

Second Edition

Medical Abortion Training Guide

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.

Ipas
Health. Access. Rights.

ISBN: 1-933095-56-3

Produced in the United States of America.

Suggested citation: Ipas. (2013). *Medical abortion training guide* (second ed.) K. L. Turner (Ed.), 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.

Acknowledgments

This second edition of Ipas' Medical Abortion Training Guide was revised by the following Ipas staff and consultants:

Katherine L. Turner, USA, editor

Jennifer Soliman, USA, revision coordinator

Lead revision team:

Alice Mark, USA

Amanda Huber, USA

Bill Powell, USA

Joan Healy, USA

Technical reviewers:

Alyson Hyman, USA

Anna de Guzman, USA

Nadia Shamsuddin, USA

*The following Ipas staff and colleagues provided valuable inputs:**

Alison Edelman, USA

Bhagawati Badal, Nepal

Dalia Brahmi, USA

Deeb Shrestha Dangol, Nepal

Ganesh Bahadur Singh, Nepal

Kalpana Khadsaka, Nepal

Manish Aryal, Nepal

Mary Fjerstad, USA

Makgoale Magwentshu, South Africa

Meena Kumari Shrestha, Nepal

Prativa Koirala, Nepal

Tarun Poudel, Nepal

We give thanks to Ipas staff who contributed to the development of the first edition:

Alfonso Carrera, Mexico

Alyson Hyman, USA

Bill Powell, USA

Cansas Mulligan, USA

Ganesh Shrestha, Nepal

Indira Basnett, Nepal

Jennie Orcutt, USA

Joachim Osur, Kenya

Joan Healy, USA

Joseph Mills, Ghana

Josephine Addy, Ghana

Karen Trueman, South Africa

Kari Koita, Kenya

Katherine Turner, USA

Karen Padilla, Nicaragua

Laura Castleman, USA

Makgoale Magwentshu, South Africa

Mary Fjerstad, USA

Mary-Jane Zondo, South Africa

Marian Abernathy, USA

Nadia Shamsuddin, Thailand

Phan Bich Thuy, Vietnam

Robyn Sneeringer, USA

Rodolfo Gómez Ponce de León, Argentina

Sangeeta Batra, India

Sarah Packer, USA

Sikiratu Kailani, Nigeria

Takele Geressu, Ethiopia

Tiemoko Ouattara, Burkina Faso

Traci Baird, USA

We give our appreciation to the Swedish International Development Agency for contributing funding to the development of the first edition of this training package through a grant to Ipas.

*We would like to thank the following people for giving their time and expertise to the development of Ipas's Medical Abortion Training Program:**

Ali Samba, Ghana
Alison Edelman, USA
Anne Burke, USA
Beth Kruse, USA
Beverly Winikoff, USA
Blami Dao, Burkina Faso
Caitlin Shannon, USA
Chanda Karki, Nepal
Christina Wegs, USA
Danielle Hassoun, France
Dalia Brahmi, USA
Fabian Rodriguez, Uruguay
George Huggins, USA
Hela Chelli, Tunisia
Helena Von Hertzen, Switzerland
Joe Taylor, Ghana
Kusum Thapa, Nepal
Lisa Memmel, USA
Lisa Moreau, USA
Meera Ojha, Nepal
Meera Upadhyay, Nepal
Melanie Peña, USA
Mitchell Creinin, USA
Nitin Joglekar, India
Nguyen Thi Nhu Ngoc,Vietnam
Paige Layno-Winn, USA
Paul Blumenthal, USA
Phillip Stubblefield, USA
Pramila Pradha, Nepal
Rodica Comendant, Moldova
Selma Hajri, Tunisia
Shilu Aryal, Nepal
Suchitra Dalvie, India
Swaraj Rajbhandari, Cambodia

**The protocols and content in this publication do not necessarily reflect the views and opinions of each individual contributor.*

We give special thanks to the many colleague agencies who field tested the first edition of the training package:

Nepal Training on Medical Abortion for Lead Trainers and the Family Health Division, Government of Nepal

Africa Regional Training of Trainers on Medication Abortion and the Centre de Formation Internationale et de Recherche (CéFIR), Tunisia

Cambodia Technical Working Group on Medical Abortion and the National Reproductive Health Program, Government of Cambodia

South African Medical Abortion Curriculum Review Committee

Table of Contents

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

Medical Abortion Study Guide (pdf file)

Medical Abortion Training Guide (pdf file)

Medical Abortion Training Guide Powerpoint Presentation (ppt file)

Quiz Show Powerpoint and Flash Plug-in (ppt and swf file)

Medical Abortion in Early Pregnancy: Information, Education, and Communication (IEC) Materials and Job Aids

MA Supply Guidance Spreadsheet (xls file)

Woman-Centered, Comprehensive Abortion Care: Reference Manual and Trainer's Manual, Second Edition (pdf and ppt files)

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)

Medical Abortion Training Guide

The *Medical Abortion Training Guide,* Second Edition is one of two companion documents in the Ipas medical abortion (MA) training package.

- *Medical Abortion Study Guide,* Second Edition – to be used for self-directed study prior to attending an in-person workshop and clinical practicum and as a resource document for future reference.
- *Medical Abortion Training Guide,* Second Edition – to be used by clinical trainers to lead participants through an in-person workshop followed by a clinical practicum.

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 for Reproductive Health* series at Ipas's website, www.ipas.org.

The *Medical Abortion Training Guide*, Second Edition includes activities and materials for trainers to use in helping health-care workers acquire the appropriate knowledge, attitudes and practical skills they need to provide first-trimester medical abortion. The *Training Guide* is divided into nine modules: seven workshop modules, a clinical practicum module, and an assessment, evaluation and closing module. Each module strengthens knowledge and skills for a specific component of MA service delivery. Trainers are highly encouraged to adapt the modules to fit the local training needs and objectives.

Objectives

Upon completion of the *Medical Abortion Training Guide,* Second Edition, learners should be able to:

1. Explain Ipas-recommended MA drug regimens
2. Describe eligibility, contraindications and precautions
3. State expected and potential side effects of MA
4. Explain information the woman should know about MA, including warning signs to seek medical care
5. Identify when women need urgent follow-up care
6. Identify personnel, facility, record-keeping and supplies requirements needed to implement MA services at their work site
7. Provide the information, counseling, clinical assessment, identification and treatment of problems and complications necessary to provide MA in their own clinical setting

Each module contains activities and materials to reinforce information participants have learned from their self-study of the Study Guide—recommended regimens, eligibility, clinical care, counseling and information and service delivery issues—and includes five elements:

1. **Time:** An estimate of how long it should take to complete the module

2. **Module Objectives:** Specific objectives to be met by the end of each module

3. **Advance Preparations:** Instructions regarding information or materials to be prepared ahead of time

4. **Instructions and Materials:** A list of the handouts, presentations, and other resources needed for each activity, followed by step-by-step guidance on how to facilitate interactive learning

5. Copies of all learner materials for distribution and answer keys for trainers

Note: The Study Guide is considered a basic resource document to be used throughout the training course. If PowerPoint (PPT) presentations are not possible, trainers can copy PPT slides onto transparencies or use photocopies as handouts.

Second edition

This training guide is designed to train providers on the delivery of high-quality, clinic-based, first-trimester medical abortion (MA), particularly in limited-resource settings. This second edition has been updated to reflect the latest evidence from the World Health Organization (WHO) and other important source documents. These updates include current clinical evidence and recommendations on providing appropriate MA care to young women and working with communities to improve information, social support and access.

This curriculum focuses on provision of MA by trained health-care providers working in facilities in the formal health-care system. There is increasing attention on making MA 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, please see the Community Access section in Additional Resources of the *Medical Abortion Study Guide*, Second Edition.

In this second edition, we also address young women's unique needs in an effort to increase MA service delivery and access. Young women

are disproportionately affected by unsafe abortion. Girls aged 10 -19 in developing countries undergo at least 2.2 to 4 million unsafe abortions and account for approximately 45 percent of unsafe abortion-related deaths each year (WHO 2007). Women under the age of 20 make up 70 percent of all hospitalizations from unsafe abortion complications (Plan 2007). 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 Additional Resources, Young Women.

MA training program

The Ipas MA training program has been designed to train providers on the delivery of high-quality, clinic-based, first-trimester MA, particularly in limited-resource settings. The *Medical Abortion Training Guide,* Second Edition and the companion *Study Guide* were designed to accompany Ipas' more comprehensive abortion care training curriculum, *Woman-Centered Comprehensive Abortion Care: Reference and Trainer's Manuals*. There are three major components to this training program:

- Self-directed study
- In-person workshop
- Clinical practicum

This blended learning approach combines the acquisition of essential knowledge through self-guided study with skills development in a face-to-face workshop setting that can then be applied to an actual clinical practice setting during the practicum.

As a participant in this training program, individuals are required to complete self-guided study using the *Medical Abortion Study Guide,* Second Edition prior to attending the workshop and practicum. We recommend administering a pre-test prior to the workshop that covers the information included in the MA Study Guide and requiring learners to score 75 percent or higher on this test to participate in the workshop and practicum. This requirement ensures all trainees have a base of requisite knowledge that they apply through skills practice in the in-person training and practicum.

Learners who do not have access to mifepristone can skip Module 2, Medical abortion with mifepristone and misoprostol, and use Module 3 instead, Medical abortion with misoprostol only. Because MA using both mifepristone and misoprostol is more effective than misoprostol only, Ipas recommends that MA be provided with the combination of the two wherever possible.

Additional options for self-guided learning are available at IpasUniversity, which 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, www.ipas.org. To register and take courses, please go to www.IpasU.org.

Intended participants

This training program is designed for health-care providers, including midwives, nurses and other midlevel providers, general practice physicians, obstetrician/gynecologists and any other providers who are authorized in their setting to provide clinic-based, first-trimester medical abortion. The content focuses on the basic information necessary for provision of care but includes resources for further study or expansion of skills, depending on participants' needs. The content builds on participants' prerequisite knowledge, skills and training in comprehensive abortion care, which are listed below. Where participants have not had this comprehensive training, trainers should supplement the MA content, drawing from Ipas' *Woman-Centered Abortion Care* curriculum, which is included on the CD-Rom and available at www.ipas.org/en/Resources.aspx.

Prerequisites

Participants in the MA training program should *minimally* already be able to:

- Demonstrate knowledge of the anatomy and physiology of the female reproductive system
- Demonstrate skills in taking a medical history and conducting a physical exam
- Accurately assess the gestational age of an early pregnancy
- Recognize and manage or refer women for treatment of abortion complications

Participants *ideally* should already be able to:

- Describe the key components of woman-centered abortion care: choice, quality and access and the importance of prioritizing each woman's individual needs
- Describe circumstances under which abortion is permitted and those under which it is restricted by law or policy
- Perform or refer women for vacuum aspiration services when needed
- Recognize clinical symptoms of ectopic pregnancy and provide or refer for appropriate treatment

Duration of training program

The following are estimates; actual times will vary:

- *Self-directed study:* 4 to 6 hours to read and complete the review and reflect questions in the Study Guide.
- *Workshop:* 2 to 4 days depending on use of the modules and expansion

or reduction of content. The workshop agenda should be tailored to meet participants' learning needs.

- *Clinical practicum*: 4 to 6 hours to complete a focused clinical practicum. These estimates are highly variable and depend greatly on the setting, caseloads and other considerations.

Blended learning pre-test requirement

To facilitate a blended learning approach in which trainees are given a base of knowledge and classroom and clinical practicum time is focused on interactive discussion for deeper learning, the following steps should be completed:

1. Program organizers or trainers should send to all potential participants the *Medical Abortion Study Guide,* Second Edition, and pre-test at least a month (preferably two) in advance of the workshop and practicum with an explanation that individuals are required to complete the *MA Study Guide* and the pre-test prior to acceptance to the workshop and practicum.

2. Organizers should inform and obtain the support of supervisors of potential participants about the blended learning process, encouraging them to allow time for the learner to complete the *Study Guide* and pre-test.

3. Participants are to complete and return the pre-test for scoring, preferably prior to the workshop. Ipas recommends that learners must score 75 percent on this pre-test to participate in the workshop and practicum *(Note: Adjust the percentage required based on local norms)*.

    — If the pre-test is not given until the first day of the workshop, it can be awkward for participants who score less than 75 percent, and difficult to turn them away from the training. However, if everyone does not have a baseline of the same information, it diminishes the classroom time together because more basic information has to be covered to bring these learners up to the same level as those who did score 75 percent or above. For this reason, the pre-test is designed to be given and scored in advance.

Finally, potential participants may use their *Study Guide* to help them answer the pre-test correctly (like an 'open book' test). This will help them gain basic knowledge needed for the course.

Documentation, certification and legal requirements

Trainers are responsible for ensuring that someone documents relevant information about participants (such as attendance and pre- and post-test results). The CD-ROM that accompanies this *Training Guide* includes sample certificates of completion and competence (trainers can use the Microsoft Word® versions to personalize the certificates). Trainers should determine whetherthe process for participant certification meets local regulations and consider legal requirements for conducting the onsite clinical practicum.

Evaluation

The pre and post-tests will serve as knowledge assessments of each individual learner while the MA Clinical Skills Checklist is to be used for skill assessment during simulated practice and the clinical practicum. Knowledge assessment and skill acquisition should be used together to determine competency of each learner.

Ipas recommends that an informal process evaluation be conducted at the end of each workshop day to assess participant satisfaction with the day's topics and activities. Participants should also complete the final evaluation after the practicum to provide feedback for future training events.

Accompanying CD-ROMs

1. A companion training CD-ROM includes several resources that are to be used in the workshop activities in this Training Guide. They are:
    - *Using Medicines for First-trimester Pregnancy Termination* (in Study Guide)
    - Medical abortion gestational dating wheel
    - Sample certificates of completion and competency in Microsoft Word®
    - Sample workshop agenda template in Microsoft Word®
    - *PowerPoint® presentations:
        — Medical Abortion Training Guide presentation
        — Medical Abortion Quiz Show
- Video clip of Medical Abortion Quiz Show instructions
- Color visual images of side effects continuum
- *Using Medicines for First-trimester Pregnancy Termination* (in Training Guide)
- Trainer and participants materials
- *Woman-Centered Comprehensive Abortion Care* curriculum (Reference and Trainer's manuals), Ipas

* The **animatedmechanismofaction.swf** file must be in the folder in order for the Mechanism of Action slide animation to work. If copying these files to a computer, make sure to copy the *swf* file as well.

2. An additional CD-ROM that contains Ipas information/education/communication (IEC) materials and *job aids for medical abortion*, can be used in the workshop as well. The IEC materials are useful in providing simple key points along with visual cues to help remember MA information. They can be adapted for use with health-care providers, women and intermediaries (people who assist women such as pharmacists or community health volunteers) from the clinic to the community level. It is recommended that the materials be adapted appropriately to the local setting where they will be used. Art files

of illustrations are included to assist in the process of adaptation. Guidance for adapting these templates for local use is also included.

Trainers should provide participants with clean copies of appropriately adapted job aids for providers and educational materials for women. Alternatively, they can provide a CD-ROM, flashdrive, pendrive or thumbdrive of the IEC files and instructions on how to edit them. Participants will not otherwise have access to these materials, as they are not provided with the *Study Guide*.

The job aids for providers are:

- Counseling flipbook
- Counseling reference sheet handout
- Counseling wall chart
- Medical abortion and MVA comparison cards
- Medical abortion dosage card
- Medical abortion gestational dating wheels

The educational materials for women are:

- Text-based and picture-based medical abortion booklets for women for use in clinic or community settings
  - — Mifepristone and misoprostol regimen: sublingual, buccal and vaginal routes
  - — Misoprostol-only regimen: sublingual and vaginal routes

Values clarification and attitude transformation (VCAT) for medical abortion training

Health-care providers and trainers may hold beliefs and attitudes about preferred abortion methods and care options for women, including young women. Providers may have a preference for one method over another that may not be directly related to women's clinical or life circumstances. They may direct women toward a particular method or regimen that doesn't respect women's needs and informed choice. Many providers are also accustomed to directly performing the abortion procedure. They may feel uncomfortable about women controlling the process themselves, particularly young women. Providers may question women's ability to monitor the medical abortion process and assess whether the medications worked.

Beliefs and attitudes such as these can have an impact on whether and how abortion services are provided. These and related issues can be useful to bring out and explore through a values clarification and attitude transformation (VCAT) process. Two VCAT activities focused on MA are

included in this *Training Guide*. Other activities from Ipas's VCAT toolkit and VCAT toolkit for young women can be tailored to specifically address beliefs and attitudes about MA compared with other methods and care options. 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 the following Ipas publications:

Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences at http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation--A-values-clarification-toolkit-for-global-audiences.aspx and Ipas'

Abortion Attitude Transformation: Values Clarification Activities Adapted for Young Women at http://www.ipas.org/en/Resources/Ipas%20Publications/Abortion-attitude-transformation--Values-clarification-activities-adapted-for-young-women.aspx

Additional resources

The following publications can be downloaded at **www.ipas.org/Publications/Index.aspx** or by contacting **training@ipas.org**.

- *The Effective Training in Reproductive Health: Course Design and Delivery, Reference Manual and Trainer's Manual* presents guiding on training planning and design. It included detailed instructions on training methods such as the garden, group norms, icebreakers, energizers, closing and evaluation activities and creatively dividing participants into small groups.
- *Clinical Updates for Reproductive Health* is a series designed to provide up-to-date, evidence-based recommendations and clinical protocols. It is available at www.ipas.org
- *Ipas University* (www.IpasU.org) offers free, online, on-demand courses for reproductive health professionals on safe abortion care and postabortion care.
- *Ipas's Medical Abortion Initiative Website* (www.ipas.org/medical abortion) contains resources about Ipas's MA programs and more.
- *Medical Abortion Matters: Sharing Global Perspectives* is a semiannual e-mail newsletter featuring summaries of the latest medical abortion research, stories of innovative and inspiring efforts to improve women's access to medical abortion, interviews, questions and answers, and highlighted resources and organizations. To subscribe to Medical Abortion Matters visit www.ipas.org/en/Pages/Newsletters.aspx.
- *Woman-Centered Comprehensive Postabortion Care* is designed to prepare health-care workers to provide high-quality PAC services. The manual covers all aspects of PAC, including the guiding principles

of woman-centered care, counseling and contraceptive services, and performing uterine evacuation with the Ipas MVA Plus® and EasyGrip® cannulae. It is appropriate for a broad audience, including health-care workers, administrators, program managers, health educators and social workers.

- *Abortion Care for Young Women: A Training Toolkit* is designed to provide information and guidance on delivering and ensuring access to appropriate induced abortion care for young women (ages 10-24). It provides experienced trainers with the background information, materials, instructions and tips necessary to effectively facilitate training sessions. Since existing research demonstrates few differences in the clinical needs of young women compared to adults, the toolkit contains more on advocacy, partnerships and service delivery than clinical issues. It is a global resource for health care providers, trainers, administrators and technical advisors of abortion care programs, but some materials also can be used to engage young people, policymakers, community groups, donors, advocates and other stakeholders.

- *Service Delivery Matters* is an e-newsletter is a biannual newsletter that shares technical news and updates – including training and service delivery strategies and tools, clinical recommendations, programmatic interventions and research results – for health-care providers, trainers, administrators, technical specialists and others who can positively influence how comprehensive abortion care is delivered. To subscribe to *Service Delivery Matters* visit www.ipas.org/en/Pages/Newsletters.aspx

Module 1: Overview

Time

Two hours and ten minutes

Unit objectives

By the end of this unit, participants will be able to:

- Discuss key content from the *Medical Abortion Study Guide, Second Edition*
- Explain the role of MA in comprehensive reproductive health services for women, including young women
- Discuss the current context of abortion services in their country, including the legal status of abortion care and barriers to access

Advance preparations

- Prepare the Workshop Agenda handout to fit with local customs (see template on CD-ROM)

- Prepare flipcharts for Expectations, Parking Lot, Ground Rules and Module 1 Objectives

- Practice using the *MA Quiz Show* **PowerPoint**® presentation or game board
- Write the *MAQ Show* instructions on a flipchart (optional)
- Ensure pre-tests completed in advance are scored and recorded
- Photocopy pre-test key (or pre-tests if they were not issued in advance)
- Learn about abortion laws and policies in the country and insert key points into the slide titled *Abortion Laws and Policies 2* in the Module 1 Overview section of the *Medical Abortion Training Guide* PowerPoint presentation

Instructions and materials

A. Introduction and training overview

Materials:

- Blank flipchart paper and stand, markers, tape, note cards

- Pre-prepared flipcharts:

  — *Expectations* (blank)

  — *Parking Lot* (blank)

  — *Ground Rules* (blank)

  — *Module 1 Objectives* (list)

1. Welcome participants to the training workshop
   - Introduce the trainers.
   - Facilitate a brief, interactive activity for participants to introduce themselves and to introduce the workshop topic.

