- Johns Hopkins University Population Communication Services, Program for Appropriate Technology in Health, & Zambia Information Services. (1997). Put yourself in her shoes [Videocassette]: JHU/PCS, PATH, and Zambia Information Services.
- John, J. (1991). Improving quality through patient-provider communication. *Journal of Health Care Marketing*, 11(4), 51-60.
- Hyman, A., Kumar, A. (2004). Defining a model for woman-centered comprehensive abortion care. *International Journal of Gynecology and Obstetrics*, 86(3), 409-410.
- Leonard, A. H., & Winkler, J. (1991). A quality of care framework for abortion care. *Advances in Abortion Care*, 1(1).
- Paulson, S., Gisbert, M. E., & Quiton, M. (2000). Rethinking differences and rights in sexual and reproductive health: A training manual for health-care providers. Research Triangle Park, NC: Family Health International.
- Postabortion Care (PAC) Consortium. (2013). From <http://www.pac-consortium.org/>. The Postabortion Care Consortium website has many useful PAC articles, tools and other resources.
- Turner, K. L., Borjesson, E., Huber, A., & Mulligan, C. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas.
- United Nations. (1994, 5-13 September 1994). *Programme of Action of the United Nations International Conference on Population and Development*. Paper presented at the International Conference on Population and Development, Cairo, Egypt.
- United Nations. (1995). *Programme of Action of the Fourth World Conference on Women*. Paper presented at the Fourth World Conference on Women, Beijing, China.
- United Nations. (1999). *Report of the Ad Hoc Committee of the Whole of the Twenty-first Special Session of the General Assembly, Including Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development*. (A/S-21/5/Add.1). New York, NY: United Nations.
- United Nations General Assembly. (2000). *United National Millennium Declaration*. (55/2). New York,

NY: United Nations.

United Nations Secretary-General. (2010). *Global strategy for women's and children's health*. Geneva, Switzerland: United Nations.

USAID Postabortion Care Working Group. *PAC Global Resources*. <http://postabortioncare.org/>

Varkey, S. J., Fonn, S., & Ketlhapile, M. (2001). *Health workers for choice: Working to improve quality of abortion services*. Johannesburg, South Africa: Women's Health Project, University of Witwatersrand.

Varkey, S. J., Ketlhapile, M., & Fonn, S. (2001). *Communities for choice: Abortion services workshop manual*. Johannesburg, South Africa: Women's Health Project.

Winkler, J., & Gringle, R. E. (1999). *Postabortion family planning: A two-day training curriculum guide for improving counseling and services*. Chapel Hill, NC: Ipas.

World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems*, (Second Edition ed.). Geneva, Switzerland: World Health Organization.

World Health Organization. (2001). *Transforming health systems: Gender and rights in reproductive health. A training curriculum for health care programme managers*. Geneva, Switzerland: World Health Organization.

Yellen, E., & Davis, G. C. (2001). Patient satisfaction in ambulatory surgery. *Association of Operating Room Nurses (AORN) Journal*, 74(4), 483-498.

Reproductive Rights

Cook, R., Dickens, B.M. & Fathalla, M.F. (2003). *Reproductive health and human rights: Integrating medicine, ethics, and law* (pp. 372-377). Oxford, UK: Oxford University Press.

Turner, K. L., Borjesson, E., Huber, A., & Mulligan, C. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas.

Hands On for Mothers and Babies. (2012). *Why Did Mrs X Die, Retold*. Dorchester, UK: Hands On for Mothers and Babies. Retrieved from <http://www.figo.org/news/why-did-mrs-x-die-retold-launched-fi-go-world-congress-2012-0010519>

World Health Organization. (2001). *Transforming health systems: Gender and rights in reproductive health. A training curriculum for health care programme managers*. Geneva, Switzerland: World Health Organization.

Community Linkages

For more information on community involvement and linkages with comprehensive abortion services, which includes postabortion care, please contact Ipas's Community Access team at cx@ipas.org.