   (For sample icebreakers, please see *Ipas' Effective Training in Reproductive Health: Course Design and Delivery, Reference Manual and Trainer's Manual*).

2. Post flipchart: *Expectations*
   - Ask participants what they hope to learn in the workshop and write their expectations on the flipchart.
   - Review participants' expectations and identify those likely to be met.
   - Clarify any expectations that may be beyond the workshop's scope.
   - Keep the list to review with participants at the end of the workshop to ensure that realistic expectations were met.

3. Distribute and review handout: *Workshop Agenda*

4. Post flipchart: *Parking Lot (also called Garden)*
   - Explain that when topics arise that the group does not have time to address in the moment, or that would be better addressed at a later time, trainers will write them on the flipchart ("park them in the Parking Lot" or "plant them in the Garden"). Trainers will determine when to make time to discuss them in the workshop.

5. Post flipchart: *Group Norms (also called Ground Rules*)
   - Explain that group norms are mutually agreed-upon guidelines to help the group work together, create a safe and respectful learning environment and accomplish tasks efficiently.
   - Ask participants to suggest group norms; write their suggestions on the flipchart. Possible group norms may include: speak one at a time; maintain confidentiality; agree to disagree, but do so respectfully; start and end on time; participate fully to your comfort level; turn cell phones on vibrate; etc.
   - Ask the group to agree to abide by these norms, monitor their process and raise concerns when they believe they are not following the norms.

6. Post and review flipchart: *Module 1: Objectives*

B. MA Study Guide review: MA Quiz Show

Note to trainers: The MA Quiz Show can also be used as a review at the end of the workshop.

Materials:

- Blank flipchart paper and stand, markers, tape
- LCD projector and screen with laptop computer (if available)
- MA Quiz Show materials:
  - — PowerPoint presentation or prepared game board (on CD-ROM)
  - — Clock or stop-watch
  - — Bell or chime
  - — Instructions
  - — Question-and-Answer Key
  - — Prizes for winning group (optional)

1. Explain that participants will review key MA content through a quiz show activity with the trainers as the game show host and judge.

   Creatively divide participants into two to three teams.

   - Ask each team to choose a name.
   - Write the team names on flipchart paper, with space underneath for scorekeeping.
   - Use the detailed *MA Quiz Show* instructions (found at the end of this module) to explain how to play the game. Another option is to write out the instructions on a flipchart and post them.
   - Refer to the *MA Quiz Show* Question-and-Answer Key (found at the end of this module) as teams respond to the questions on each slide.

2. Announce the winning team after the game is complete. Give prizes to the winning team (optional).

C. MA Study Guide review: Pre-test

This presumes pre-tests were completed in advance as recommended in the blended learning approach; more time will be needed if pre-tests will be completed now.

Materials:

- Scored pre-tests of each participant
- Copies of pre-test answer key
- Copies of pre-tests if they were not given in advance of the workshop

1. If pre-tests were taken in advance and submitted to training organizers, return scored pre-tests and an answer key to participants. If pre-tests were not completed in advance, issue them at this time (Note: Time will need to be adjusted for learners to take the pre-test, for trainers to score them and then return them at a later point.)

2. Go over pre-test answers briefly, and inform participants that all the topics will be covered more thoroughly over the course of the workshop.

3. Answer any outstanding questions or put them in the Parking Lot to be covered later.

D. Overview of medical abortion

Materials:

LCD projector and screen with laptop computer, or overhead projector with pre-printed transparencies, or pre-prepared flipcharts if the training site has no or unreliable electricity

- MA Training Guide PowerPoint presentation, Module One: Overview (on CD-ROM)

1. Show slide: *MA in Woman-Centered Care*
   - Highly effective and safe
   - Highly acceptable to women
   - Can be provided in very low resource settings

Review the following information:

- Can be provided in very low resource settings as long as there is an emergency response plan in place in the rare case of a serious complication
- Because it can be provided in low-resource settings, it can increase access to safe abortion care, especially for young women, and thus decrease maternal mortality and morbidity

2. Show Module 1: *Overview of the Medical Abortion Training Guide PowerPoint Presentation, beginning with the Mechanism of Action slide.*

Facilitate an interactive presentation about the role of MA in increasing access to safe abortion care, and the acceptability of MA to women. If you do not have access to presentation equipment, make sure that your discussion includes information on:

- *How MA can help increase access to safe abortion care for young women*
- *Mechanism of action*
- *Advantages and disadvantages of MA and vacuum aspiration*
- *Public health impact of unsafe abortion (almost 22 million per year, with 47,000 resulting in death)*

- *High acceptability of MA to women*

3. Show slide: *Abortion Laws and Policies 1*
   - What restrictions do laws and policies place on the provision of abortion care?
   - Are there any special restrictions on the provision of MA specifically?
   - Are there restrictions on the provision of abortion care based on age or marital status?
   - Does the law restrict the provision of abortion care based on marital status or age?
   - What do women, particularly young women, know about the legal indications for abortion?

After hearing from a few participants, show and discuss slide Abortion Laws and Policies 2 **(Note:** *Trainer will need to develop content for this slide*.)

4. Inform participants that the workshop focuses on building the knowledge and skills they need to provide high-quality MA services for all women, regardless of age.

5. Answer any outstanding questions.

Module 1: Materials

1. *MA Quiz Show (MAQ Show) instructions* *(for trainers)*

2. *MA Quiz Show question-and-answer key* *(for trainers)*

3. Medical abortion pre/post-test *(for participants)*

4. Medical abortion pre/post-test answer key *(for trainers and participants)*

For trainers

MA Quiz Show (MAQ Show) instructions

Instructions for PowerPoint version of *MA Quiz Show*

*(***Note:** *These instructions are also demonstrated through a video clip that can be found on the CD-ROM.)*

Trainers should practice the entire PowerPoint presentation at least once, using these instructions, prior to presenting it to the group.

1. Open the presentation and start the slide show. The first slide (#1) is Medical Abortion Quiz Show. Advance to the next slide (#2), which shows a chart with numbers. *(***Note:** *You can refer to the numbers as local currency or points.)*

2. After the second slide has finished loading, advance through the next slides, reading aloud the following **response categories** teams can choose from:
   - MA Issues & Information
   - Regimens
   - Eligibility
   - Side Effects & Complications
   - MA or MVA
   - Potpourri (surprise!)

3. Tell the teams that they will take turns answering the questions. Decide which team will go first (toss a coin if available).

4. The next slide is the main screen/category play board (slide #9). Ask the first team to choose a **category and numerical amount**, then click on the corresponding square and read the question. The team must answer the question within 15 seconds *(***Note:** *Use a clock or stopwatch for timekeeping and a bell or chime for when they must answer.)*

5. Use the Question-and-Answer Key to determine whether the team's answer is correct. *(***Note:** *Some questions have several possible correct answers. The answers on pages 9-15 follow the Medical Abortion Study Guide, Second Edition and provide suggestions but this is not an exhaustive answer key. Use your judgment to decide whether a team's answer is correct or not.)*

6. If the answer is correct, click on the **green** button at the bottom of the screen. (There will be a sound effect and you will be taken back to the main screen/category board). Record team points or money amount on flipchart paper.

7. If the answer is incorrect, click on the **red** button. (There will be a sound effect and the question screen will remain).

8. If the team answers incorrectly or cannot answer the question, allow another team to answer if they can *(***Note:** *If the next team answered the question that the previous team couldn't answer, then that team still gets to take their normal turn. They get to go again.)*

9. If no team can answer, click the **blue** button (no sound effect) to be taken back to the main screen/ category play board.

10. Allow the next team to choose a **category and numerical amount** from the remaining squares on the board.

11. For each answer, continue to click on the **green, red,** or **blue** buttons, and return to the main game board when the question is answered correctly. Be sure to record scores on the flipchart.

12. Play until all squares on the board have been answered or as long as time allows.

13. Add up scores. The team with the highest amount wins.

14. Give a prize to the highest scoring team (optional).

Instructions for paper version of *MA Quiz Show*

If PowerPoint presentation equipment is not available, the MA Quiz Show game can be played using a paper version. Print out the PowerPoint slides and use them to assemble the game board.

1. Prepare the game board:
   - Using the MA Quiz Show Question-and-Answer Key and illustration below as a guide, create a game board on paper, poster board or a white board. Create a grid with six columns and six rows.
   - Post the categories across the top row and the questions onto the remaining rows, following the order of their monetary or point value (lowest to highest). Be sure to put the questions on the correct category (column) and number amount (row). Use the Question-and-Answer Key as a guide.
   - Take the printouts of the numbers and cover each question, but leave the categories in the top row visible. It should then look like this:

MA Issues & Information	Regimens	Eligibility	Side Effects & Complications	MA or MVA	Potpourri (Surprise!)
100	100	100	100	100	100
200	200	200	200	200	200
300	300	300	300	300	300
400	400	400	400	400	400
500	500	500	500	500	500

2. Conduct the game as instructed above. Manually reveal the numbered questions as teams choose categories and numerical amounts.

For trainers

MA Quiz Show question and answer key

MA issues and information

100

Q: What is one reason MA is important to offer to women seeking abortion services?

Possible answers:

- It can be used in low-resource settings and where access to other safe methods is limited
- It has the potential to dramatically reduce maternal morbidity and mortality
- It is simple to use
- The necessary medications do not require refrigeration
- The method can be safely given by provider cadres other than physicians, potentially reaching women closer to their communities

200

Q: Why is it important for health-care providers to show empathy to women undergoing MA?

Possible answer: Positive encounters with empathetic, respectful health-care workers heighten women's satisfaction with their care, increase their adherence to medical-care instructions and make them more inclined to trust health-care workers and seek appropriate medical care in the future. Empathetic counseling should be offered to all women undergoing MA, regardless of age, marital status or HIV status.

300

Q: What are two potential barriers to women seeking MA services?

Possible answers:

- Narrow interpretations of legal indications for abortion
- Clinic restrictions that affect access, such as physician attitudes about MA as an acceptable abortion method
- Provider shortages (not enough trained providers)
- High charges for the medications
- Provider personal objections or refusal to give care

400

Q: What are three myths or misconceptions about MA?

Possible answers:

- Only doctors can provide MA
- Ultrasound exams are necessary for MA services
- MA is not appropriate for women without immediate back-up services at the facility at which they received the MA
- MA is not safe or effective for young women
- MA is less effective for women who have never had children
- Obese women need an increased dose of misoprostol
- Women with multiple pregnancies need an increased dose of the MA drugs
- Women who have had prior C-sections should not use MA
- Women must have access to a telephone to use MA

500

Q: What are three things a provider should inform a woman about MA before she begins the regimen?

Possible answers:

- What she will experience—vaginal bleeding and cramping
- What the success rates for MA are
- How long the MA might take
- What kind of pain management she can use
- What side effects, risks and complications are associated with the method
- What kind of follow-up care is available
- The counselor should be certain that the woman understands the information and has provided informed consent

Regimens

100

Q: What are the current abortion methods/regimens available in your country?

Answers will vary.

200

Q: True or False? The combination of mifepristone + misoprostol is more effective in achieving complete abortion than either drug used alone.

Answer: True

When used together, mifepristone and misoprostol are more than 95 percent effective up to 13 weeks LMP. Misoprostol only is 85% effective up to 13 weeks LMP.

300

Q: How does misoprostol work in MA?

Answer: It softens the cervix and causes strong uterine contractions which lead to expulsion of the pregnancy.

400

Q: Which misoprostol route does Ipas recommend for up to nine weeks LMP?

Answer: Sublingual, buccal or vaginal if used in combination with mifepristone. Sublingual or vaginal if using misoprostol only. Ipas does not express a preference for one route over the other.

500

Q: What if the woman inserts the misoprostol vaginally, buccally or sublingually and the pills don't dissolve– what should she do?

Answer: Women need to be reassured that the active medicine within misoprostol will absorb within 30 minutes through the mucus membranes into the bloodstream; the outer pill casing may not dissolve but the medicine is absorbed.

Eligibility

100

Q: True or False? MA with mifepristone and misoprostol can be given to women in the following categories: Living with HIV,STIs, young women under the age of 18, breastfeeding, asthma, obesity ,multiple gestation

Answer: True

Women with controlled asthma or women using inhaled medications including inhaled corticosteroids may use MA with mifepristone and misoprostol. Women with severe uncontrolled asthma or women with oral or IV steroid-dependent asthma can be given MA with mifepristone and misoprostol with caution based on the provider's clinical judgment and ability to monitor for complications. Misoprostol only is not contraindicated in women with asthma. Women with HIV or AIDS may use MA. Due to the risk of anemia in women with HIV, if severe bleeding occurs, provide prompt treatment with MVA. There is no evidence to suggest that MA drugs are harmful to infants. Women who are concerned may nurse immediately before taking medications or wait four to five hours after their last dose of medication. STI treatment can be started on the same day as the MA drug. There is no dose adjustment needed for obese women or women with multiple pregnancies. MA is safe and effective for young women.

200

Q: What are three questions you could ask a woman to help her remember the date of her last menstrual cycle?

Possible answers:

- What were you doing the day you started your period or one of the days that you remember having your period?
- Where were you when your period started?
- Who were you with when your period started?
- What day of the week was it when your period began?
- Was the first day of your period close to a holiday, special event, market day or weekend day?
- What was the weather like when your period started?
- What were you wearing on the day your period began?

300

Q: What are three commonly used approaches for pregnancy dating?

Answers:

- Determining the date of the last menstrual period (LMP)
- Performing a bimanual exam to assess uterine size
- Using ultrasound

400

Q: If a bimanual exam indicates the uterus is larger than expected, what are three possible causes?

Possible answers:

- Inaccurate menstrual dating (pregnancy more advanced than expected)
- Multiple pregnancies
- Uterine anomalies such as fibroids or bicornuate uterus
- Gestational trophoblasticneoplasm (molar pregnancy)
- Normal variation between women at a given length of pregnancy

500

Q: What are two precautions and two contraindications to MA with mifepristone and misoprostol?

Possible answers:

Contraindications:

- Previous allergic reaction to one of the drugs involved
- Inherited porphyria
- Chronic adrenal failure
- Known or suspected ectopic pregnancy

Precautions:

- IUD in place. Evaluate for the presence of ectopic pregnancy. If none, remove the IUD.
- Severe uncontrolled asthma or long-term corticosteroid therapy. No evidence exists regarding use of mifepristone in steroid-dependent women. Providers must use clinical

judgment if no other alternatives to safe abortion exist. Increase steroid dose for 3-4 days and monitor the woman very closely. Conditions such as poorly controlled asthma may still be worsened.

- Severe/unstable health problems including but not limited to hemorrhagic disorders, heart disease, severe anemia. No evidence exists on the use of MA in women with hemorrhagic disorder, heart disease, severe anemia or severe/unstable health problems. Whether to provide medical abortion to women with these conditions will depend on the available options for safe abortion care, referrals, and clinical judgment. If medical abortion is given, it should be given under close observation.

Note to trainers: Severe health problems are dependent on the location, patient population, provider's level of training and situation. Precautions are a matter of judgment – some cases may be appropriate to do if the level of skill and monitoring is adequate. In some cases and settings, however, the risks of doing MA may outweigh the benefits.

Specific information about contraindications and precautions for misoprostol only may be found in the *Medical Abortion Study Guide*.

Side effects and complications

100

Q: What pain medications can be taken to relieve MA cramping?

Possible answers:

Ibuprofen or narcostic analgesics or narcotic analgesics plus acetaminophen. Ibuprofen was found to be significantly more effective for pain relief after medical abortion compared with acetaminophen. Narcotic analgesics are another option for pain control although the optimal drug, dose and timing is not known. Acetaminophen alone is not effective in reducing pain from MA.

200

Q: What are two rare, but possible, complications that could occur during or after MA?

Possible answers:

- Hemorrhage
- Infection
- Allergic reactions

300

Q: What are four potential side effects associated with misoprostol?

Possible answers:

- Nausea
- Diarrhea
- Vomiting
- Fever, warmth or chills
- Headache
- Dizziness

400

Q: What is one possible diagnosis of intense, persistent pain (longer than four to six hours that is unrelieved by pain medication) with no bleeding after misoprostol?

Possible answers:

- Pregnancy tissue trapped in the os
- Ectopic pregnancy
- Upper reproductive tract infection
- Low pain tolerance

500

Q: What are three indications that bleeding requires immediate medical attention?

Possible answers:

- Excessive bleeding: soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, lightheadedness, and increasing fatigue
- Abundant gushing bleeding
- Bleeding like a heavy period that persists for weeks leading to significant anemia and hypovolemia
- Pale appearance accompanied by weakness, agitation or disorientation
- Blood pressure drop or woman feels faint when she stands up
- Rapid pulse especially when associated with low blood pressure

MA or MVA

100

Q: True or False? Both MVA and MA less than nine weeks LMP should be done onsite for safety reasons.

Answer: False

MA for pregnancies less than nine weeks can be safely and effectively done outside the clinic. The woman can take the pills and abort at home or in a safe space, once she has received screening, counseling and instruction from trained providers.

200

Q: What is a benefit that MA offers women that MVA does not?

Possible answers:

- MA is simple and easy to use by women themselves.
- No surgery or anesthesia is needed.
- MA can be done at home or in a safe space rather than the clinic.
- MA is managed more by the woman herself rather than a clinician, allowing some women a better sense of control and confidence.
- MA is often seen as a more natural process by women, including young women.

300

Q: What is a benefit that MVA offers women that MA does not?

Possible answers:

- Procedure is done in a clinic by a health care provider.
- Procedure is completed usually in less than 10 minutes.
- Abortion is confirmed as complete by the provider the day of the procedure.
- Women have fewer overall days of bleeding after MVA compared to MA.

400

Q: What are two benefits of offering both MA and MVA at service-delivery sites?

Possible answers:

- Services are strengthened when these complementary technologies are offered together because women can choose the method that best meets their needs and have an enhanced degree of control over the timing and setting of its use.
- Training for these two technologies can be combined, maximizing efficiency and use of personnel.
- MVA can be used to complete a failed medical abortion.

500

Q: What is the follow-up procedure in the case of ongoing pregnancy for MA?

Possible answers:

- Vacuum aspiration
- Repeat dose of misoprostol

Vacuum aspiration is recommended. Repeat dose of misoprostol 800mcg vaginally can be given if there are no aspiration services or if a woman does not want a VA procedure. She needs to be followed closely because the rate of successful expulsion is only 1 in 3.

Potpourri (Surprise!)

100

Q: What does this image depict? [pills in the cheek of the mouth]

Answer: Buccal route of taking misoprostol

200

Q: How does MA differ from emergency contraception (EC)?

Answer: MA stops an implanted pregnancy from growing and causes expulsion of the pregnancy (abortion) but EC prevents a pregnancy from occurring in the first place (it cannot abort an already established pregnancy.)

300

Q: What are three important things to tell a woman before she leaves the clinic after choosing MA?

Possible answers:

- Warning signs about possible complications
- Instructions about when and where to seek medical help in case of an emergency (plan for emergencies)
- Pain medication available
- To plan for personal support during the process

400

Q: What are two options that can be offered if a woman has not aborted within a week of taking the medications?

Answers:

- Vacuum aspiration. The standard treatment is vacuum aspiration, and is particularly recommended if the woman prefers not to make return visits if she will be beyond the limit for legal abortion if she takes a repeat dose of misoprostol and returns in one week.
- A repeat dose of vaginal misoprostol . An additional dose of misoprostol 800 mcg vaginally can be given to women who have persistent gestational sac or an ongoing pregnancy (if she is still eligible) but the success rate is low. She should be followed closely to see if the second dose causes a successful abortion. This has not been studied after a misoprostol-only abortion, so vacuum aspiration is the only recommended treatment in this case.

500

Q: What are four different warning signs indicating that a woman should contact her health-care provider immediately?

Possible answers:

- Excessive bleeding: soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, lightheadedness, and increasing fatigue
- Fever that occurs any day after the day misoprostol is taken
- Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain
- Severe abdominal pain that occurs any day after the day misoprostol is taken
- Feeling very sick with or without fever, and persistent severe nausea or vomiting after the day misoprostol is used
- No bleeding

For participants

Medical abortion pre/post-test

True or false questions

Select whether the statement is true or false.

1. Monitoring and evaluation systems promote woman-centered MA.
   a. True
   b. False

2. MA has the potential to improve access to safe abortion, in part because provider cadres other than physicians can be trained to give information and the medicines.
   a. True
   b. False

Multiple choice questions

Circle the correct answer. There is only one correct answer for each question.

3. Why do many women feel that medical abortion is highly acceptable?
   a. The medicines can be taken at home or in a safe place outside the clinic.
   b. It is over in less than an hour.
   c. It is relatively painless.
   d. The bleeding duration is very short.

4. Excluding medical conditions, what criteria below would make a woman a potential candidate for medical abortion?
   a. She is hoping the abortion process will be finished quickly.
   b. She has received information on all methods and opts for medical abortion.
   c. She is unwilling to sign the legally required consent form.
   d. She would prefer to undergo vacuum aspiration.

5. Which of the following is a contraindication to medical abortion with mifepristone and misoprostol?
   a. Well controlled asthma on inhaled corticosteroids
   b. HIV and AIDS
   c. Allergy to the medicines
   d. Breastfeeding
   e. Age below 18 years

6. What is the sublingual route of taking misoprostol?
   a. Swallowing the pills
   b. Putting the pills inside the uterus
   c. Putting the pills under the tongue
   d. Putting the pills between the cheek and gum

7. How does misoprostol work to cause abortion?
   a. Prevents sperm from fertilizing the egg
   b. Prevents ovulation
   c. Causes cervical softening and uterine contractions
   d. Causes an increase in pregnancy hormones

8. During a bimanual exam, if the uterus is smaller than expected, what might this indicate?
   a. Ectopic pregnancy
   b. Multiple pregnancies
   c. Fibroid uterus
   d. Anemia

9. Which is the most effective regimen for MA?
   a. Misoprostol
   b. Methotrexate and misoprostol
   c. Mifepristone and misoprostol
   d. Mifepristone only

10. Which statement below is true?
    a. Nausea and vomiting are very rare after using misoprostol.
    b. All women experience gastrointestinal side effects after using misoprostol.
    c. Bleeding is not a side effect, it is an expected effect after using misoprostol.
    d. Experience of cramping or pain after using misoprostol is quite similar for all women.

11. What are the warning signs of complications?
    a. Bleeding that includes clots or tissue
    b. Fever the day misoprostol is used
    c. Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain
    d. Mild nausea and vomiting

12. Which contraceptive methods can be started with the first pill of an MA regimen?
    a. Oral pills, natural family planning, injectables
    b. Injectables, IUDs, implants
    c. IUDs, oral pills, sterilization
    d. Implants, oral pills, injectables

13. What are side effects that women may experience after taking misoprostol?
    a. Nausea, diarrhea, fever, chills
    b. Nausea, diarrhea, itching
    c. Nausea, fever, chills, nose bleeds
    d. Fever, chills, blurred vision, diarrhea

14. Common side effects of MA include:
    a. Allergic reaction
    b. Excessive bleeding requiring emergency treatment
    c. Uterine perforation
    d. Fever after taking misoprostol
    e. Infertility

15. MA information for women should include:
    a. Possible side effects, clinical details of how the drugs work, and a list of the commercial names under which the drugs are marketed internationally
    b. The range of normal bleeding expected, possible side effects, and warning signs for which the woman should contact her provider
    c. Warning signs for which the woman should contact her provider, and that narcotic analgesics are the only recommended pain management medications
    d. Possible side effects, and to take a pregnancy test in two weeks

16. Which of the following are useful approaches to pain management for MA?
    a. General anesthesia
    b. Acetaminophen
    c. Non-narcotic and narcotic analgesics
    d. Hot tea

17. What are some signs that a woman might have an ongoing pregnancy after MA?
    a. She had heavy bleeding with clots after taking misoprostol
    b. She has bleeding when she comes to visit you two weeks after taking misoprostol
    c. She feels breast tenderness and has nausea two weeks after taking misoprostol
    d. Her uterus is small and non-tender on bimanual exam two weeks after taking misoprostol

18. What are other gynecologic or obstetric uses for misoprostol?
    a. Chlamydia
    b. Prevention and treatment of postpartum hemorrhage
    c. Uterine fibroids
    d. Uterine prolapse

19. About how many women will have an ongoing pregnancy after medical abortion with misoprostol only?
    a. 1 in 5
    b. 1 in 10
    c. 1 in 20
    d. 1 in 100

20. What is a potential complication of MA?
    a. Infection
    b. Uterine perforation
    c. Endometriosis
    d. Spotting or light bleeding lasting for three weeks or longer

21. What is a symptom of ectopic pregnancy?
    a. Feeling cold all over
    b. Persistent fever
    c. Lower abdominal pain
    d. Bad-smelling discharge

22. What should be done if pelvic infection is suspected after MA?
    a. Give reassurance
    b. Treat according to the severity of the infection
    c. Provide a vaginal anti-fungal
    d. Only treat if she has a fever too

23. What are the preferred methods for uterine evacuation in the first trimester according to the World Health Organization (WHO)?
    a. Medical abortion, sharp curettage and vacuum aspiration
    b. Sharp curettage and medical abortion
    c. Vacuum aspiration and medical abortion
    d. Uterotonic instillation and medical abortion

24. What does allowing women to take misoprostol at home or in a safe place mean?
    a. The MA will not be as safe
    b. They can have family or friends present for support if they wish
    c. They have to have any follow-up care in the location they take the misoprostol
    d. The MA may not be as effective as in the clinic

25. What should be provided for all women undergoing MA?
    a. Contact information in case of questions or emergencies
    b. Hemoglobin test
    c. Sterilization procedure
    d. Follow-up visit appointment

For trainers

Medical abortion pre/post-test answer key

Answers

(Answers are in bold)

1. True or False: Monitoring and evaluation systems promote woman-centered MA.

   a. True

   b. False

2. MA has the potential to improve access to safe abortion, in part because provider cadres other than physicians can be trained to give information and the medicines.

   a. True

   b. False

3. Why do many women feel that medical abortion is highly acceptable?

   a. The medicines can be taken at home or in a safe place outside the clinic

   b. It is over in less than an hour

   c. It is relatively painless

   d. The bleeding duration is very short

4. Excluding medical conditions, what criteria below would make a woman a potential candidate for medical abortion?

   a. She is hoping the abortion process will be finished quickly.

   b. She has received information on all methods and opts for medical abortion.

   c. She is unwilling to sign the legally required consent form.

   d. She would prefer to undergo vacuum aspiration.

5. Which of the following is a contraindication to medical abortion with mifepristone and misoprostol?

   a. Well controlled asthma on inhaled corticosteroids

   b. HIV and AIDS

   c. Allergy to the medicines

   d. Breastfeeding

   e. Age below 18 years

6. What is the sublingual route of taking misoprostol?
    a. Swallowing the pills
    b. Putting the pills inside the uterus
    c. Putting the pills under the tongue
    d. Putting the pills between the cheek and gum

7. How does misoprostol work to cause abortion?
    a. Prevents sperm from fertilizing the egg
    b. Prevents ovulation
    c. Causes cervical softening and uterine contractions
    d. Causes an increase in pregnancy hormones

8. During a bimanual exam, if the uterus is smaller than expected, what might this indicate?
    a. Ectopic pregnancy
    b. Multiple pregnancies
    c. Fibroid uterus
    d. Anemia

9. Which is the most effective regimen for MA?
    a. Misoprostol
    b. Methotrexate and misoprostol
    c. Mifepristone and misoprostol
    d. Mifepristone only

10. Which statement below is true?
    a. Nausea and vomiting are very rare after using misoprostol.
    b. All women experience gastrointestinal side effects after using misoprostol.
    c. Bleeding is not a side effect, it is an expected effect after using misoprostol.
    d. Experience of cramping or pain after using misoprostol is quite similar for all women.

11. What are the warning signs of complications?
    a. Bleeding that includes clots or tissue
    b. Fever the day misoprostol is used
    c. Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain
    d. Mild nausea and vomiting

12. Which contraceptive methods can be started with the first pill of an MA regimen?
    a. Oral pills, natural family planning, injectables
    b. Injectables, IUDs, implants
    c. IUDs, oral pills, sterilization
    d. Implants, oral pills, injectables

13. What are side effects that women may experience after taking misoprostol?
    a. Nausea, diarrhea, fever, chills
    b. Nausea, diarrhea, itching
    c. Nausea, fever, chills, nose bleeds
    d. Fever, chills, blurred vision, diarrhea

14. Common side effects of MA include:
    a. Allergic reaction
    b. Excessive bleeding requiring emergency treatment
    c. Uterine perforation
    d. Fever after taking misoprostol
    e. Infertility

15. MA information for women should include:
    a. Possible side effects, clinical details of how the drugs work, and a list of the commercial names under which the drugs are marketed internationally
    b. The range of normal bleeding expected, possible side effects, and warning signs for which the woman should contact her provider
    c. Warning signs for which the woman should contact her provider, and that narcotic analgesics are the only recommended pain management medications
    d. Possible side effects, and to take a pregnancy test in two weeks

16. Which of the following are useful approaches to pain management for MA?
    a. General anesthesia
    b. Acetaminophen
    c. Non-narcotic and narcotic analgesics
    d. Hot tea

17. What are some signs that a woman might have an ongoing pregnancy after MA?
    a. She had heavy bleeding with clots after taking misoprostol
    b. She has bleeding when she comes to visit you two weeks after taking misoprostol
    c. She feels breast tenderness and has nausea two weeks after taking misoprostol
    d. Her uterus is small and non-tender on bimanual exam two weeks after taking misoprostol

18. What are other gynecologic or obstetric uses for misoprostol?
    a. Chlamydia
    b. Prevention and treatment of postpartum hemorrhage
    c. Uterine fibroids
    d. Uterine prolapse

19. About how many women will have an ongoing pregnancy after medical abortion with misoprostol only?
    a. 1 in 5
    b. 1 in 10
    c. 1 in 20
    d. 1 in 100

20. What is a potential complication of MA?
    a. Infection
    b. Uterine perforation
    c. Endometriosis
    d. Spotting or light bleeding lasting for three weeks or longer

21. What is a symptom of ectopic pregnancy?
    a. Feeling cold all over
    b. Persistent fever
    c. Lower abdominal pain
    d. Bad-smelling discharge

22. What should be done if pelvic infection is suspected after MA?

    a. Give reassurance

    b. Treat according to the severity of the infection

    c. Provide a vaginal anti-fungal

    d. Only treat if she has a fever too

23. What are the preferred methods for uterine evacuation in the first trimester according to the World Health Organization (WHO)?

    a. Medical abortion, sharp curettage and vacuum aspiration

    b. Sharp curettage and medical abortion

    c. Vacuum aspiration and medical abortion

    d. Uterotonic instillation and medical abortion

24. What does allowing women to take misoprostol at home or in a safe place mean?

    a. The MA will not be as safe

    b. They can have family or friends present for support if they wish

    c. They have to have any follow-up care in the location they take the misoprostol

    d. The MA may not be as effective as in the clinic

25. What should be provided for all women undergoing MA?

    a. Contact information in case of questions or emergencies

    b. Hemoglobin test

    c. Sterilization procedure

    d. Follow-up visit appointment

Module 2: Medical Abortion Regimens

Time

One hour, 10 minutes

Module objectives

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

- Discuss eligibility, contraindications, precautions for use and special considerations for MA
- Describe the efficacy, mechanisms of action, regimens, routes and timing of the medications used for MA

Advance preparations

Prepare flipchart with Module 2: Objectives

- Tailor the PowerPoint presentation slides from the *Medical Abortion Training Guide*, with particular attention to Module 2: Medical Abortion Regimens, to the MA regimen(s) you will be focusing on:

  — Mifepristone and misoprostol

  — Misoprostol-only

  — Both regimens (mifepristone/misoprostol and misoprostol-only)

- If discussing both MA regimens, it may be helpful to make copies of the *Contraindications and Precautions* handout to clarify small differences between the two regimens.

Instructions and materials

A. MA eligibility: Contraindications, precautions and special considerations

Materials:

- Blank flipchart paper and stand, markers
- Pre-prepared flipchart: *Module 2 Objectives*
- Handout: *Contraindications and Precautions* (optional)
- *Medical Abortion Training Guide* PowerPoint presentation, Module 2: Medical Abortion Regimens (on CD-ROM)

1. Post and review flipchart: *Module 2 Objectives*

2. Show slide *Eligibility:*
   - MA is a medical process with clinical considerations.
   - Most women are probably eligible for MA.
   - It is essential to confirm that a woman has no medical contraindications before undergoing MA.
   - It is uncommon to identify a contraindication to MA.

Review the following information:

- Ensure that participants can correctly define the terms "contraindication" and "precaution" as they relate to MA provision:

  — **Contraindications for MA:** If a woman has these specific conditions, under no circumstances should she be offered MA. MVA may be considered, or she should be referred to a facility where she can be offered alternate care. In cases of a contraindication for mifepristone, she can also be offered misoprostol-only MA if she has no contraindications for misoprostol (Please see Medical Abortion Study Guide, Module 2B: Medical Abortion with Misoprostol Only for Misoprostol-Specific Contraindications).

  — **Precautions for MA**: If a woman has these specific conditions, MA has higher risks than normal. The risks, benefits and availability of alternatives to MA must be considered. MA provision may require a higher degree of clinical judgment, skill and monitoring. Referral to a higher-level facility may be appropriate.

3. Post a piece of blank flipchart paper.
   - Draw a straight line down the page to divide it into two halves.
   - Write "contraindications" at the top of one column, and "precautions" at the top of the other column.
   - Ask participants to state the contraindications and precautions for MA, focusing on the specific regimens that will be covered during the course (mifepristone with misoprostol, misoprostol-only or both). Clarify which contraindications and precautions relate only to mifepristone with misoprostol and which also relate to misoprostol-only. Write them on the flipchart. Add any missing information until the flipchart includes all the correct information.

Show slide *Contraindications:*

- Previous allergic reaction to one of the drugs involved
- Inherited porphyria
- Chronic adrenal failure
- Known or suspected ectopic pregnancy

Show slide *Precautions:*

- IUD in place (remove before MA)
- Severe or unstable health conditions (use clinical judgment)
- Severe uncontrolled asthma or long-term corticosteroid therapy (mifepristone + misoprostol regimen)
- Hemorrhagic disorder or concurrent anticoagulant therapy
- Severe anemia
- Heart disease

Review the following information:

- If a woman has a precautioned condition, MA has higher risks than normal. The risks, benefits and availability of alternatives to MA must be considered. MA provision may require a higher degree of clinical judgment, skill and monitoring. Referral to a higher-level facility may be appropriate.

4. If the pretest and MA Quiz Show indicate that participants are not very familiar with the contraindications for MA, use the *Contraindications Rationale* slides to explain. Explain that it is uncommon to identify a contraindication to MA. For example, most clinicians have never seen porphyria and many do not know what it is.

Contraindications Rationale slide:

Allergy to one of the medicines –

- Can give mild or severe allergic (anaphylaxis) reactions
- Extremely rare
- Would only be known if a woman had received them before.

Porphyria –

- Extremely rare metabolic blood disorder which causes problems in the production of heme (a protein in hemoglobin)
- Mifepristone causes a worsening of the disorder in animals; no studies of humans have been done

(Cable 1994, Kobrynski 2007).

Contraindications Rationale, continued:

Chronic adrenal failure –

- Mifepristone is a glucocorticoid receptor antagonist, blocks negative feedback mechanisms that control cortisol secretion
- Mifepristone may exacerbate the adrenal insufficiency

Confirmed or suspected ectopic pregnancy –

- Mifepristone and misoprostol do not treat ectopic pregnancy
- Using MA when there is concern of an ectopic pregnancy could delay or disguise the diagnosis

Review the following information:

- Mifepristone works by blocking progesterone receptors; there are no progesterone receptors in the fallopian tubes where 95-97% of ectopic pregnancies are located
- Mifepristone and misoprostol do not make an ectopic pregnancy worse (i.e., cause tubal rupture)

(Land 1992, Sitruk-Ware and Spitz 2003, Spitz and Bardin 1993).

- If the pretest and MA Quiz Show indicate that participants are not very familiar with the precautions for MA, use the slides *Precautions Rationale* in the presentation to explain the rationale for the precautions.

Precautions Rationale:

Inhaled corticosteroids –

- Medications in asthma inhalers are not systemically absorbed
- Some prostaglandins are vasoconstrictors, but misoprostol promotes bronchodilation, decreases inflammation, increases oxygen flow

Poorly controlled/severe asthma, oral/intravenous steroids –

- Mifepristone may block the activity of steroids, making the underlying condition worse
- Temporarily increasing the dose of steroids may or may not overcome the effects of mifepristone

(Bernstein &Kandinow 2004, Sitruk-Ware 2006).

Precautions Rationale, continued*:*

IUD –

- A woman who becomes pregnant with an IUD in place has an increased risk of ectopic pregnancy
- Remove IUD before giving medications for MA.

Severe anemia, hemorrhagic disorders or severe or unstable health problems –

- No evidence exists on the use of MA with these conditions

Review the following information:

- For severe or unstable conditions, provider should consider the condition itself, its severity, the available options for safe abortion care, referrals and clinical judgment and monitoring.
- **If participants need more information on contraindications and precautions, it is available in Davey (2006) and Sitruk-Ware (2006). (See reference section for the full citation).**
- **Optional:** If the training covers both regimens of mifepristone with misoprostol and misoprostol-only, it may be helpful to distribute the Contraindications and Precautions handout. The handout can also be edited to include only one of these regimens.

5. Show slide: *Special Considerations:*

- Women with the following conditions may have MA:

  — Asthma (for women who use inhalers)

  — HIV and AIDS

  — Breastfeeding

  — Sexually transmitted infections (STIs)

  — Multiple gestation

  — Obesity

- Ask participants how common it is for them to care for women, including young women, with asthma, HIV, AIDS, STIs, those who are breastfeeding, have multiple gestations, or are obese.
- Explain that women in all the previously stated categories (young women, asthma, HIV, AIDS, STIs, those who are breastfeeding, have multiple gestations, or are obese) can undergo MA.
- Ask learners whether they think that young women (ages 10-24) can undergo MA.

6. Show slide: *Special Considerations*, continued*:*

- MA is safe and effective for young women
- MA is found to be even more effective in women who have never given birth
- There is no need to change the regimen for young women
- Age is not a contraindication or precaution for MA
- MA information should be provided respectfully to young women and tailored to their needs.

Review the following information:

- Young women have the same right to information and care as adult women do, and it should be provided respectfully in a way that meets their needs.
- Optional: Divide into six groups and assign each group a "special consideration" to discuss for five minutes, using the *Medical Abortion Study Guide* for reference. Ask groups to discuss the key considerations and best way to proceed. Have each group briefly report the highlights of their discussion to the larger group.

7. Ask participants to summarize eligibility considerations, and write the point on a flipchart or white board. Make sure the points include:
   - Women who have **contraindications** should not be given MA and should explore other options with their providers.
   - Women who have **precautions** may be candidates for MA after consideration and counseling and with close monitoring.
   - Women with conditions known as "special considerations" can undergo MA as described in the *Medical Abortion Study Guide*
   - MA is safe and effective for young women

B. MA regimens

Materials:

- LCD projector and screen with laptop computer, or overhead projector with pre-printed transparencies, or pre-prepared flipcharts
- *Medical Abortion Training Guide* PowerPoint presentation, Module 2: Medical Abortion Regimens (on CD-ROM)

1. Facilitate an interactive presentation, focusing on the regimen(s) that will be used in the participants' setting.

2. Show slide: *Recommended Evidence-Based Regimens:*
   - Mifepristone and misoprostol - preferred regimen
     - — Higher efficacy: complete uterine evacuation without further intervention in over 95% of cases (first trimester)
   - Misoprostol-only – where mifepristone is not available
     - — Lower efficacy: Complete uterine evacuation without further intervention in over 85% of cases (first trimester)
     - — Rate of ongoing pregnancy is about 5%

3. Show slide: *Mifepristone and Misoprostol: Recommended Regimens for Gestational Age*

Table 2-1: Mifepristone and misoprostol recommended regimens by gestational age

Gestational Age	Mifepristone Day 1	Misoprostol			Efficacy
		Dose	Route	Timing	
Up to 9 weeks LMP*	200 mg orally (one 200 mg pill)	800 mcg (four 200 mcg pills)	Buccally, Sublingually, or Vaginally	After 24-48 hours	95-98%
9 to 10 weeks LMP	200 mg orally (one 200 mg pill)	800 mcg (four 200 mcg tablets)	Buccally	After 24-48 hours	93-96%
10 to 13 weeks LMP	200 mg orally (one 200 mg pill)	800 mcg (four 200 mcg tablets) Initial dose 400 mcg (two 200 mcg tablets) Follow-up doses every 3 hours For maximum of 5 doses	Vaginally (initial dose) Vaginally or sublingually (follow-up doses)	After 36-48 hours	95-97%

since last menstrual period

4. Show slide: *Misoprostol-only Regimen*:

Table 2-2: Misoprostol-only regimen

Gestational Age	Misoprostol Dose	Route	Timing	Efficacy
Up to 13 weeks LMP	800 mcg (four 200 mcg pills)	Vaginally	Every 3-12 hours for a maximum of 3 doses	85%
	800 mcg (four 200 mcg pills)	Sublingually	Every 3 hours for a maximum of 3 doses	85%

5. Show slide *Mifepristone Route:*

Oral use

- Take mifepristone pill with water
- Can be used up to 13 weeks

6. Show slide *Misoprostol Routes Sublingual:*

Sublingual use

- Place 4 pills under the tongue.
- After 30 minutes, swallow anything remaining of pills.
- This method can be used up to 13 weeks with either regimen.