Cohen, L., Baer, N., & Satterwhite, P. (2002). Developing effective coalitions: An eight step guide. In M. E. Wurzbach (Ed.), *Community health education and promotion: A guide to program design and evaluation* (second ed.). Gaithersburg, MD: Aspen Publishers Inc.

de Souza Briggs, X. (2003). *Community problem-solving: Strategy for a changing world*. Retrieved from <http://www.community-problem-solving.net/CMS/?pageId=216&parentPageId=1>

Health Communications Partnership. *How to mobilize communities for health and social change*. Retrieved from <http://www.jhuccp.org/node/1256>

IRH/Pathfinder International/Save the Children. (2013). *The Gender Roles, Equality, and Transformations (GREAT) Scalable Toolkit*. Entebbe, Uganda. Retrieved from <http://irh.org/resource-library/great-scalable-toolkit/>

Kretzmann, J. P., & McKnight, J. L. (1993). *Building communities from the inside out: A path towards finding and mobilizing community assets*. Chicago, IL: ACTA Publications.

Mchombu, K. (2004). *Sharing knowledge for community development and transformation: A handbook*. Ottawa, ON: Oxfam Canada.

Pathfinder International. (2013). *Straight to the Point Capacity Building Tools*. Watertown, MA: Pathfinder International. Retrieved from <http://www.pathfinder.org/publications-tools/publication-series/Straight-to-the-Point-Capacity-Building-Tools.html>

Prevention Institute. (2002). *Developing Effective Coalitions: An Eight Step Guide*. Oakland, CA: Prevention Institute. Retrieved from http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=104&Itemid=127

Prevention Institute. 2011. *Collaboration Multiplier*. Oakland, CA: Prevention Institute. Retrieved from http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=44&Itemid=127

Samuels, B., Ashan, N., & Garcia, J. (1995). *Know your community: A step-by-step guide to community needs and resource assessment*. Chicago, IL: Family Resource Coalition.

U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, & National Cancer Institute. (1989). *Making health communication programs work: A planner's guide*. (89-1493). Retrieved from http://www.cancer.gov/cancertopics/cancerlibrary/pinkbook/Pink_Book.pdf

Welbourn, A., & Bollinger, A. (1995). *Stepping Stones: A training package in HIV/AIDS, communication and relationship skills*. Retrieved from <http://www.steppingstonesfeedback.org/index.php/page/Home/gb>

Winer, M., & Ray, K. (1994). *Collaboration handbook: Creating, sustaining, and enjoying the journey*. St. Paul, MN: Amherst H. Wilder Foundation.

Uterine Evacuation Methods

Ipas. (2011). *MA supply guidance calculator*. Chapel Hill, NC: Ipas. Retrieved from <http://www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Elements-of-Comprehensive-Abortion-Care/Medical-Abortion--MA-/Medical-Abortion--MA--Supply-Guidance.aspx>

Ipas. (2008). *MVA calculator*. Chapel Hill, NC: Ipas. Retrieved from <http://www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Elements-of-Comprehensive-Abortion-Care/MVA/MVA-Calculator.aspx>

Ipas. (2008). *MVA sustainable supply workbook*. Chapel Hill, NC: Ipas. Retrieved from <http://www.ipas.org/en/Resources/Ipas%20Publications/MVA-sustainable-supply-workbook.aspx>

Ipas. (2008). *Stocking facilities with MVA equipment according to caseload*. Chapel Hill, NC: Ipas. Retrieved from <http://www.ipas.org/en/Resources/Ipas%20Publications/Stocking-facilities-with-MVA-equipment-according-to-caseload.aspx>

John Snow, Inc./DELIVER in collaboration with the World Health Organization. (2003). *Guidelines for the Storage of Essential Medicines and Other Health Commodities*. Arlington, VA: John Snow, Inc./DELIVER, for the U.S. Agency for International Development. Retrieved from http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/GuidStorEsse_Pock.pdf

Monitoring to Improve Services

Balkhy, H. H., Memish, Z. A., & Almuneeef, M. A. (2003). Effect of intensive surveillance on cesarean-section wound infection rate in a Saudi Arabian hospital. *American Journal of Infection Control*, 31(5), 288-290.

EngenderHealth. (2003). *COPE® Handbook: A process for improving quality in health services, revised edition*. New York, NY: EngenderHealth.