7. Show slide *Misoprostol Routes Buccal:*

Buccal use

- Place two pills between each cheek and gums (four total).
- After 30 minutes swallow anything remaining of pills.
- This method be used up to 9 weeks with mifepristone + misoprostol regimen .
- This is not recommended for misoprostol-only regimen.

8. Show slide *Misoprostol Routes Vaginal:*

Vaginal use

- Advise woman to empty bladder and lie down.
- If clinician is inserting pills, wash hands and put on clean gloves.
- Insert all the misoprostol pills (four per initial or follow-up dose).
- Push the pills as far into the vagina as possible; they do not need to be in any special place in the vagina.
- Fragments of the pills may remain.
- After 30 minutes, the active medicine has been absorbed.
- This method can be used up to 13 weeks.

9. Show slide: *Clinic or Home Use*

Misoprostol only up to 9 weeks LMP or mifepristone plus misoprostol up to 10 weeks LMP

- Misoprostol can be safely taken at home or in another safe place

MA after this (9 or 10 weeks LMP, depending on regimen)

- Misoprostol should be given in the health-care facility where the woman can be monitored until the abortion is complete

10. Review and have participants discuss the following:

- Whenever possible, women should be offered a choice of location (clinic or home) because different women have different needs and desires.
- Drug mechanism of action
- Regimens by gestational age
- Efficacy
- Routes and timing of the medications

11. Answer any outstanding questions.

Module 2: Materials

1. Contraindications and precautions for MA *(for participants)*

2. Contraindications and precautions for MA *(for trainers)*

For participants

Contraindications and precautions for MA

A check mark ✓ in the box indicates that the contraindication or precaution applies to the regimen. An ✗ mark in the box that indicates that the statement does not apply to the regimen.

Contraindications	**Regimens**	
	Mifepristone and Misoprostol	Misoprostol only
Known allergy to mifepristone (if using a combined regimen with mifepristone), misoprostol or to other prostaglandins		
Confirmed or suspected ectopic pregnancy		
Chronic adrenal failure		
Inherited porphyria		
Precautions	Mifepristone and Misoprostol	Misoprostol only
IUD in place (remove before beginning regimen)		
Steroid-dependent women		
Severe anemia		
Severe/unstable health problems		

For trainers

Contraindications and precautions for MA

A check mark ✓ in the box indicates that the contraindication or precaution applies to the regimen. An ✗ mark in the box that indicates that the statement does not apply to the regimen.

Contraindications	**Regimens**	
	Mifepristone and Misoprostol	Misoprostol only
Known allergy to mifepristone (if using a combined regimen with mifepristone), misoprostol or to other prostaglandins	✓	✓
Confirmed or suspected ectopic pregnancy	✓	✓
Chronic adrenal failure	✓	✗
Inherited porphyria	✓	✗
Precautions	Mifepristone and Misoprostol	Misoprostol only
IUD in place (remove before beginning regimen)	✓	✓
Steroid-dependent women	✓	✗
Severe anemia	✓	✓
Severe/unstable health problems	✓	✓

Module 3: Clinical Care

Time

Three hours

Module objectives

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

- Describe care that should be provided to a woman prior to the MA procedure
- Discuss strategies for dating pregnancy using last menstrual period (LMP) and bimanual exam
- List the signs and symptoms of ectopic pregnancy
- Assess clinical eligibility for MA
- Describe the MA process, including expected effects, possible side effects and strategies for managing them
- Describe strategies for prevention and management of pain associated with MA
- Recognize warning signs

Advance preparations

- Prepare flipchart with Module 3 Objectives
- Cut up three sets of Pre-Procedure Care Steps strips; distribute a set (mix up the strips) into each of three envelopes and seal them.
- *Assemble Gestational Dating Wheels (these can be obtained from Ipas by contacting medical abortion@ipas.org or produced locally from the file found on the accompanying CD-ROM)*
- Prepare flipchart with Scenarios for Gestational Dating Wheel Practice.
- Prepare three flipcharts with questions about gestational dating by bimanual exam.
- Review case studies and ensure that they are appropriate for your setting. Modify if necessary.
- Cut up the six case studies to use for group work.

- Cut up side effect strips and place in basket or bowl.
- Prepare three flipcharts with the headings: 1) Expected Effects, 2) Possible Side Effects, and 3) Warning Signs

Instructions and materials

A. Pre-procedure care (15 minutes)

Materials:

- Blank flipchart paper and stand, markers, envelopes, tape, bowl or basket
- Pre-prepared flipchart: *Module 3 Objectives* (list)
- Envelopes
- Pre-procedure care strips (one set of strips in each envelope). Pre-procedure care strips can be found in the materials section at the end of this module).
- Prize for winning team (optional)

1. Post and review flipchart: *Module 3 Objectives*

2. Tell participants the next activity is a game to review the steps that need to be taken before giving a woman MA pills.

3. Divide participants into three teams and give each team a sealed envelope with the pre-procedure care strips set.

4. Explain that in the envelope are strips of paper with the steps a provider should take before giving a woman the MA drugs.
   - Each team should order the steps correctly and tape them on a whiteboard, flipchart or regular paper. Note which team finishes first, second and third.
   - The first group to finish presents the order of their steps. If their steps are correct, they win the activity. If they are incorrect, the next team to finish presents their steps, until a team presents the correct steps.
   - Give a small prize to the winning team (optional).

5. Reiterate the key steps:
   - Offer pregnancy options counseling if needed
   - Conduct clinical assessment
   - Conduct informed consent process
   - Provide woman-centered counseling (including contraceptive counseling) if desired

- Schedule follow-up visit if woman requests it or she is using misoprostol only

B. Clinical assessment: Role of gestational dating (5 minutes)

1. Show slide: *Gestational Dating*
   - Accurate assessment of gestational age is important to increase the success of medical abortion and decrease the risk of complications
   - Underestimating gestational age is not likely to be clinically important

Review the following information:

- MA is safe and effective over a range of gestations. However, the regimens, protocols, efficacy, side effects and potential for complications are different depending on gestational age.

2. Show slide: *Gestational Dating*, continued
   - Confirm LMP by bimanual exam
   - If LMP and exam not in agreement, may use:
     — A second provider's opinion
     — Other testing such as ultrasound, if available
   - If ultrasound is not available, MA can still be offered.
   - MA can be provided to women with LMPs greater than 13 weeks (2nd trimester), with additional training.

Review the following information:

- LMP should not be the sole factor used to determine gestational age.
- For more information on MA for LMPs greater than 13 weeks, please see Medical Abortion for Second-Trimester Abortion in the Additional Resources section of the Medical Abortion Study Guide, Second Edition.

3. Answer any outstanding questions.

C. Gestational dating by last menstrual period (LMP) (20 minutes)

Materials:

- Assembled MA Gestational Dating Wheels
- Pre-prepared flipchart: Scenarios for Gestational Dating Wheel Practice. Write the following scenarios on the flipchart:
  — *Ava's last period started June 19. Today is September 24. What is Ava's gestational age?*

— *Maria's last period started December 1. Today is January 15. What is Maria's gestational age?*

— *Fatima's last period started February 5. Today is April 30. What is Fatima's gestational age?*

1. Ask participants to brainstorm questions that might help women remember their LMP; write the questions on a flipchart. Possible questions include:
   - What were you doing the day that your period started?
   - Where were you?
   - What were you wearing?
   - Who were you with?
   - What day of the week was it?
   - Was it close to a holiday, special event, market day or weekend?
   - What was the weather like?

2. Ask participants to recall difficulties women have had in accurately estimating LMP. Some answers might include:
   - Bleeding during early pregnancy (which might be mistaken for a period)
   - Pregnancy during breastfeeding, even in the absence of regular periods
   - Many indigenous women are not sure of their LMP because they do not use calendars the way that modern calendars are used in medical settings.
   - Women who have irregular periods with spotting in between may have a hard time identifying and remembering their last actual period.
   - Women may experience amenorrhea due to contraception
   - A young woman may experience irregular menstrual cycles or may never have experienced a menstrual period before she became pregnant.

3. Distribute the gestational dating wheels.
   - Explain that the gestational wheel is a tool that providers can use to help determine MA eligibility based on LMP.
   - Demonstrate how to use the wheel.

4. Post flipchart of LMP scenarios for gestational dating wheel practice.

- Ask a volunteer to read the first scenario aloud.
- Have participants use the wheels to decide if the woman is eligible for MA.
- Move around among participants to provide assistance using the wheel.
- Ask someone to share his or her answer.
- Continue until you have discussed all three scenarios.
  - — Only Maria and Fatima are eligible for first-trimester MA by LMP dating. Ava is beyond 12 weeks, Maria is below nine weeks and Fatima is just at 12 weeks (so her MA should be done in the clinic setting).
  - — *You might want to create more or different scenarios with which to practice.*
- Invite participants to share what they think about the gestational wheel as a job aid.

5. Ask participants what other strategies and tools they use to help women remember their LMP and to determine women's eligibility for MA based on LMP.

D. Gestational dating by bimanual examination (25 minutes)

Materials:

- Pre-prepared flipcharts with questions:
  - — What methods do you use for sizing early pregnancies?
  - — In a bimanual exam, if the uterus is smaller than expected, what might this indicate?
  - — In a bimanual exam, if the uterus is larger than expected, what might this indicate?

1. Emphasize that determining uterine size in an early pregnancy can be challenging and requires practice.

2. Divide participants into pairs to discuss uterine sizing in early pregnancy.
   - Post three pre-prepared flipcharts with questions at the front of the room.
   - Give pairs 10 minutes to discuss the three questions.
   - Invite the pairs to come write their answers on the flipcharts.
   - Review with the large group what has been written and add any

missing information until the flipcharts include all the important answers as below:

1) **What methods do you use for dating early pregnancies?**

   Answers include:

   - Bimanual exam
   - Review of pregnancy symptoms
   - Comparing LMP to bimanual exam
   - Ultrasound

2) **In bimanual exam, if the uterus is smaller than expected, what might this indicate**?

   Answers include:

   - The woman is not pregnant
   - Inaccurate menstrual dating (pregnancy is not as far along as thought)
   - Ectopic pregnancy
   - Early pregnancy failure, including missed abortion
   - Normal variation between women

3) **In a bimanual exam, if the uterus is larger than expected, what might this indicate?**

   Answers include:

   - Inaccurate menstrual dating (pregnancy is more advanced than thought)
   - Multiple pregnancies
   - Uterine abnormalities such as fibroids or bicornuate uterus
   - Gestational trophoblastic neoplasm/molar pregnancy
   - Normal variation between women

3. Explain that small discrepancies of one to two weeks do not change the outcome of medical abortion.
   - For example, if the woman's LMP indicates nine weeks but you feel the uterine size is seven to eight weeks, there is really no need for additional testing or examination unless there are other warning signs (of ectopic pregnancy, for instance). The MA regimens will be the same at either gestational age.

4. *Optional. (If participants are knowledgeable about gestational dating, go to step 5)*

Further discuss uterine size:

- Ask participants to make a circle with their hands to show the approximate size of a uterus that is:
  - — Non-pregnant
  - — 6 weeks pregnant
  - — 7-8 weeks pregnant
  - — 9 weeks pregnant
  - — 10-weeks pregnant
  - — 12-weeks pregnant
- Assist the learners in determining the appropriate size (use flipchart to draw on as needed)

Creative method for training on gestational dating

Margulies and Miller at the University of Washington used fruit to describe different uterine sizes in the first trimester to help trainees learn gestational dating (Margulies 2001). They compared ultrasound measurements of increasing uterine sizes with certain fruit. This method of uterine sizing used along with LMP may be a useful guide for less experienced clinicians. Locally available fruits should be used.

5. Show slide: *Care Considerations*

Women may:

- Have never had a bimanual exam before and be nervous or uncomfortable (especially young women)
- Fear being touched or be particularly concerned about pain

6. Ask a few participants to share techniques that can make the bimanual exam more comfortable for women and address the needs of women who are concerned about it.

E. Identifying ectopic pregnancy (25 minutes)

1. Ask participants why ectopic pregnancy is a key concern when performing MA. Take a few answers.

2. Ask participants when have they seen a woman with ectopic pregnancy and if they can remember the signs and symptoms of it prior to rupture. Have a few learners share and discuss their experiences.

3. Describe the next activity, which focuses on identifying ectopic pregnancy.
   - Divide participants into three groups to discuss:
     - — Risk factors (group one)
     - — Signs and symptoms (group two)
     - — What to do if ectopic pregnancy is suspected (group three)

- Instruct each group to pick a note-taker and someone who will report back to the larger group.
- Remind participants to refer to the *Medical Abortion Study Guide*, Second Edition as needed (Modules 4 and 6).
- Allow the groups 10 minutes to discuss their topic.
- After 10 minutes, ask the first group to report back to the full group; once they have finished presenting, invite comments, questions, and feedback from the other groups.
- Ask the second and third groups to present their results to the full group and continue to discuss.

4. Show slide: *Ectopic Pregnancy Risk*

- More than half of identified ectopic pregnancies occur in women without known risk factors.
- Risk factors include:

  — Previous tubal surgery

  — Previous ectopic pregnancies

  — IUD in place

Review the following information:

- Becoming pregnant with an IUD device in place is rare, but an estimated 25 to 50 percent of such pregnancies are ectopic (Barnhart 2009).

5. Show slide: *Ectopic Pregnancy Symptoms*

Signs and symptoms of ectopic pregnancy may include:

- Spotting/irregular bleeding
- Smaller uterine size than expected
- Sudden and intense lower abdominal pain, often one-sided
- Fainting and/or dizziness
- Shoulder pain
- Rapid heartbeat

Early ectopic pregnancy may not have any symptoms at all.

Review the following information:

- The symptoms of ectopic pregnancy are nonspecific.
- Symptoms of ectopic pregnancy may also be associated with

threatened or spontaneous abortion or normally developing intrauterine pregnancy

- Spotting/ irregular bleeding is the most common symptom of ectopic pregnancy, but spotting is also common in early pregnancy.

6. Show slide: *Ectopic Pregnancy Diagnosis*
   - Uterus typically grows somewhat larger than non-pregnant size, often 6 week size.
   - Rarely, an adnexal mass in the fallopian tube can be palpated.
   - Ultrasound, serial BHCG testing and vacuum aspiration with careful tissue inspection can be used in diagnosis of unruptured ectopic pregnancy.

7. Show slide: *Ectopic Pregnancy Diagnosis*, continued

Clinical evidence of a possible ruptured ectopic pregnancy includes:

- Low blood pressure
- Falling hemoglobin or hematocrit
- Guarding
- Rebound tenderness
- Severe abdominal pain

8. Show slide: *Discussing Ectopic Pregnancy*
   - Educate any woman with suspected ectopic pregnancy about the risks, including tubal rupture, hemorrhage and death.
   - Ectopic pregnancy can be life-threatening and should be treated or transferred for diagnosis and treatment immediately.
   - Ruptured ectopic pregnancy is a gynecologic emergency that requires immediate surgical intervention.

F. Determining MA eligibility: Clinical assessment case studies (45 minutes)

Materials:

- MA Clinical Assessment Case Studies
- MA Clinical Assessment Case Study Answer Key

1. Inform participants that the next activity will help them to practice determining MA eligibility.
   - Divide participants into six groups and hand out the case studies.
   - Assign each group a case study to review and discuss.

- Instruct each group to pick a note-taker and someone who will report back to the larger group.
- Remind participants that they can refer to the *Medical Abortion Study Guide,* Second Edition for information.
- Allow the groups 10 minutes to discuss their case study and five minutes for report-back and questions or comments.
- After 10 minutes, call participants back together. Ask each group to briefly review their case study and the conclusions they reached.
- Take questions and comments from the full group after each case.
- Fill in any missing points, using the answer key.

2. Have participants refer to Module 3:Clinical Care and Module 2A or 2B in the *Medical Abortion Study Guide,* Second Edition as appropriate to the regimens participants will be using. Summarize key points of determining eligibility through clinical assessment.

G. Identifying symptoms and signs (15 minutes)

Materials:

- Side effects continuum pictures (posted on wall or drawn on board)
- Side effects strips in basket or bowl
- Flipcharts for notes with headings: *Expected Effects, Potential Side Effects, and Warning Signs*.

1. Show slide: *MA Effects*
   - During the MA process, all women will experience a range of normal or expected effects.
   - Many women will experience other minor side effects.
   - In a smaller number of cases, women will experience warning signs that require immediate follow-up.

   Discuss the following information:

   - To manage side effects (or seek emergency care when needed), women must know what side effects are normal and possible, and must be able to recognize the signs of more serious concerns.

2. Explain that the next exercise lets participants review what they have learned about the MA process from their self-directed study of the *Medical Abortion Study Guide*.
   - Post the "side effects continuum" at the front of the room.
   - Ask participants to look at the continuum.
   - Ask several volunteers to choose a side effects strip from a basket or bowl.

- Ask each volunteer to read their strip aloud and tape the strip on the continuum under the appropriate sign:

  — Band-aid: Normal side effect

  — Phone: Woman should call the clinic

  — Red cross: woman should go to the emergency room (ER)

- After each strip is placed on the continuum, ask the other participants if they agree with the strip's placement; correct the placement, if necessary. In a few cases, the answer could fall under more than one category; explain and discuss as needed. Refer to the Side Effects Continuum Answer Key for additional information.

- As participants discuss the strips, take notes on the appropriate flipchart, distinguishing between Expected Effects, Possible Side Effects, and Warning Signs.

- *Use these flipcharts again when discussing the next few sections: Expected Effects, Possible Side Effects and Warning Signs.*

3. Show slide: *Symptom Severity*
   - Symptoms that are usually a minor side effect can move up the continuum of severity.
   - Example: Cramping is often a normal effect of MA, but if the cramps are severe and pain pills don't help, the woman should call the clinic.

4. Return to the flipcharts and ask participants to add any missing information, using their *Medical Abortion Study Guide,* Second Edition for reference (in Module 3: Clinical Care, refer to the sections on Abortion Process, Potential Side Effects and Complications).

H. Expected effects (10 minutes)

Materials:

- Flipcharts from the previous activity (Identifying Symptoms and Signs)

1. Review expected effects:
   - Refer to the flipchart from the previous activity (G. Identifying Symptoms and Signs).
   - Explain that women have a range of experiences with bleeding and cramping when undergoing MA.
   - You may use the "Bell Curve" described in the *Medical Abortion Study Guide,* Second Edition to illustrate this point.)

Show slide: *Expected Effects*

- Bleeding

- Cramping

The MA process may:

- Feel like an intense, painful menstrual period
- Be similar to a spontaneous miscarriage

2. Show slide: *Bleeding*

- Usually heavier than a menstrual period
- Often accompanied by passage of clots
- Usually starts within three hours after taking misoprostol
- Usually decreases after the pregnancy has been expelled
- On average, women have bleeding or spotting for two weeks after MA
- 20% of women will have bleeding or spotting for more than a month

Review the following information:

- Vaginal bleeding is a normal, expected and necessary part of the MA process.

3. Show slide: *Bleeding*, continued

- There is more bleeding with MA than with vacuum aspiration.
- The number of days of bleeding and spotting are longer with MA compared to MVA, but amount of blood loss is not clinically different.
- Women who express discomfort with heavy bleeding may be better candidates for vacuum aspiration.
- Severe hemorrhage and prolonged heavy bleeding require immediate attention.

Review the following information:

- Severe hemorrhage and prolonged heavy bleeding will be discussed in Module 6: Problems, Complications and Emergencies.

4. Show slide: *Cramping*

- Can begin 30 minutes after taking misoprostol
- Pain levels vary greatly among women.
- Perception of pain and use of analgesia for MA is higher in younger women than older women.

Discuss the following:

- Providers who are aware that young women may be more sensitive to pain can take the necessary measures to improve a young women's abortion experience.

5. Show slide: *Cramping*, continued

   - Occurs during uterine contractions and when the pregnancy is expelled
   - Diminishes after the pregnancy has expelled
   - Important to address pain before it gets severe
   - Can be managed with oral analgesics taken with misoprostol or once cramping begins

6. Ask participants to brainstorm ways to help women know what to expect and how to manage their pain. Be sure the following points are covered:
   - Verbal support
     - — Counseling about what to expect
     - — Reassurance during the abortion
   - Pain management
     - — Heat to the abdomen or lower back
     - — Hot-water bottle or warm cloths
     - — Hot bath or shower
   - Pain medications (should be taken before cramping begins)
     - — Non-narcotic and narcotic analgesics can be used
     - — NSAIDs such as ibuprofen
     - — Narcotic analgesics with or without acetaminophen.
     - — Acetaminophen alone has not been shown to be effective for pain management for Medical Abortion

7. Ask participants to name locally available medications that could be used for pain relief during MA.

I. Possible side effects (10 minutes)

Materials:

- Flipchart from Activity G (Identifying Symptoms and Signs)
- Handout: *Proportion of Women Who Experience a Side Effect*

1. Review Side Effects:
   - Refer to the flipchart from Activity G (Identifying Symptoms and Signs).
   - Show slide: *Possible Side Effects*

- Nausea
- Vomiting
- Diarrhea
- Fever, warmth or chills
- Headache
- Weakness
- Dizziness

Review the following information:

- Explain that some of these symptoms may be caused by the pregnancy itself rather than MA.
- Symptoms caused by the pregnancy may actually decrease after the MA begins.

2. Show slide: *Side Effects*

- Most side effects begin after taking misoprostol.
- Most side effects are temporary and do not need treatment.
- With proper counseling, most women are able to manage their side effects without major difficulties.

J. Warning signs (10 minutes)

Materials:

- Flipchart from Activity G (Identifying Symptoms and Signs)

1. Review Warning Signs:

- Refer to the flipchart from Activity G (Identifying Symptoms and Signs).
- Show slide: *Warning Signs*

Excessive bleeding

- Fever any day after the day misoprostol is used
- Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain
- Severe abdominal pain that occurs any day after the day misoprostol is taken
- Feeling very sick with or without fever
- Persistent severe nausea or vomiting after the day of taking misoprostol

Review the following information:

- Excessive bleeding (i.e., soaking more than two sanitary pads per hour for two consecutive hours), especially if accompanied by prolonged dizziness, lightheadedness and increasing fatigue
- Fever any day after the day misoprostol is used. (Note: Misoprostol commonly causes fever the day it is taken and should not be a symptom of concern in that context. Concern should arise only if the fever occurs on days after the day misoprostol is taken.)

2. Remind participants that it is essential for providers to give women the information they need to:
   - Manage expected effects
   - Manage any side effects
   - Distinguish expected effects and side effects from true warning signs of complications

3. Answer any remaining questions.

Module 3: Materials

1. Key components of pre-procedure care strips *(for trainers)*

2. Clinical assessment case studies *(for participants)*

3. Clinical assessment case studies: Answer key *(for trainers)*

4. Side-effects continuum instructions *(for trainers)*

5. Side-effects continuum strips *(for participants)*

6. Side-effects continuum: Answer key *(for trainers)*

7. Proportion of women who experience a side effect *(for participants)*

For trainers

Key components of pre-procedure care strips

Instructions: Make three copies of this sheet, then cut into three sets of strips and put a mixed up set in each of three envelopes, then seal the envelope.

Conduct pregnancy options counseling

Conduct clinical assessment

Provide woman-centered counseling
(including contraceptive counseling) if desired

Conduct informed consent process

Schedule follow-up visit if woman requests it or she is using misoprostol only

---

For participants

Clinical assessment case studies

Case study 1

A 20-year-old woman comes to the clinic two weeks after her missed period, or six weeks since her last menstrual period (LMP). She was not using any contraceptive method and usually has regular periods every 28-30 days. She says she's been having mild nausea and breast tenderness. You perform a bimanual exam and find her uterus to be consistent with six weeks LMP. You find no masses or tenderness. She has heard about MA and asks if she can take the pills today or if she needs an ultrasound.

Question: *How do you respond?*

Case study 2

A 17-year-old woman comes to the clinic because she thinks she may be pregnant and was told that she could take a medicine to make her period "come down." When you ask about her last menstrual period she says she cannot remember when it last came. You do a pelvic exam and estimate a seven-week pregnancy.

Question: *What else could you do to confirm your pelvic exam estimate?*

Case study 3

A 30-year-old woman comes to the clinic wanting to terminate her pregnancy, which she confidently estimates is about eight weeks by LMP. Her pelvic exam concerns you because you feel a large uterus with many fibroids that you estimate to be comparable to a 12-week pregnancy.

Question: *If you are unsure of your exam, what are your options?*

Case study 4

A 24-year-old woman has three children. She wants to get the "abortion pill." She plans to tell her family that she is having a miscarriage, and does not want to tell her husband or anyone else that she is having an abortion. She had her period about nine weeks ago. You review her menstrual history. Since she stopped breastfeeding, she has had regular periods. The woman has noticed that her breasts became larger and tender about five weeks ago, and she has had occasional nausea since then. She has never used contraception. You perform a bimanual exam and the uterus feels about nine-week sized.

Question: *Do you feel confident she is within the eligible range for MA?*

Case study 5

A woman is 28 years old with four children. She does not want another child. Her periods have always been irregular. Sometimes her period lasts a day or two while at other times she bleeds for a week. Sometimes she has a period every month but sometimes her period skips a month. She does not remember when her last period was. You try to help her think back to an event in her life that might help her recall the date of her last period, but this does not help her remember. She had severe bleeding with two of her deliveries but never had a blood transfusion. The woman appears to be somewhat pale and she states she often feels tired. You perform a bimanual exam and her uterus is easily palpable and feels like she is eight weeks pregnant.

Question: *Do you think she is eligible for MA?*

Case study 6

A woman is 32 years old and has children who are 11, 15 and 16 years old. She has regular monthly periods. She is certain that her period was eight weeks ago. She does not want any more children and requests a MA. You perform a bimanual exam and feel that the uterus is about 10 weeks in size.

Question: *What do you do next?*

For trainers

Clinical assessment case studies: Answer key

Case study 1

A 20-year-old woman comes to the clinic two weeks after her missed period, or six weeks since her last menstrual period (LMP). She was not using any contraceptive method and usually has regular periods every 28-30 days. She says she's been having mild nausea and breast tenderness. You perform a bimanual exam and find her uterus to be consistent with six weeks LMP. You find no masses or tenderness. She has heard about MA and asks if she can take the pills today or if she needs an ultrasound.

Question: *How do you respond?*

Discussion:

This is a straightforward case of early pregnancy diagnosed by a reliable LMP and a consistent pelvic exam done by an experienced clinician. There is no need for an ultrasound and the woman is within the gestational range eligible for medical abortion.

In most cases of MA, women's report of LMP, in combination with review of pregnancy symptoms and bimanual exam, can safely be substituted for routine ultrasound, unless there are clinically significant discrepancies or inconsistencies for gestational dating.

Case study 2

A 17-year-old woman comes to the clinic because she thinks she may be pregnant and was told that she could take a medicine to make her period "come down." When you ask about her last menstrual period she says she cannot remember when it last came. You do a pelvic exam and estimate a seven-week pregnancy.

Question: *What else could you do to confirm your pelvic exam estimate?*

Discussion:

MA is a safe and effective method for young women.

In most cases, in a relatively slim woman, a pelvic exam by an experienced clinician is sufficient to assess gestational age. If further information is needed, it may be useful to review pregnancy symptoms and help the woman to remember her LMP. In cases where women are unable to remember their LMP, they can be helped by a calendar and memory recall cues such as "What day of the week was it?" "What were you doing?" "What part of the month?" "Was there a special event going on?" and "Are your periods regular?" It may also be useful to ask when the woman first noticed pregnancy symptoms such as breast tenderness or nausea. Breast tenderness and nipple sensitivity typically begin around three to four weeks LMP, followed by fatigue, nausea and urinary frequency at four weeks LMP. An exam by another clinician may also help confirm your estimate of a seven-week pregnant uterus.

There is a high correlation between pregnancy dating as determined by a clinician (based on bimanual examination and history) and dating determined by ultrasound. When the two approaches produce differing dates, clinician estimation is generally more conservative — overestimating gestational age.

Because medical abortion is effective over a wide range of gestational ages, slightly over or underestimating gestational age is unlikely to decrease the efficacy or increase the complications for a particular woman.

Adding testing such as ultrasound before medical abortion is a barrier to abortion access, delays the procedure and does not necessarily increase safety, especially for young women who may have limited resources to purchase extra testing.

Case study 3

A 30-year-old woman comes to the clinic wanting to terminate her pregnancy, which she confidently estimates is about eight weeks by LMP. Her pelvic exam concerns you because you feel a large uterus with many fibroids that you estimate to be comparable to a 12-week pregnancy.

Question: *If you are unsure of your exam, what are your options?*

Discussion:

When there is a discrepancy between LMP and exam, ultrasound can be useful if it is available. If ultrasound is available at a referral site, ultrasound may verify that the woman is indeed eight weeks LMP but fibroids are causing uterine enlargement and distortion. Fibroids are not a contraindication to MA. In fact, when fibroids distort the uterus, making access by instrumentation difficult or impossible, MA may be the better abortion method to use.

You may also ask another clinician to confirm your exam. If the exam continues to be inconsistent with the LMP and estimates that the pregnancy is beyond nine weeks, then you may offer the woman a uterine evacuation with vacuum aspiration. Another approach is to offer MA using a regimen and clinical protocols appropriate for her gestational age. MA at this gestational age should be done in the health center and not at home.

Case study 4

A 24-year-old woman has three children. She wants to get the "abortion pill." She plans to tell her family that she is having a miscarriage, and does not want to tell her husband or anyone else that she is having an abortion. She had her period about nine weeks ago. You review her menstrual history. Since she stopped breastfeeding, she has had regular periods. The woman has noticed that her breasts became larger and tender about five weeks ago, and she has had occasional nausea since then. She has never used contraception. You perform a bimanual exam and the uterus feels about nine-week sized.

Question: *Do you feel confident she is within the eligible range for MA?*

Discussion:

Depending on the gestational eligibility criteria in this particular setting, the woman is a candidate for MA. Even if the clinician's assessment by bimanual exam and LMP is a slight underestimation, MA is very effective.

Other than the straightforward clinical considerations of this case, there should be some discussion with the woman about why she wants to keep the abortion secret from her family, including her husband. The woman should be reassured that it is impossible for a family member to tell the difference between a spontaneous miscarriage and a medical abortion, but that entails hiding the misoprostol and ensuring that no one tells the husband that the woman was seen in the clinic where abortion services are provided. Women who do not disclose to their partners that they are having an abortion are more likely to be victims of abuse than women who do disclose (Woo 2005)

and the possibility of domestic violence in the home should be explored. MVA may be offered as an alternative.

Case study 5

A woman is 28 years old with four children. She does not want another child. Her periods have always been irregular. Sometimes her period lasts a day or two while at other times she bleeds for a week. Sometimes she has a period every month but sometimes her period skips a month. She does not remember when her last period was. You try to help her think back to an event in her life that might help her recall the date of her last period, but this does not help her remember. She had severe bleeding with two of her deliveries but never had a blood transfusion. The woman appears to be somewhat pale and she states she often feels tired. You perform a bimanual exam and her uterus is easily palpable and feels like she is eight weeks pregnant.

Question: *Do you think she is eligible for MA?*

Discussion:

The woman is within the gestational eligibility for MA, but because of her anemia on clinical exam and her history of postpartum hemorrhage, it might be advisable for her to either take the misoprostol in the clinic and remain there until expulsion, or take it at home only if her home is not remote from a facility that can provide urgent care with MVA if she experiences excessive bleeding.

For the long term, inform the woman of iron-rich foods and provide iron supplementation if possible. Oral contraceptive pills, injections, implants and the levonorgestrel containing IUD may be good options for birth control because they reduce menstrual bleeding.

Case study 6

A woman is 32 years old and has children who are 11, 15 and 16 years old. She has regular monthly periods. She is certain that her period was eight weeks ago. She does not want any more children and requests a MA. You perform a bimanual exam and feel that the uterus is about 10 weeks in size.

Question: *What do you do next?*

Discussion:

There are several possibilities for the discrepancy of bimanual exam and her estimated LMP. She may have a uterine enlargement secondary to fibroids or multiple gestation. If this is the case, she is eligible for MA using a regimen appropriate for women <9 weeks. She may be 10 weeks pregnant, in which case she is still eligible for MA but with a slightly different regimen.

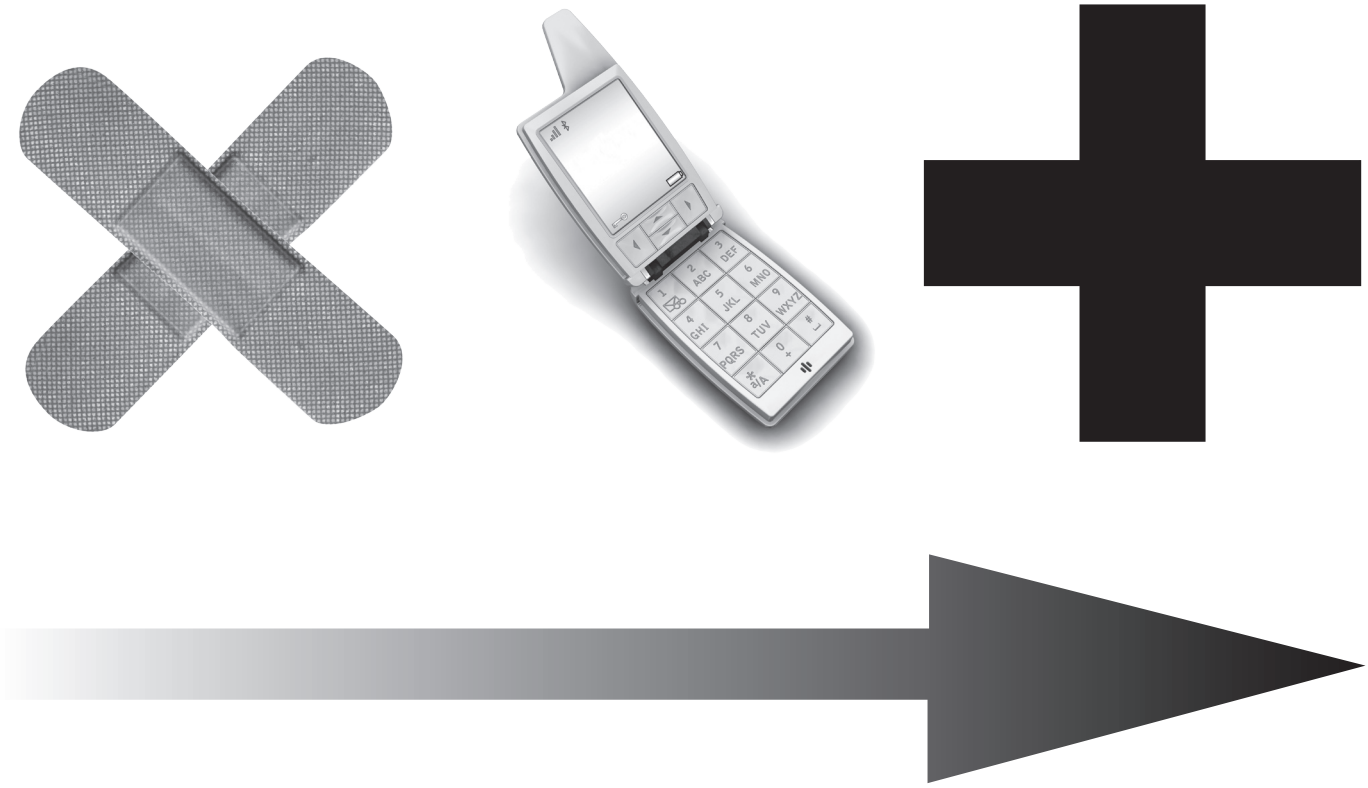
If available, her gestational age can be confirmed by ultrasound to determine the appropriate MA regimen and whether misoprostol can be taken at home. If ultrasound is not available, she could be offered vacuum aspiration or medical abortion with a regimen appropriate 10 weeks gestation. Given the increased risk of bleeding, misoprostol is given in the health care setting after 9 weeks

You should also discuss with her long acting or permanent contraception since she does not want any more children. Her age should not be a barrier to her receiving permanent contraception as long as she has made a fully informed decision.

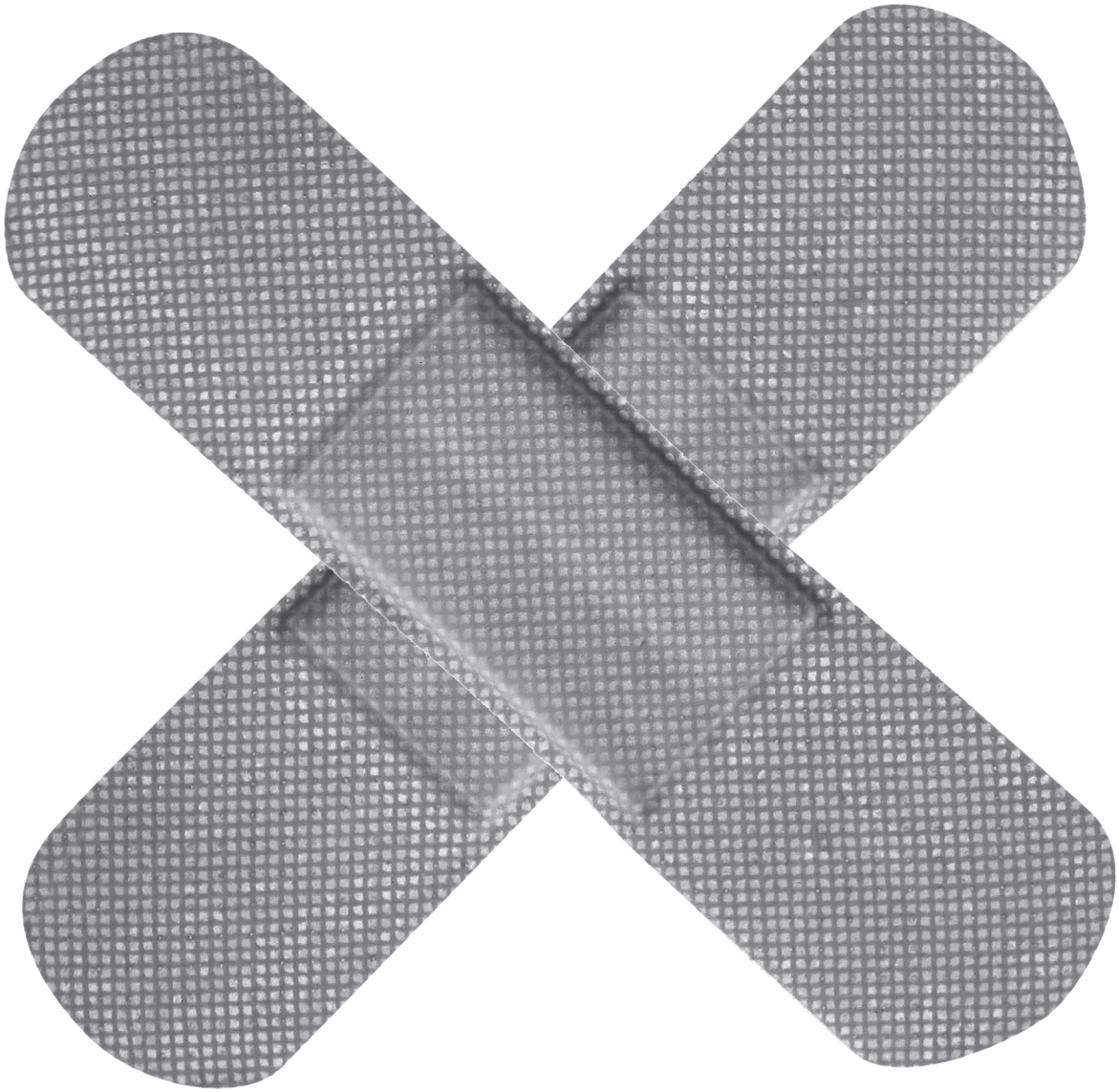
For trainers

Side effects continuum instructions

Instructions : Print and post the pictures below in a "continuum" at the front of the room. *(Note: color versions of these visuals are available on the CD-ROM in large size*)

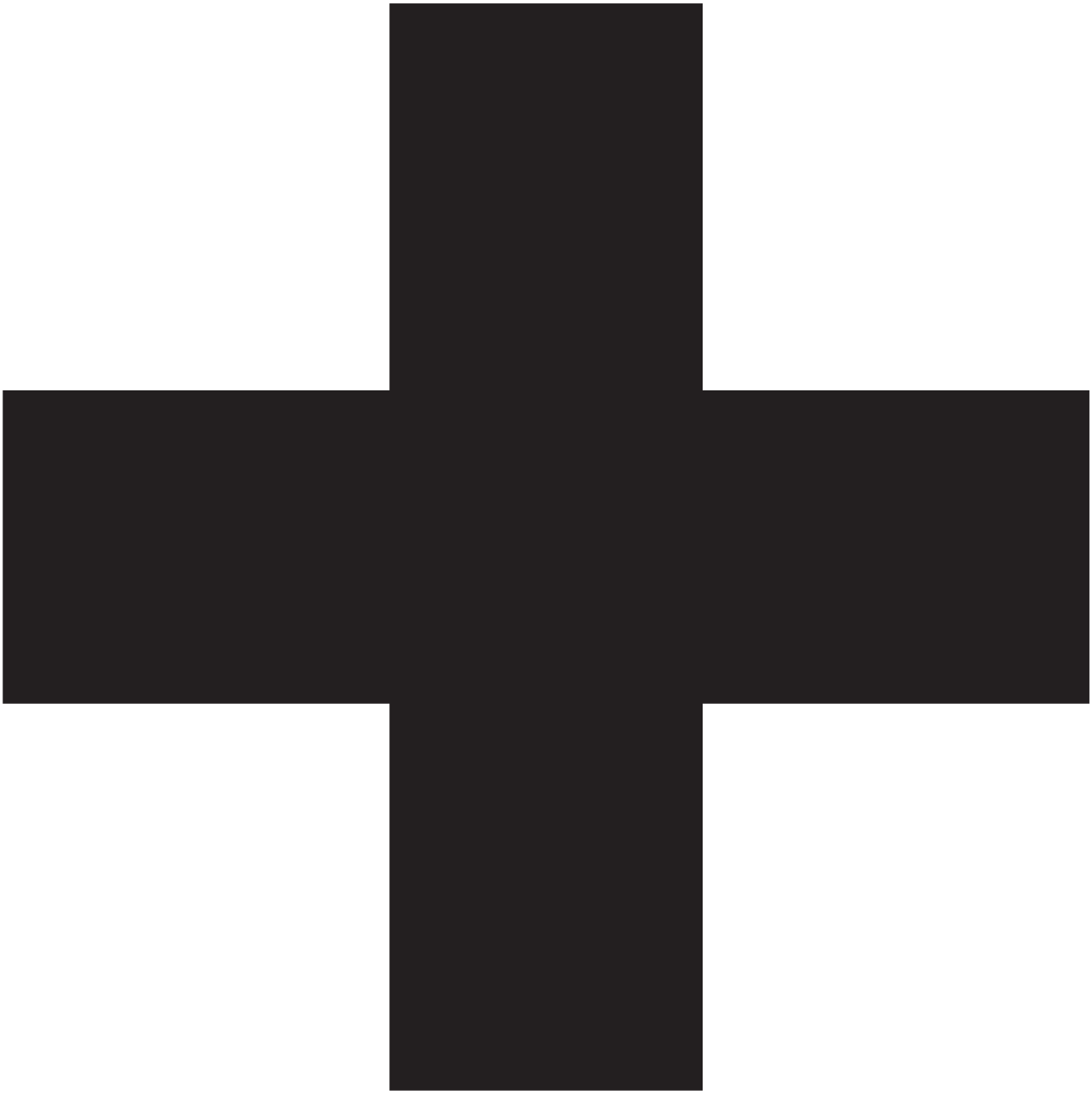


Normal



Call Clinic

Go to E.R.