Ipas. (2010). *Safe Abortion Care Toolkit*. Chapel Hill, NC: Ipas. Retrieved from <http://www.ipas.org/en/resources/ipas%20publications/safe-abortion-care--sac--toolkit--cd-.aspx>

Informed Consent, Information and Counseling

EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum*. New York, EngenderHealth. <http://www.engenderhealth.org/pubs/maternal/pac-counseling.php>

Rinehart, Ward, Sharon Rudy and Megan Drennan. (1998). GATHER guide to counseling. *Population reports*, Series J, No. 48. Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program. Retrieved from : <http://archive.k4health.org/toolkits/INFO-publications/gather-guide-counseling>

Turner, K. L., & Page, K. C. (2008). *Abortion attitude transformation: A values clarification toolkit for global audiences*. Chapel Hill, NC: Ipas.

Turner, Katherine L., Evelina Borjesson, Amanda Huber, Cansas Mulligan. (2011). *Abortion care for young women: A training toolkit*. Chapel Hill, NC: Ipas.

WHO and UNAIDS. (2007). *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva: WHO. Retrieved from: <http://www.who.int/hiv/pub/vct/pitc/en/index.html>

Contraceptive Services

American Medical Women's Association. (1997). *Fourth-year curriculum in reproductive health, module 6: Contraception*. Alexandria, VA: American Medical Women's Association.

The Center for Reproductive Law and Policy. (2000). *Speak EC: What every woman needs to know about emergency contraception*. Produced by Barbara Becker and Susan Wynn. 11 minutes. Videocassette.

Consortium for Emergency Contraception. (1996). *Using emergency contraceptive pills (ECPs): A prototype ECP training curriculum*. Research Triangle Park, NC: Consortium for Emergency Contraception.

Consortium for Emergency Contraception. (1996). *Uso de piladores anticonceptivos de emergencia (PAE): Entrenamiento sobre PAE*. Research Triangle Park, NC: Consortium for Emergency Contraception.

Contraceptive Choice Project. *Long-Acting Reversible Contraception (LARC) FIRST Resource Center*. St. Louis, MO: Washington University in St. Louis. Retrieved from www.larcfirst.com

Farrell, Betty, Cathy Solter and Douglas Huber. (2000). *Emergency contraceptive pills, module 5*. Watertown, MA: Pathfinder International.

FIGO, Population Council, and Reproductive Health Supplies Coalition. (2012). *Bellagio Consensus: Recommendations for Action to Increase Access to Highly Effective, Long-Acting, Reversible Contraception*. New York, NY: The Population Council. Retrieved from: <http://www.popcouncil.org/mediacenter/>

ter/newsreleases/2012_BellagioRecommendations.asp

Kumar, J., L. Bakamjian, H. Connor, and S. Harris. (2013). *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Tools*. Washington, DC: Futures Group and EngenderHealth.

Pathfinder International. (2013). *Cue cards for counseling adolescents on contraception*. Watertown, MA: Pathfinder International. Retrieved from <http://www.pathfinder.org/publications-tools/cue-cards-for-counseling-adolescents-on-contraception.html>

Turner, Katherine L., Evelina Borjesson, Amanda Huber, Cansas Mulligan. 2011. *Abortion Care for young women: A training toolkit*. Chapel Hill, NC: Ipas.

World Health Organization. (2010). *Medical eligibility criteria for contraceptive use (4th ed.)*. Geneva, Switzerland: World Health Organization.

Infection Prevention

Association of Operating Room Nurses (AORN). (2010). Aseptic technique, video. Denver, AORN. Retrieved from: http://www.aorn.org/CustomApps/ISGStdRender/Default.aspx?opt=ProductDetail&Product_code=10751/7501

Centers for Disease Control and Prevention. (2001). Appendix B: Management of occupational blood exposures. *Morbidity and mortality weekly report*, 50(RR11): 45–6. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a3.htm>

EngenderHealth. (2011). *Infection prevention: A reference booklet for health care providers*, 2nd edition. New York, NY: EngenderHealth. Retrieved from: <http://www.engenderhealth.org/files/pubs/qi/ip/ip-ref-eng-new.pdf>

Siegel, Jane D, Emily Rhinehart, Marguerite Jackson, Linda Chiarello. (2007). *Guideline for isolation precautions: Preventing transmission of infectious agents in healthcare settings*. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved from: <http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>

Tietjen, Linda, Débora Bossemeyer and Noel MacIntosh. (2003). *Infection prevention: Guidelines for healthcare facilities with limited resources*. Baltimore, MD: JHPIEGO. Retrieved from: <http://www.jhpiego.org/en/node/448>

World Health Organization (WHO). (2009). *WHO Guidelines on Hand Hygiene in Health Care*. Geneva, Switzerland: WHO. Retrieved from: http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf

World Health Organization (WHO). (2012). *Clean care is safer care*. Geneva, Switzerland: WHO. Retrieved from: <http://www.who.int/gpsc/en/>

Clinical Assessment

National Abortion Federation. (2005). *Clinical training curriculum in abortion practice*, 2nd edition. Washington, DC: National Abortion Federation.