For participants

Side-effects continuum strips

Trainer Instructions: *Copy this sheet and cut it into separate strips for each side effect situation. Place strips in a basket, bowl or envelope.*

Cramping and vaginal bleeding like a heavy menstrual period, but less than two pads per hour

Vomiting and diarrhea 24 hours after taking misoprostol

Woman worries during MA and thinks she should go to the emergency room

Fever and chills the day misoprostol is taken

One week after taking misoprostol, woman soaks through two pads for two hours in a row

Cramping that has improved a little with ibuprofen, but woman wants something more for pain

Severe nausea and vomiting 24 hours after taking misoprostol

Weakness and feeling very sick, unable to easily get out of bed

Sudden feeling of faintness or already fainted

Unusual or bad-smelling vaginal discharge with a fever or accompanied by severe abdominal pain

Bleeding in small amounts for three weeks after the MA

For trainers

Side-effects continuum: Answer key

Common side effects:

- Cramping and vaginal bleeding saturating menstrual pads (but less than two pads per hour for two consecutive hours) is an expected effect, not a side effect
- Fever and chills the day misoprostol is taken
- Passing of heavy blood clots from vagina within four hours of taking misoprostol
- Bleeding in small amounts for three weeks after the MA

Call clinic:

- Woman worries during MA and thinks she should go to the emergency room
- Cramping that has improved a little with ibuprofen, but woman wants something more for pain

Call clinic or go to E.R.:

(Note: These signs could fall under either category and still be correct)

- Vomiting and diarrhea 24 hours after taking misoprostol
- Severe nausea and vomiting 24 hours after taking misoprostol

Go to E.R.:

- One week **after** taking misoprostol, woman soaks through two pads for two hours in a row
- Weakness and feeling very sick, unable to easily get out of bed
- Sudden feeling of faintness or already fainted
- Unusual or bad-smelling vaginal discharge with a fever or accompanied by severe abdominal pain

For participants

Proportion of women who experience a side effect

Table 3-1: MA through 9 weeks using mifepristone and misoprostol, % of women experiencing side effects with various routes of misoprostol

Side effect	Misoprostol 800mcg buccally (Winikoff 2008)	Misoprostol 600mcg sublingually (Hamoda 2003, Hamoda 2005a)	Misoprostol 800mcg vaginally (Hamoda 2003, Hamoda 2005a)	Misoprostol 400mcg sublingually (Raghavan 2009	Misoprostol 800mcg sublingually (Tang 2003)
None	8	Not reported	Not reported	Not reported	Not reported
Nausea	66	79	78	52	54
Vomiting	40	57	37	17	37
Diarrhea	34	62	41	Not reported	40
Fever/chills	41	85	80	28	69
Headache	34	11	34	21	12
Dizziness	33	41	50	36	25
Weakness/ fatigue	45	81	80	53	37

Module 4: Informed Consent, Information and Counseling

Time

Three hours

Module objectives

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

- Provide unbiased options counseling to women seeking MA services
- Discuss with women the benefits, risks and alternatives to abortion, the consequences of not receiving abortion care, the details of planned procedure, then obtain informed consent
- Articulate their own comfort levels discussing, advocating for and providing MA services, including for young women
- Discuss how their personal level of comfort providing MA services relates to societal norms about abortion and MA
- Offer emotional support and woman-centered counseling to women seeking MA services
- Provide postabortion contraceptive counseling
- Help women manage MA side effects, identify warning signs and know when to make a follow-up care plan

Advance preparations

- Prepare flipchart with Module 4 Objectives
- Prepare three signs on paper: “A Lot,” “A Little” and “Not At All.”
- Review and, if needed, revise comfort continuum statements to be most relevant for participants.
- Label flipcharts for “Information Provision” and “Woman-Centered Counseling”
- Copy counseling handouts for group presentation work.
- Copy counseling and information handouts for role plays.
- Choose and copy the MA skills checklist (1 or 2) of the relevant regimen to be used by learners.

- Cut up the six Contraceptive Counseling Scenarios and place in a bowl, basket, or envelope.
- *Optional:* Prepare Four Corners activity (in appendices).

A. Information provision and woman-centered counseling (One hour, 15 minutes)

Materials:

- Labeled and posted flipchart papers:
  - — *Options counseling*
  - — *Informed consent*
  - — *Woman-centered abortion counseling*
  - — *Information provision*
- Information Provision and Woman-Centered Counseling handouts
- Tape
- Markers

1. Explain that in this activity, participants will highlight important considerations for providers to consider when offering pregnancy options counseling, ensuring informed consent, providing MA information and offering woman-centered abortion counseling.

2. Post flipcharts labeled: options counseling, informed consent, woman-centered abortion counseling and information provision.

3. Ask participants to take 30 minutes to rotate from one flipchart to the next, writing important considerations for each. Circulate among the groups to provide assistance. If participants are having difficulty, trainers can ask probing questions.

4. After the 30 minutes, ask participants to highlight the key considerations from each flipchart. Please see materials at the end of this module—Information Provision and Woman-Centered Counseling; Key Considerations—for possible responses.

5. Review information on the following slides to reinforce important considerations.

6. Show slide: *Pregnancy Options*
   - A woman seeking an abortion has usually carefully considered her options and decision prior to seeking care
   - If she has questions about her pregnancy options, discuss them with her:

—— Continue the pregnancy to term and parent or release the child for adoption

—— Terminate the pregnancy

Discuss the following:

- Pregnancy options counseling should not be required or serve as a barrier to receiving abortion care.
- Counseling should be respectful of every woman's rights and needs, regardless of her age, marital or HIV status.
- By providing any information needed and supporting a woman's decision, providers can help women feel confident and comfortable that they are making the decision about their pregnancy that is best for themselves and other important people in their lives.

7. Show slide: *Informed Consent*

Informed consent is a process in which a woman gathers the information she needs to make a voluntary choice to undergo an abortion procedure.

8. Show slide: *Informed Consent,* continued

Informed consent requires the following information:

- The benefits, risks of, and alternatives to abortion
- Consequences of not receiving abortion care
- Details of the planned procedure, once the method has been determined

Discuss the following:

- To ensure that women are giving informed consent for the abortion, providers should discuss and confirm that women have understood the information they've been given.

9. Show slide: *Keys to Informed Consent*

- Explain in simple language.
- Ensure that the woman has understood it.
- Ensure that woman has given consent voluntarily, without coercion.
- Privacy and confidentiality are critical to the informed consent process.
- Young women are capable of making the decision to terminate a pregnancy, and may require more information than older women.

Discuss the following:

- Young women are capable of making the decision to terminate a pregnancy.
- Because they are often not given adequate information or are specifically targeted with misinformation about sexuality, pregnancy and abortion, they may need more information to aid their decision making and informed consent process.
- Providers should listen to and talk with young women to gauge the degree of support they require.

10. Show slide: *Procedure Options*
    - Discuss the possible benefits, risks and what to expect with each procedure
    - As long as the different methods are clinically appropriate, providers should:
        - — Keep their own preferences out of discussion
        - — Support a woman's decision
    - Obtain informed consent only after all her questions are answered and she has made her decision about which procedure to have

Discuss the following:

- For details of the risks and benefits of MA and VA, see Table 3: Vacuum aspiration and medical abortion in the first trimester, in Module 4 of the *Medical Abortion Study Guide*.

B. Comfort level with medical abortion (30 minutes)

Materials:

- Blank flipchart paper and stand, markers, basket or bowl, envelopes and tape
- Pre-prepared flipchart: Module 4 Objectives (list)
- Three paper signs labeled "A Lot," "A Little" and "Not At All"
- Comfort continuum statements

1. Post and review flipchart: *Module 4 Objectives*

2. Introduce the Comfort Continuum VCAT activity. Explain that this activity asks participants to reflect on their level of comfort discussing, advocating for and providing MA services.

3. Tape the three signs on the wall or floor in an open area where there is enough space for participants to move around. Place the signs in order in a row to indicate a continuum:

Not At All **A Little** **A lot**

4. Read aloud the statements one at a time, and ask participants to physically move to the point along the continuum that best represents their feelings. Encourage participants to be honest about their feelings and to resist being influenced by where others are standing. *(Note: Do not read all the statements; choose those that are most relevant.)*

5. After participants have arranged themselves, ask volunteers at different points along the continuum to explain why they chose to stand where they did.
   - If, based on someone's explanation, participants want to move to another point on the continuum, invite them to do so.
   - After finishing all the statements, ask participants to return to their seats and invite two or three participants to share their feelings about the activity.

6. Refer to the reasons participants gave about their place on the continuum as you facilitate a brief discussion about the different responses and levels of comfort in the room. Some discussion questions could include:
   - *What observations do you have about your responses? Other people's responses?*
   - *Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?*
   - *What about your responses surprised you? How about other people's responses?*
   - *What did you learn about your own and others' comfort levels on MA?*
   - *Did your comfort level change based on women's age or marital status?*
   - *What observations do you have about the group's overall level of comfort with MA (not individual people's responses)? How about the group's level of comfort with MA for young women?*

7. Discuss how different levels of comfort with MA impact societal norms, women's feelings about themselves when they have a MA and providers' feelings about performing MA.
   - Discuss how their comfort levels impact the provision and quality of MA services.
   - Emphasize the impact providers' attitudes have on their provision of services and women's experience and satisfaction with those services.

8. Optional MA values clarification and attitude transformation (VCAT) Activity: Four Corners
   - *The Four Corners VCAT activity has been adapted for MA. This activity requires strong facilitation skills to maximize its potential. Please see the Appendices for the activity.*

VCAT activities included in this module have been adapted from: Turner, Katherine L and Kimberly Chapman. (2008) *Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences*. Chapel Hill, NC: Ipas, 2008.

C. Counseling role plays (50 minutes)

Materials:

- Handouts:
  - —*Counseling and Information Role Plays*
  - —*MA Skills Checklist 1: Mifepristone and Misoprostol Regimen or MA Skills Checklist 2: Misoprostol-only Regimen*
  - —*Visual aids from IEC CD-ROM for providers to explain regimens and routes of administration to women*

1. Explain that role playing can help participants practice their counseling skills and integrate new knowledge.

2. Divide participants into groups of three, and explain how the role-play activity will work.
   - Each group should complete three role plays, so each member has the opportunity to play each role once.
   - During the role play, one person acts as the "provider," a second person acts as the "woman" and a third person serves as the "observer," using the *MA Skills Checklist* to take notes. *(Be sure to distribute the checklist for the appropriate MA regimen).*
   - For each round, the "woman" should choose a role play from the *Counseling and Information Role Plays* handout. Each group should use at least one case of a young woman.
   - Each "woman" should take one or two minutes to read through her role play, create the character's name and come up with other personal information about the character.
   - The "provider" should practice explaining regimens and routes of administration to women in language they can easily understand. If possible, the "provider" should use visual aids from the IEC CD-ROM to enhance their information provision to the "woman."
   - When the "woman" is ready, the group has about eight minutes to conduct the first role play.

- After the role play, the "provider" should assess their performance and then the "woman" and "observer" give specific feedback to the "provider." Allow 5 minutes for all feedback.
- Groups should repeat this process, switching roles until each person has had a chance to play the "woman," the "provider" and the "observer." *(It is helpful for trainers to ring a bell or announce when time is up and the groups should switch to the next role play).*

3. Bring the groups together after they have completed three role plays. Ask the full group the following summary questions:
   - *What went well with the counseling sessions?*
   - What was challenging about the counseling sessions?
   - *What are some non-verbal behaviors the counselor used or could use to show respect and concern for the woman?*
   - *What would help you become more comfortable with providing counseling?*

D. Postabortion contraceptive counseling (25 minutes)

Materials:

- Bowl, basket or envelope
- Contraceptive Counseling Scenarios strips
- Handouts:

  —*Contraceptive Counseling Key Considerations*

1. Show slide: *Contraceptive Counseling*
   - Women can become pregnant again as early as 8 days after the MA procedure
   - Most women can begin contraception soon after a medical abortion
   - Depending on the method, contraception can be started as early as with the first pill of a MA regimen

2. Facilitate an interactive activity about contraceptive counseling, using the seven Contraceptive Counseling Scenarios.
   - Explain that this activity will examine different scenarios about contraceptive counseling for women seeking MA.
   - Ask a volunteer to randomly pick a scenario from the bowl, basket or envelope and read it aloud to the whole group.
   - Invite the group to discuss and consider the elements of the scenario, key considerations and possible contraceptive counseling approaches.

- After the discussion is over, hand out the Contraceptive Counseling Key Considerations. *(Note: The scenarios could also be explored in two-person role plays or groups of three rather than in the large group, but that may require more time.)*

3. Answer any remaining questions about counseling.

Module 4: Materials

1. Comfort continuum statements *(for trainers)*

2. Information provision and woman-centered counseling: Key elements *(for trainers)*

3. Role plays for counseling and information *(for participants)*

4. MA skills checklists *(for participants)*

5. Contraceptive counseling scenarios *(for participants)*

6. Contraceptive counseling scenarios key considerations *(for trainers)*

For trainers

Comfort continuum statements

Trainer instructions: Below are statements appropriate for health-care providers and health workers. Choose some of the following statements or develop other statements that are more relevant in your country or setting.

1. How comfortable are you with MA services being provided in your setting?
2. How comfortable are you discussing MA with colleagues at work?
3. How comfortable are you discussing MA outside of your work setting?
4. How much disapproval would you expect to feel from your family and friends if you provided (or assisted with) MA services?
5. How comfortable are you providing (or assisting with) a medical abortion?
6. How comfortable are you with women choosing to use misoprostol at home or in a safe place rather than in the clinic?
7. How comfortable are you receiving phone calls from women off-hours (possibly nights or weekends) if they need reassurance or are worried?
8. How comfortable are you with the amount of bleeding women may experience with MA and that they will be assessing the bleeding themselves at home?
9. How comfortable are you with telephone follow-up after MA rather than an in-person scheduled follow-up visit?
10. How comfortable are you providing (or assisting with) MA for every woman who desires it, regardless of her reasons?
11. How comfortable are you providing (or assisting with) MA for unmarried women?
12. How comfortable are you providing (or assisting with) MA for young women?
13. How comfortable are you screening and counseling a woman for MA and then giving her a prescription for obtaining and using it herself?
14. How comfortable are you advocating for increased provision and access to MA?

Activity adapted from: Turner, Katherine L. and Kimberly Chapman Page. (2008). *Abortion attitude transformation: A values clarification toolkit for global audiences.* Chapel Hill, NC: Ipas.

For trainers

Information provision and woman-centered counseling: Key elements

Pregnancy options counseling

- Most women have already carefully considered their decision to have an abortion.
- Pregnancy options counseling is optional for the woman – she may not need it.
- Provider should give any information the woman needs and support her decision.
- The options are:

  1) Continue the pregnancy to term and parent or release the child for adoption; or

  2) Terminate the pregnancy

If she decides to continue the pregnancy, the provider should refer appropriately.

Informed consent

- Respect privacy and ensure confidentiality.
- Use simple language.
- To ensure that women are giving informed consent for the abortion, providers should discuss and confirm that women have understood:

  — The benefits and risks of abortion, and alternatives to abortion

  — Consequences of not receiving abortion care

  — Procedure options

  — Details of the planned procedure, once the method has been determined
- Confirm that the woman understands.
- Ensure consent is voluntary – no pressure or coercion by anyone.
- With information and support, young women are capable of making health-care decisions and provide consent without third-party involvement.
- Ensure all of women's questions have been answered.
- Obtain informed consent.

Woman-centered abortion counseling

- Woman's experience is both emotional and physical
- Health-care providers should be prepared to offer compassionate support and, if desired, counseling that focuses on the woman's needs.
- Emotional support may improve experience and outcome.
- Be empathetic and respectful to all women.
- Counseling sessions with some women may take longer, because they may:
  - —Feel less comfortable and require more rapport-building
  - —Have had little or less opportunity to learn about sexual and reproductive health
  - —Have inadequate information or misinformation about sexuality, pregnancy and/or abortion
- Young women have varying levels of maturity that do not always correspond with chronological age; not all young women need the same degree of support
- Positive encounters with health-care workers may increase women's satisfaction with care, adherence to care instructions, trust of health-care workers and likelihood of seeking medical care in future.
- Provider attitudes and beliefs affect care.
- Beliefs may be unconscious.
- MA can give more control of the abortion to the woman, which providers may find uncomfortable.
- Discomfort with women managing abortion may affect provision of MA.
- Identify personal beliefs and values on abortion and MA.
- Separate beliefs from those of clients.
- Values clarification can help providers prepare for woman-centered counseling.

Information provision

- Use simple, non-technical language
- Provide information in a respectful and appropriate way
- Help the woman understand the entire process
- Invite her companion to hear the information as well, if the woman wants
- Ensure she understands the information
- Use visual aids to increase her understanding
- Provide a pamphlet or handout and pictorial resources
- Provide all women as much information as they need
- Young women in particular may need more information (for example, on anatomy and pregnancy) because they did not received factually correct sexuality education or were given misinformation.

For participants

Role plays for counseling and information

(Note: There are many more role plays here than needed for the activity. You can choose from the list based on your preferences, but please be sure your group uses at least one case of a young woman.)

1. You are a pregnant 15-year-old woman who has not had any children yet. You have come to the clinic with your sister because you would like to terminate your pregnancy. You are afraid your father will find out you are pregnant.

2. You are a 40-year-old woman who has four children. Your husband travels much of the time and you do not want to have another child. However, your husband would be very angry if he knew you were pregnant and considering having an abortion.

3. You are a young, unmarried woman with no children. You do not understand how you got pregnant or how MA works. You have been brought to the clinic by an older man who insists that you cannot have "his child." You are afraid than an abortion will be very painful and are not sure you want to terminate the pregnancy. During your session, you ask your counselor, "Will the drugs hurt the baby?"

4. You are married with a one-year-old child. You are pregnant but do not want another baby so soon. Your mother-in-law knows you are pregnant and is opposed to abortion.

5. You are 17 years old and have been raped and are now pregnant. You are very afraid of being touched and don't want to continue the pregnancy. Your sister is at the clinic with you.

6. You are a 32-year-old woman who has three children. Your husband is a truck driver who is gone most of the week. You got pregnant while breastfeeding your six-month-old daughter because you thought you would be "safe" from pregnancy and didn't use contraception. You want to have an abortion but are afraid of surgery.

7. You are a 28-year-old woman who lives two hours from the clinic. Your last menstrual period was near your birthday—which was nine weeks ago. You don't want your husband to know you are pregnant or considering an abortion.

8. You are an 18-year-old woman who has come to the clinic with your mother, who does not know you are pregnant. You don't want her to be in the room with you when you see the nurse. You want to have an abortion but are afraid your mother won't allow it

9. You are 39 years old with two children, ages 14 and 16. You have also had one miscarriage at around nine weeks. By bimanual exam and history of LMP, you are around seven weeks pregnant. You are concerned about keeping this abortion private from your children. Your husband knows and is supportive. You would like strategies to ensure the most privacy and comfort during your abortion.

10. You are 21 years old and about eight weeks pregnant. You have never been pregnant before and have a history of painful periods. You don't want to continue this pregnancy. You live with your mother and aunt. You don't want them to know about the abortion.

11. You are 24 years old and live alone. You are new to the city and haven't made many friends here. You have a job with a schedule that changes a lot. You are eight weeks pregnant by LMP. This is your second abortion (the first was with MVA).

12. You are 26 years old and a single mother with two children (ages five and eight). Your former husband left you but he comes frequently to see the children. You are seven weeks pregnant from a new boyfriend who your children don't know about. You want to end this pregnancy but you are worried about your former husband finding out about the abortion and using this information to hurt you or take the children away.

13. You are 15 years old, and are six weeks pregnant by LMP. Your mother is with you today, and really wants you to have a MA because she's worried about that a surgical abortion will affect your future fertility. You are not sure what to do.

14. You are 22 years old, single, and accompanied by your boyfriend. You are nine weeks pregnant by LMP and bimanual exam, and really want to have a MA. Your boyfriend is very worried about whether this medicine is safe and about whether you are going to be in a lot of pain.

15. You are 15 years old and are here with your grandmother, with whom you live most of the time. This will be your second abortion; your first pregnancy was the result of rape by your stepfather and is why you moved in with your grandmother.

16. You are 25 years old and about to be married to a well-known man in town. You are very worried about confidentiality. You got pregnant with another man when you were briefly separated from your fiancé. You are eight weeks pregnant, and this is your first pregnancy. Your schedule is demanding, and you have already had to reschedule this appointment twice.

17. You are 24 years old, and have come in with your husband. You have a 10-month-old and two-year-old and do not want another child so soon. Your mother-in-law lives with you. The mother-in-law knows about the pregnancy and is opposed to abortion. You are seven weeks pregnant and are still breastfeeding your daughter occasionally

18. You are 46 years old and six weeks pregnant. Your periods have been irregular and lighter for the past year as you start to go through perimenopause. You had a positive pregnancy test this week. You don't want to tell your husband because you feel embarrassed. You didn't think you could get pregnant anymore and so you stopped using birth control. You want to have a MA because you think it's better to end the pregnancy before it's too late.

19. You are a 37-year-old mother of two and are eight weeks pregnant. You had a miscarriage last year. You want to have a MA.

20. You are 21 years old and have three children. You are seven weeks pregnant and want to "get this over with right away." You live far from the hospital and want to take the medicines for MA at home because there is nobody who can take care of your children while you are away. Your husband has to be out most of the time because of work.

For participants:

Medical abortion skills checklist 1: Mifepristone and misoprostol regimen

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 *(Note: this may be part of local protocols but may not be feasible or routine in many settings)*			
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 86-89)

For participants:

Medical abortion skills checklist 1: Mifepristone and misoprostol regimen

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 *(if misoprostol was not given on the first visit for home use)*	**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)			

For participants:

Medical abortion skills checklist 1: Mifepristone and misoprostol regimen

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			

For participants:

Medical abortion skills checklist 1: Mifepristone and misoprostol regimen

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.			

For participants:

Medical abortion skills checklist 1: Mifepristone and misoprostol regimen

Possible Follow-Up Visit (continued) *(if needed or desired by the woman)*	Yes	No	Comments
If the woman is still pregnant, discusses options: • 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			

For participants:

Medical abortion skills checklist 2: Misoprostol-only regimen

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 *(Note: this may be part of local protocols but may not be feasible or routine in many settings)*			
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 91-92)

For participants:

Medical abortion skills checklist 2: Misoprostol-only regimen

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. 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 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 abortion process, asking her if she thinks the abortion is complete			

For participants:

Medical abortion skills checklist 2: Misoprostol-only regimen

Possible Follow-Up Visit	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 and 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			

For participants

Contraceptive counseling scenarios

Trainer Instructions: Copy and cut this handout into strips, with one scenario per strip. Fold the strips and place them in a bowl, basket or envelope.

Scenario 1

A 20-year-old woman in good overall health had a MA 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. You think she may be a sex worker.

Scenario 2

A 27-year-old woman who had a MA is back for a follow-up visit 2 weeks after taking MA. She was given condoms during the initial, but she says she didn't have sex during that time because she was still bleeding. She is still having light spotting but says she wants to start using a hormonal contraceptive because she thinks she'll have sex with her husband soon and doesn't want to become pregnant again right away.

Scenario 3

A 39-year-old woman with four children came to your facility seeking a MA. She and her husband decided before she came that she should get permanent contraception. She came to this facility for abortion 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.

Scenario 4

A 21-year-old woman with no children had a successful MA two weeks ago. She is monogamous with her current partner, denies sexual activity since her MA and desires an IUD or implant for contraception because she does not want children for several years. She reports feeling well and is continuing to have light bleeding.

Scenario 5

A married 36-year-old woman has had a recent MA. She says that she wants to have one more child but she wants to wait at least one year. She smokes and has high blood pressure. When you mention the IUD, she says that she is not interested because it might get lost inside her body.

Scenario 6

A 32-year-old woman with three children says that this is the second time she has had a MA. After the first abortion, she did not want contraceptive information because she had been using natural family planning for years. She and her husband believe that contraceptives cause cancer.

Scenario 7

A 16-year-old woman in good overall health had a MA with no complications. She does not want to get pregnant again, but is scared that contraceptive methods are dangerous and cause you to "lose your ability to have a child when you get married." She also does not want her parents to know that she is using contraceptives.

For trainers

Contraceptive counseling scenarios key considerations

Instructions: Check whether the skill was performed or not and add comments as needed.

Scenario 1

A 20-year-old woman in good overall health had a MA 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. You think she may be a sex worker.

Key considerations:

1. Discuss discreet options including long-acting methods such as IUDs
2. Screen for domestic and sexual violence
3. Provide STI/HIV screening and education
4. Discuss barrier methods that protect against STIs/HIV
5. Dispel myths about hormonal contraception

Scenario 2

A 27-year-old woman who had a MA is back for a follow-up visit 2 weeks after taking MA. She was given condoms during the initial, but she says she didn't have sex during that time because she was still bleeding. She is still having light spotting but says she wants to start using a hormonal contraceptive because she thinks she'll have sex with her husband soon and doesn't want to become pregnant again right away.

Key considerations:

1. Discuss bleeding expectations post-MA
2. Discuss contraceptive options, including long-acting reversible methods

Scenario 3

A 39-year-old woman with four children came to your facility seeking a MA. She and her husband decided before she came that she should get permanent contraception. She came to this facility for abortion 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.

Key considerations:

1. Since she lives very far from the facility, consider whether there is a back-up for MVA if it is necessary or whether she will be able to return for MA follow-up (depending on which method she chooses)
2. Discuss long-acting reversible methods versus permanent methods

3. Provide an interim method of contraception until sterilization can be scheduled
4. Discuss male sterilization, which can be performed at any time.

Scenario 4

A 21-year-old woman with no children had a successful MA two weeks ago. She is monogamous with her current partner, has not had sexual activity since her MA and desires an IUD or implant for contraception because she does not want children for several years. She reports feeling well and is continuing to have light bleeding.

Key considerations:

1. Discuss when to initiate different types of contraception after MA
2. She may have an IUD or implant inserted today during this visit. IUDs may be inserted as early as one week after MA when it is determined that the woman is no longer pregnant. Implants may be started with the first pill of a MA regimen.

Scenario 5

A married 36-year-old woman has had a recent MA. She says that she wants to have one more child but she wants to wait at least one year. She smokes and has high blood pressure. When you mention the IUD, she says that she is not interested because it might get lost inside her body.

Key considerations:

1. Discuss progestin-only methods (pills, injections, implants) and barrier methods.
2. Dispel myths regarding IUDs.
3. Discuss smoking cessation.
4. Mention pre-conception counseling (folic acid, immunizations) for when she is ready to try to become pregnant again.

Scenario 6

A 32-year-old woman with three children says that this is the second time she has had a MA. After the first abortion, she did not want contraceptive information because she had been using natural family planning for years. She and her husband believe that contraceptives cause cancer.

Key considerations:

1. Ask if and when she wants more children in the future
2. Discuss contraceptive options, non-contraceptive benefits and dispel myths. Hormonal methods of contraception have been found to decrease rates of ovarian and endometrial cancer.
3. Discuss non-hormonal contraceptives, if this is the woman's decision, including the IUD and sterilization, depending upon her desire for future children.
4. Discuss bleeding expectations and when she might be able to start using natural family planning post-MA.

Scenario 7

A 16-year-old woman in good overall health had a MA with no complications. She does not want to get pregnant again, but is scared that contraceptive methods are dangerous and cause you to "lose your ability to have a child when you get married." She also does not want her parents to know that she is using contraceptives.

Key considerations:

1. Discuss discreet options and dispel myths, including the myth that a MA harms future fertility or affects future children a woman may have.
2. Discuss short-term methods versus long-acting reversible methods.
3. Screen for domestic and sexual violence.
4. Discuss barrier methods that protect against STIs/HIV.

Module 5: Follow-up Care

Time

One hour, 30 minutes

Module objectives

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

- Describe the purpose and key components of optional follow-up care
- Discuss methods for determining if a woman is still pregnant after taking MA
- Describe management approaches for problematic bleeding
- Demonstrate skills in providing support to women by telephone
- Explain ways in which outreach workers can provide support

Advance preparations

- Prepare flipchart with Module 5 Objectives
- Copy Medical Abortion Telephone Support Role Plays

Instructions and materials

A. Providing follow-up care (10 minutes)

Materials:

- Blank flipchart paper and stand, markers
- Pre-prepared flipchart: Module 5 Objectives (list)

1. Post and review flipchart: Module 5 Objectives

2. Explain that there is no medical need for an in-person follow-up after MA with mifepristone and misoprostol (or vacuum aspiration) if the woman has no complications and feels that she is no longer pregnant, but that such care is available if needed or desired. Women who use misoprostol only should have follow-up after 7-14 days due to the higher rate of ongoing pregnancy.

3. Show slide: *Follow-Up Care*
   - Address any questions or concerns about her MA process
   - Examine the woman's overall health status
   - Confirm that she is no longer pregnant
   - Assess that the woman's bleeding is within normal range
   - Determine whether heavy bleeding is affecting her health or if an infection is present

4. Show slide: *Follow-Up Care, continued:*
   - Assess and treat any other complications, including ectopic pregnancy
   - Provide contraceptive method if desired or ensure initiated contraception is meeting the woman's needs
   - Address any concerns or questions the woman may have about her chosen contraception
   - Complete unsuccessful abortion, if desired
   - Refer her to additional services if needed

B. Confirming the MA worked (15 minutes)

1. Ask participants to divide into pairs.

2. Ask each pair to spend a few minutes discussing:
   - Ways to confirm that the MA worked (she is no longer pregnant)
   - Specific questions to ask a woman to assess whether she is still pregnant

3. After a few minutes, ask some pairs to share their ideas, writing them on a flipchart at the front of the room.

4. Review the final list of steps and key questions. Show slide: *Confirming MA Worked*
   - Ask the woman whether she felt like she expelled the pregnancy
   - Ask the woman if she ever felt pregnant, and if she still feels pregnant now. Review what pregnancy symptoms she experienced prior to and after the abortion.
   - Review how she took each medication
   - Review the following information:

Ask questions like
   - "Did you have bleeding at least as heavy as your usual period after you took all of the medical abortion tablets?"

- "Did you pass blood clots or tissue after you took all of the medical abortion tablets?"
- "Do you think you are still pregnant?"
- "Have your pregnancy symptoms gone away?"
- Tell me how and when you took each pill."

5. Show slide: *Confirming MA Worked,* continued*:*

Pelvic exam:

- Up to seven weeks gestation at clinical assessment, uterus should feel non-pregnant two weeks after taking MA medications.
- Eight weeks gestation or more - uterus should be smaller two weeks after taking MA medications.

Review the following information:

- Perform a pelvic exam. Compare it to the exam documented prior to the MA.

6. Show slide: *Abortion is probably complete if*

- The woman believes she had a successful abortion.
- The woman's pregnancy symptoms have stopped.
- Her bleeding and cramping pattern is normal.
- Her uterine size is non-pregnant or smaller than before.

If there is still doubt about whether the MA worked, the provider can conduct or refer for an ultrasound

C. What to expect at a visit after MA (20 minutes)

1. Show slide: *After MA*

- Usually she starts feeling better the day after taking misoprostol.
- Typically pregnancy symptoms abate over the next week.
- Bleeding and cramping may be significant the first day but diminish over the next week.
- Bleeding may continue for several weeks; in some women can last for over a month.

Review the following information:

- Continued bleeding may range from a menstrual-type flow to light spotting.

2. Show slide: *Problematic Bleeding*

If problematic but not severe:

- Wait
- Perform vacuum aspiration

Review the following information:

- Some women experience tiresome or problematic bleeding for a few weeks, despite the fact that the pregnancy is not continuing, pregnancy symptoms have resolved and the uterus is smaller in size.
- Twenty percent of women will have light bleeding or spotting that persists for more than a month. These bleeding patterns are normal.
- The vacuum aspiration option should be available to women who request it because they are tired of the bleeding.
- Symptomatic bleeding may be a reason to perform a vacuum aspiration.

3. Ask participants to describe different patterns of problematic bleeding and recommend strategies for managing them. Write participants' recommendations on flipcharts. Ensure that responses include:

- Persistently heavy bleeding (continuous bleeding like a menstrual cycle since taking misoprostol)

  Strategies:

  — If the woman has clinical symptoms of anemia due to bleeding (fatigue, weakness especially upon standing, racing pulse, feeling faint), and/or if hemoglobin or hematocrit has dropped significantly from the initial value, vacuum aspiration should be performed.

  — Offer reassurance and see the woman again in 1-2 weeks.

  — Increased fluid intake (oral hydration) and iron-rich foods or iron supplements should be strongly encouraged.

- Erratic bleeding (days of very little or no bleeding followed irregularly by heavy, gushing bleeding)

  Strategies:

  — If the woman is symptomatic of anemia, perform vacuum aspiration.

  — Increased fluid intake (oral hydration) and iron-rich foods or iron supplements should be strongly encouraged.

- Delayed bleeding (very rarely, after several weeks of little or no bleeding and no other complications, a woman will experience sudden, heavy bleeding)

Strategies:

— Treat the woman according to the severity of clinical presentation.

- Hemorrhage (Please see Module 6: Problems, Complications and Emergencies in the *Medical Abortion Study Guide,* Second Edition.)

D. Telephone support (45 minutes)

Materials:

Medical Abortion Telephone Follow-up Role Plays

1. Show slide: *Telephone Support*

If full information is given during the visit, telephone support can work:

- When women call the clinic after taking MA with questions or concerns
- When women do not or cannot return to the clinic but want additional support to ascertain whether the abortion has been successful

Review the following information:

- Women are good at telling if they're not pregnant.
- There are situations in which follow-up support can be provided effectively over the phone or by an outreach worker, but only if proper information, guidance and counseling have been provided at the visit.
- Women having a misoprostol-only abortion should return in person for a follow-up visit.

2. Show slide: *MA Success Checklist:*

	Yes	No
1. Did you have cramping after you took all of the medical abortion tablets?		
2. Did you have bleeding at least as heavy as your usual period after you took all of the medical abortion tablets?		
3. Did you pass blood clots or tissue after you took all of the medical abortion tablets?		
4. Have your pregnancy symptoms gone away?		
5. Do you think you are still pregnant?		
6. Are you having heavy bleeding today?		
7. Do you have a fever today?		
8. Are you having bad cramping or pain today?		

Review the following information:

- **If there is at least one tick in the shaded area**, she should see a health-care provider. She may still be pregnant or need additional medical care.
- **If there are no ticks in the shaded area**, there is a high likelihood that her medical abortion was successful. She should use contraception to prevent an unwanted pregnancy.

3. Ask the group to brainstorm some potential challenges in providing information and counseling to women over the phone (versus in person). Possible challenges include:
   - Lack of non-verbal cues (nods, body language)
   - No direct observation to facilitate understanding
   - Language barriers

4. Show slide: *Phone Call Topics*

Typical questions include:

- Is the woman is bleeding enough?
- Is a follow-up visit needed?
- Are activities such as sexual activity, bathing or swimming allowed?

Review the following information:

- The majority of phone calls about MA involve straightforward questions for which a woman seeks reassurance.

5. Tell participants they will now practice providing effective support in a phone role play activity.
   - Divide participants into five groups.
   - Select five of the role play scenarios provided and give each group a different role play.
   - Ask the groups to spend five minutes preparing the role play. They should choose one group member to play a woman calling the clinic for help, and another group member to play a provider who will offer support over the phone. The provider should focus on providing reassurance and asking probing questions. Explain that they will simulate a telephone conversation by sitting back to back. Everyone in the group should help prepare the role play and ensure that it only lasts a few (no more than five) minutes.
   - Ask the first pair to come the front of the room.
   - Have the "woman" and the "provider" sit facing away from each other (back-to-back); ask them to complete the role play, simulating a phone conversation.

- At the end of the role play, have the group briefly review their case and recommended course of action.
- Complete this process with all five groups.

6. After all the groups have completed their role plays, discuss the following questions with the full group:
   - *How did it feel to be the caller?*
   - *As a caller, how well did the provider address all of your concerns?*
   - *What was challenging about providing support over the telephone?*
   - *What effective strategies did the providers use to address these challenges?*

7. Show slide: *Outreach Workers*
   - Can sometimes help provide follow-up care
   - Abortion is still highly stigmatized in many settings
   - Outreach workers must protect women's privacy and confidentiality
   - Discuss with woman in advance if appropriate for outreach worker to follow up

Review the following information:

- Where telephone access is not possible or easy, outreach workers can sometimes help provide follow-up care.
- However, because abortion is still highly stigmatized in many settings, outreach workers should take great care to protect women's privacy and confidentiality when conducting outreach visits.
- If an outreach worker referred the woman for MA services, it makes sense for the outreach worker to provide follow-up.

8. Show slide: *Telephone Support Questions*
   - *Did you have cramping and bleeding heavier than a period?*
   - *Did you pass clots or tissue?*
   - *What was the highest number of pads you soaked per hour?*
   - *Do you still feel pregnant now?*
   - *Do you think you passed the pregnancy?*

Review the following information:

- A study of 133 women found that using these questions by telephone allowed providers to evaluate women successfully, only asking 6% of women in the study to come in for a follow-up visit within 7 days.

- Of those who were asked to return, 1/4 were still pregnant (2 of 8). Of the women who were not asked to return, none were still pregnant at 30 days after mifepristone administration.

9. Ask learners whether they think it could be useful for trained outreach workers to ask these questions to women who had MA to help them determine if the MA was successful or they might have an ongoing pregnancy. This might help women decide if they should return to the clinic for assessment.

10. Solicit final questions and comments and thank participants for their participation.

Module 5: Materials

1. Telephone support role play scenarios *(for participants)*

For participants

Telephone support role play scenarios

Case 1

Woman: You are 19 years old with an eight -week pregnancy and undergoing a MA. You took your misoprostol six hours ago. For the last two hours, you have been bleeding heavily and soaked through one large pad. You do not feel bad—just worried due to all the bleeding. You decide to call the clinic to make sure everything is all right.

Provider: This woman's situation sounds like a normal bleeding pattern after MA. It is important to confirm that she has no symptoms of excessive blood loss (dizziness, feeling faint or very weak). Reassure her that bleeding is a normal part of the process. The bleeding suggests that the medication is working and it should decrease in the next few hours. Suggest that you can call her in a few hours to check on her status.

Case 2

Woman: You are a 25-year-old mother of two small children who was eight weeks pregnant when you took misoprostol three days ago. You had bleeding heavier than a menstrual period for a day and now your bleeding is like a normal menstrual period. You bought a pregnancy test at the pharmacy and the result is positive. You are very worried that the MA failed.

Provider: Pregnancy hormones (hCG) drop sharply when a woman has a successful MA. However, the hormonal level is at its height at eight to nine weeks in pregnancy, and it may take weeks for the level to drop lower than the sensitivity of the urine test. Reassure the woman that the pregnancy test does not mean the MA was unsuccessful. Tell her that the pregnancy test is not accurate this early after the MA and advise her not to do any more pregnancy tests. Reassure her that by her symptoms her MA was probably successful. If she would like reassurance, invite her for a follow-up visit where you will assess whether the MA was successful.