Uterine Evacuation with Ipas MVA Plus

Please write to customerservice@womancareglobal.org if you have specific questions about the Ipas MVA instruments.

Uterine Evacuation with Medical Methods

Gynuity Health Projects and Ipas. (2012). *Misoprostol for treatment of incomplete abortion: Training guide*. New York, NY and Chapel Hill, NC: Gynuity Health Projects and Ipas.

Gynuity Health Projects website: <http://www.gynuity.org>

Information Package on Medical Abortion and other resources are available for download on the International Consortium for Medical Abortion (ICMA) website: <http://www.medicalabortionconsortium.org>

Ipas. (2013). *Medical abortion study guide* (second ed.). K. L. Turner (Ed.). Chapel Hill, NC: Ipas.

Ipas. (2013). *Medical abortion training guide* (second ed.). K. L. Turner (Ed.). Chapel Hill, NC: Ipas.

Complications

Agency for Healthcare Research and Quality (AHRQ) - Patient Safety Network. (2012). *Patient Safety Primers: Root Cause Analysis*. Rockville, MD: AHRQ. Retrieved from <http://psnet.ahrq.gov/primer.aspx?primerID=10>

American Medical Women's Association. (1997). *Fourth-year elective curriculum in reproductive health, module 4: Sexually transmitted diseases*. Alexandria, VA: American Medical Women's Association.

Buffington, S.T., Beck, D.R., and P.A. Clark. (2008). *Life-saving skills manual for midwives, module 7: Infections*. Silver Spring, MD: American College of Nurse Midwives.

Institute for Healthcare Improvement. (2004). *Cause and Effect Diagram*. Boston, MA: Institute for Healthcare Improvement. Retrieved from http://nciph.sph.unc.edu/mlc/presentations/perf_imp/CauseandEffect1.pdf

National Abortion Federation. (2005). *Clinical training curriculum in abortion practice, 2nd edition*. Washington, DC: National Abortion Federation.

NHS Institute for Innovation and Improvement. (2008). *Quality and Service Improvement Tools: Root Cause Analysis Using Five Whys*. London, UK: NHS. Retrieved from http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/identifying_problems_-_root_cause_analysis_using5_whys.html

Paul, M., F. H. Stewart, T. A. Weitz, N. Wilcox and J. M. Tracey. (2003). *Early abortion training workbook*. San Francisco, CA: UCSF Center for Reproductive Health Research & Policy.

World Health Organization. (2008). *Learning from error: Patient safety workshop* (video and booklet). Retrieved from http://www.who.int/patientsafety/education/vincristine_download/en/index.html

Clinical Practicum

Intrah and JHPEIGO. (2002). *Transfer of learning: A guide for strengthening the performance of health care workers*. Chapel Hill, NC and Baltimore, MD: Intrah/PRIME II and JHPEIGO.

JHPEIGO. (2001). *Advanced training skills: Course notebook for trainers*. Baltimore, MD: JHPEIGO.

Schaefer, L., R. Sullivan, A. Blouse, J. Smith and E. Lowry. (2000). *Advanced training skills for reproductive health professionals*. Baltimore, MD: JHPEIGO.

Sullivan, Rick and Lynne Gaffikin. (1997). *Instructional design skills for reproductive health professionals*. Baltimore, MD: JHPIEGO.

Sullivan, R., R. Magarick, G. Bergthold, A. Blouse and N. McIntosh. (1995). *Clinical training skills for reproductive health professionals*. Baltimore, MD: JHPIEGO.

Wegs, Christina, Katherine Turner and Betsy Randall-David. (2003). *Effective training in reproductive health: Course design and delivery*. Reference manual. Chapel Hill, NC: Ipas.

Werner, David and Bill Bower. (2001). *Helping health workers learn*. Palo Alto, CA: Hesperian Foundation.