Case 3

Woman: You are 35 years old and are having a MA. You took your misoprostol under the tongue (sublingually) at the clinic this morning. As soon as you returned home one hour later, you began vomiting. You have felt sick over the last few weeks but not like this, and you are afraid you may have vomited the pills the nurse gave you. You call the clinic to see if you should be worried.

Provider: If it has been more than 30 minutes since she took misoprostol, there is likely enough misoprostol in her bloodstream to complete the abortion. If a woman vomits immediately after ingesting misoprostol, an additional dose should be given. Reassure her that vomiting can be a side effect of misoprostol. Ask her if she would like a family member to pick up a prescription for an anti-emetic (since she has already vomited, a rectal suppository may be the best route). For women who are experiencing frequent vomiting with their pregnancy, it may help to give them crackers to settle their stomach before giving them the misoprostol. Advise her to call in the morning to see if her bleeding and cramping were consistent with successful MA.

Case 4

Woman: You are an 18-year-old woman who was eight weeks LMP when you received MA. You call the clinic today, two days after taking misoprostol, because your bleeding was only as heavy as a normal period. You are worried that you did not bleed as much as you were told to expect and thus the MA did not work.

Provider: Women experience a range of bleeding when undergoing MA. Many women bleed more than a normal menstrual period but for some, bleeding is lighter than a menstrual period. Ask the young woman if her pregnancy symptoms have gone away or are subsiding. Reassure her that bleeding like a normal period is within the range of bleeding expected, and that the MA was probably successful. If she would like more reassurance, ask her to come in for a visit 1-2 weeks after taking the medications. While it is good to prepare women for bleeding that is significantly heavier than a menstrual period, possibly with large clots, it is always helpful to explain that a range of bleeding is possible, from bleeding lighter than a menstrual period to bleeding that is much heavier than a normal period. As long as there is some bleeding, it is a reassuring sign that the MA is working.

Case 5

Woman: You are 22 years old and having a MA of a seven-week pregnancy. You took your misoprostol four hours ago. You have such bad cramps that it is hard to stand. You have taken paracetemol but it has not helped the cramping. Additionally, you have soaked through two large pads in the last hour, and you remember the doctor saying something about this being bad.

Provider: This woman is experiencing uncontrolled pain which likely is a sign of the pregnancy passing, but it might be a rare occurrence such as tissue trapped in the os or, more unlikely, an ectopic pregnancy. Over the phone, try to get a description of her pain and assess whether she has access to clinical follow-up care. Is it a sharp pain localized to one part of her body or is it cramping pain like when she has her period? If available, advise her to take ibuprofen (which works better than paracetemol). She might also try applying a hot water bottle or hot cloth to the painful area. It sounds like she is worried and this anxiety can increase pain, so try to answer any questions about bleeding or other concerns. The bleeding is only a problem if it continues at this rate for several hours and if she is symptomatic (dizzy, weak, faint). If she tries all of this, and the bleeding and pain do not improve in the next hour, ask her to come to the clinic for evaluation and stronger pain medicines if necessary.

Case 6

Woman: You are 21 years old and having a MA of a seven-week pregnancy. You took the misoprostol at home as instructed and started bleeding as the clinic staff described. Your bleeding started as dark clots and now you have soaked six pads in the last three hours. You felt dizzy and light-headed the last time you got up to change your pad and now you are very worried.

Provider: This woman is experiencing very heavy bleeding that needs urgent treatment which cannot be provided over the phone. The woman is experiencing symptoms of blood loss such as dizziness, suggesting this is severe bleeding or hemorrhage. Ask if a family member is with her. Someone should accompany her to the clinic immediately. She will probably need vacuum aspiration (unless the bleeding has completely subsided by the time she reaches the clinic). You can offer to speak with a friend or relative about why she must be taken to the clinic immediately.

Case 7

Woman: You are 17 years old and your friend is with you as you undergo an MA. You took the misoprostol 10 minutes ago but nothing has happened. You and your friend are both very worried that the MA is not working.

Provider: Bleeding and cramping may start within thirty minutes to several hours of taking misoprostol. Reassure the young woman and her friend that 10 minutes is not enough time for the medicines to have taken effect. If she has had no bleeding within 24 hours, tell her to call you back. Remind her to take ibuprofen if she experiences painful cramping. Be mindful in your response that the young woman is genuinely worried and that even though this is not a clinical emergency, the concern is real to her.

Case 8

Woman: You took your 15-year-old daughter to the clinic five days ago, where she had a MA. She has been bleeding, but not too heavily, so she is not sure she has passed the pregnancy. Tonight she cannot sleep and is hot and dizzy. She has a fever as well as a vaginal discharge in addition to her light bleeding. You are worried so you call the clinic.

Provider: The daughter likely has an infection and should seek immediate attention for antibiotics and possible vacuum aspiration. Over the phone, you should assess the daughter's bleeding and fluid intake over the last few days. Also, ask if she placed anything in her vagina other than the medicines given her. Emphasize the importance of seeking health care immediately.

Module 6: Problems, Complications and Emergencies

Time

One hour, 15 minutes

Module objectives

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

- Demonstrate an ability to identify and manage MA problems, complications and emergencies
- Describe elements of a good emergency response system

Advance preparations

- Prepare flipchart with Module 6 Objectives
- Cut up *Medical Abortion Problems, Complications and Emergencies Case Studies* into strips.
- Copy *Medical Abortion Problems, Complications and Emergencies Case Studie*s Answer Key

Instructions and materials

A. Overview of problems and complications (10 minutes)

Materials:

- Blank flipchart paper, markers, masking tape, basket, and easel
- Pre-prepared flipchart: Module 6 Objectives (list)

1. Post and review flipchart: Module 6 Objectives

2. Show slide: *Problems*
   - Most women have no problems or complications
   - Range from minor to true emergencies
   - Problems reduced if women know what to expect and when to seek care

Review the following information:

- Major complications are rare, and can sometimes be avoided by intervening at the right time with the proper treatment.

- Problems are reduced if appropriate care is provided in a timely manner.

3. Show slide: *Problems with MA*

- Failure due to a continuing pregnancy or unacceptable symptoms such as hemorrhage
- Persistent pain
- Ectopic pregnancy

Review the following information:

- MA failure with need for aspiration. Failure may include persistent bleeding, retained products of conception or ongoing pregnancy.
- Persistent pain warrants further examination to ensure that there is no upper reproductive tract infection, ectopic pregnancy, pregnancy tissue trapped in the os, or low pain tolerance.
- Ectopic pregnancy is a different type of emergency that MA with mifepristone and misoprostol will not resolve.

4. Show slide: *Infrequent Complications of MA*

- Hemorrhage
- Infection
- Allergic reactions

If needed, the trainer can review with participants the information on problems and complications in Module 6: Problems, Complications and Emergencies of the *Medical Abortion Study Guide,* Second Edition.

5. Show slide: *Treatment of Problems*

- Give clear, timely and accurate information
- Include women, including young women, in decisionmaking about treatment
- Give clear treatment instructions and educational materials

Review the following information:

When women experience complications, continuing pregnancy, or ectopic pregnancy:

- Providers should provide clear, timely and accurate information about what to expect and about all treatment options.
- Women, including young women, should be included in decisionmaking about their treatment options. Women, especially young women, need adequate information and time to understand treatment options and instructions.
- Women should be provided with clear instructions and educational

materials to help them adhere to treatment instructions and manage their stress and pain.

B. Case studies (50 minutes)

Materials:

Handouts:

- *Medical Abortion Problems, Complications and Emergencies Case Studies*
- *Medical Abortion Problems, Complications and Emergencies Answer Key*

1. Show slide: *Reassurance or Treatment?*
   - Most client concerns and phone calls are not about true complications
   - Most questions and concerns simply require reassurance
   - It is important to be able to distinguish what is an emergency

   Review the following information:
   - Women having complications need reassurance, too.

2. Tell participants that they are going to discuss case studies to practice diagnosing and managing problems, complications and emergencies after MA.
   - Divide participants into five small groups, and assign each group two case studies (without the answer key).
   - Ask each group to diagnose the situation described in their case study and recommend appropriate treatment options.
   - Remind participants that they may refer to the *Medical Abortion Study Guide* , Second Edition as they prepare their answers.
   - Ask each group to prepare a flipchart with a brief summary of the diagnosis and recommended management strategies.
   - After 5-10 minutes, bring the whole group back together and ask each group to briefly present their case studies.
   - Using the answer key as a guide, seek consensus from the group about the diagnosis and management of each case.
   - Summarize the symptoms and recommended management strategies for each situation, adding any missing information if needed.
   - Distribute the answer key to all participants for future reference.

C. Responding to medical emergencies (15 minutes)

1. Show slide: *Emergency Response Systems*
   - All facilities should be prepared to handle or refer severe complications and medical emergencies.

- All facilities should be able to respond quickly and efficiently when emergencies occur

  — Develop emergency response plans.
- May need to transfer her to higher levels of care

Review the following information:

- Although severe complications after MA are rare, all facilities should be prepared to handle or refer severe complications and medical emergencies.
- All facilities should have emergency response plans in place so that they can respond quickly and efficiently when emergencies occur.
- Sometimes the woman may need to be transferred to higher levels of care.

2. Ask participants if they have emergency response plans at their facilities. Ask them to share the different components of an emergency response plan, including key personnel and referral systems. Write ideas on a flipchart. Ensure they include:
   - On-call clinicians available to answer women's question and provide or refer for care 24 hours a day
   - Established relationships with referral facilities to ensure that women can be referred to an accessible hospital if needed
   - Memorandums of understanding or formal facility-to-facility relationships
   - Easily accessible emergency contact numbers for information-sharing in case of emergency transfer
   - Systems for sharing medical records between facilities
   - Emergency transport systems
   - Emergency supply cart with all needed supplies and medicines
   - Written emergency plans
   - Review and practice for emergencies by health-care staff
   - Education of community leaders and organizations about signs and symptoms of MA complications, as well as how and where women can receive emergency care

3. Ask participants what they have done (or what could be done) to establish and strengthen relationships with referral facilities. Add these ideas to the flipchart. Ideas may include:
   - Visits between facilities
   - Information-sharing
   - Orientation on MA
4. Solicit final questions and comments and thank participants for their participation.

Module 6: Materials

1. Medical abortion problems, complications and emergencies case studies *(for participants)*

2. Medical abortion problems, complications and emergencies case studies answer key *(for trainers and participants)*

For participants

Medical abortion problems, complications and emergencies case studies

Case study 1

A 19-year-old woman who was approximately seven weeks pregnant when she had a MA contacts the clinic because she continues to have vaginal bleeding 30 days after a MA. She had a visit two weeks after taking misoprostol and no longer felt pregnant at that visit. 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.

Question: *What is the likely diagnosis and what advice can you offer her?*

Case study 2

A young woman calls you at midnight two hours after taking misoprostol and she is alarmed. She is bleeding like a heavy period, soaking one pad per hour, but what is upsetting her is that she is passing clots the size of lemons (or clots the size of a small person's fist). She has intense cramps right before she passes a clot, and then once the clot passes, the cramps decrease. She has never seen clots this big and is worried she needs emergency help.

Question: *What is the likely diagnosis and what advice can you offer her?*

Case study 3

A 26-year-old woman who was eight weeks pregnant when she received her MA returns for a visit two weeks later. She had little bleeding after taking the misoprostol and is wondering if there is anything wrong. When you review the MA protocol with her she reports taking the medicines correctly and has had no vomiting. She is in no pain but complains of breast tenderness. You do a pelvic exam and her uterus is larger than at your last exam.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

Case study 4

A 35-year-old woman is approximately eight weeks pregnant as indicated by LMP and wants a MA. She is having some spotting and wonders if she is having a miscarriage. On pelvic exam you feel a retroverted uterus approximately six–eight week size and speculum exam shows a closed cervical os with no blood. She has no uterine or pelvic tenderness. She is given the medicines for MA with full instructions about how to take them. She returns to the clinic after three days and reports that she had very little bleeding after she took the medicines. The main reason she is returning is because she is having some sharp left lower abdominal pain, but not like menstrual pain, and she continues to feel pregnant. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at your site.

Question: *What is the likely diagnosis and what treatment options do you recommend*?

Case study 5

A 20-year-old woman was nine weeks LMP at the time she received MA. Her bleeding was heavier than a period for three days, and she noticed some clots in the first four hours after taking misoprostol. She had cramps, which she described as severe, but they were helped with ibuprofen. She is in the clinic for follow-up two weeks after her MA. You perform a pelvic examination and her uterus is non-tender and is non-pregnant size. However, her pregnancy test is still positive.

Question: *What is the likely diagnosis and what advice do you give her?*

Case study 6

The sister of a 22-year-old woman contacts the clinic because her sister has soaked seven pads in the last three hours after taking misoprostol two hours ago at approximately eight weeks of pregnancy. She says her sister is very weak, cannot stand without becoming dizzy, and is worried.

Question: *What is the likely diagnosis and what advice do you give to the woman about her sister?*

Case study 7

A 28-year-old woman reports abdominal tenderness four days after taking misoprostol. She first noticed it when her small son was sitting on her lap. She is concerned because the pain is now severe. She has a fever and feels generally unwell. She had a mild fever and chills after taking the misoprostol, but thought this was a side effect of the medicines.

Question: *What is the likely diagnosis and what advice do you give her?*

Case Study 8

A 17-year-old woman was eight weeks at the time she received MA. She is returning for a visit two weeks later. She had a day of very heavy bleeding the day she used misoprostol, but the bleeding steadily declined after the first day. 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.

Question: *What is the likely diagnosis and what advice do you give her?*

Case study 9

A 21-year-old woman with three small children requested a MA at about seven weeks LMP. By pelvic examination, her uterine size was about eight weeks. Her husband calls you three hours after she took misoprostol, very upset that she is bleeding so heavily. He knew she was having an abortion with pills but he is frightened that this is dangerous for her. You ask to speak to the woman. She tells you that she is bleeding like a very heavy period. She soaked two pads for an hour and is now saturating one pad per hour. She noticed large clots and had intense cramps for about an hour. Then she took ibuprofen, which helped. She feels she expelled the pregnancy and now her bleeding and cramping are diminishing. Her husband's anxiety is worrying her, but she herself does not think what is happening is different from the experience she was told to expect.

Question: *What is the likely diagnosis and what advice can you offer?*

Case study 10

A 16-year-old woman seeking a MA came to your clinic with her mother and, after counseling and consent, received mifepristone. Her mother planned to be home to support her on the day she took misoprostol. The young woman's father, the mother's husband, was expected to be away for at least a week. He unexpectedly returned home the day before the young woman was supposed to take the misoprostol. They are both very worried that the father will find out that the young woman was pregnant and will be very angry and perhaps even become violent with them or the young woman's boyfriend. The young woman calls to ask what she should do.

Question: *What is the likely diagnosis and what advice can you offer?*

For trainers and participants

Medical abortion problems, complications and emergencies case studies answer key

The majority of women undergoing medical abortion do not have any problems or complications. Problems following MA, if they occur, can range from minor to true emergencies. Major complications are rare, but can sometimes be avoided by intervening at the right time with the proper treatment.

Case study 1

A 19-year-old woman who was approximately seven weeks pregnant when she had her MA now comes to the clinic because she continues to have vaginal bleeding 30 days after a MA, even though she no longer feels pregnant. 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.

Question: *What is the likely diagnosis and what advice can you offer her?*

Diagnosis: *Prolonged bleeding that is expected in some women after MA*

Discussion: Many clinicians (and sometimes the women themselves) are concerned about prolonged bleeding. Bleeding time is variable with MA. On average, bleeding or spotting will last for two weeks but can continue for as long as 45 days. This woman needs reassurance that she is having variable bleeding that is a normal part of MA. She has no signs of hypovolemia. As long as the general pattern of bleeding is that it is diminishing over time, this is normal.

The woman should be informed of three choices to manage problematic prolonged bleeding:

1. Wait and watch (reassurance)
2. Vacuum aspiration
3. 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.

Encourage iron-rich foods and provide iron tablets if available.

Case study 2

A young woman calls you at midnight two hours after taking misoprostol and she is alarmed. She is bleeding like a heavy period, soaking one pad per hour, but what is upsetting her is that she is passing clots the size of lemons (or clots the size of a small person's fist). She has intense cramps right before she passes a clot, and then once the clot passes, the cramps decrease. She has never seen clots this big and is worried she needs emergency help.

Question: *What is the likely diagnosis and what advice can you offer her?*

Diagnosis: *Normal MA process*

Discussion: Comprehensive information prior to the MA could have helped this woman avoid unnecessary anxiety and an after-hours phone call. Her bleeding (heavier than a period, soaking one

pad per hour) is normal after taking misoprostol and it is common to see large blood clots. Reassure her that the medicines are working and that she is almost certainly in the process of aborting the pregnancy, and that what she is experiencing is normal. Remind her of the warning signs that should prompt her to call you. If you're willing, tell her to call you in two hours to report how she is doing. In most cases, having a reassuring, experienced person available to women is all that is needed. Ibuprofen may provide some pain relief, so remind her to take it as directed.

Case study 3

A 26-year-old woman who was eight weeks pregnant when she received her MA returns for a visit two weeks later. She had little bleeding after taking the misoprostol and is wondering if there is anything wrong. When you review the MA protocol with her, she reports taking the medicines correctly and has had no vomiting. She is in no pain but complains of breast tenderness. You do a pelvic exam and her uterus is larger than at your last exam.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

Diagnosis: *Continuing pregnancy*

Discussion: These symptoms indicate a failed MA. The pelvic exam suggests a growing pregnancy. Vacuum aspiration is recommended. Aspiration of pregnancy tissue will rule out ectopic pregnancy and complete the abortion. If the woman is still eligible for medical abortion, in areas where aspiration is not available, a second dose of misoprostol 800mcg vaginally may be offered, but close follow up is advised as the success rate is low.

Case study 4

A 35-year-old woman is approximately eight weeks pregnant as indicated by LMP and wants a MA. She is having some spotting and wonders if she is having a miscarriage. On pelvic exam you feel a retroverted uterus approximately six-to-eight-week size and speculum exam shows a closed cervical os with no blood. She has no uterine or pelvic tenderness. She is given the medicines for MA with full instructions about how to take them. She returns to the clinic after three days and reports that she had very little bleeding after she took the medicines. The main reason she is returning is because she is having some sharp left lower abdominal pain, but not like menstrual pain, and she continues to feel pregnant. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at your site.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

Diagnosis: *Possible Ectopic pregnancy*

Discussion: These symptoms indicate a possible ectopic pregnancy and this woman needs immediate medical attention. The initial pelvic exam may have been difficult because of the position of her uterus and uterine enlargement is common even if the pregnancy is ectopic. The pain and lack of history of expulsion of the pregnancy (little bleeding and cramping pain) suggest that there was not an intrauterine pregnancy (or a failed abortion of an intrauterine pregnancy). You may be able to feel an adnexal mass on exam, although it is rare to palpate an adnexal mass of ectopic pregnancy.

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. Early diagnosis and treatment of ectopic pregnancy save women's lives and help preserve their fertility.

Case study 5

A 20-year-old woman was nine weeks LMP at the time she received MA. Her bleeding was heavier than a period for three days, and she noticed some clots in the first four hours after taking misoprostol. She had cramps which she described as severe, but they were helped with ibuprofen. She is in the clinic for optional follow-up care two weeks after her MA. You perform a pelvic examination and her uterus is non-tender and is non-pregnant size. However, her urine pregnancy test is still positive.

Question: *What is the likely diagnosis and what advice can you offer?*

Diagnosis: *Successful medical abortion*

Discussion: A positive urine pregnancy test does not provide useful information two weeks after MA. Her urine beta hCG (pregnancy hormones) would have dropped sharply after a successful MA, but they are at their peak level around 8-9 weeks (Callen 2000). Even if the MA was successful (as all clinical findings indicate in this case), her pregnancy test would very likely still be positive. In other words, a negative pregnancy test would be reassuring but a positive test does not mean much (Perriera 2009). Urine pregnancy tests after MA generally add confusion, not clarification, at the MA follow-up and are not recommended for women who, by history and exam, have had a successful MA. This woman has had a successful MA and no further follow-up is required.

Case study 6

The sister of a 22-year-old woman contacts the clinic because her sister has completely soaked through seven pads in the last three hours after taking misoprostol two hours ago at approximately eight weeks of pregnancy. She says her sister is very weak, cannot stand without becoming dizzy, and is worried.

Question: *What is the likely diagnosis and what advice do you give to the woman about her sister?*

Diagnosis: *Hemorrhage*

Discussion: The woman is experiencing excessive blood loss or hemorrhage, and requires medical attention immediately. The dizziness and consistent bleeding of more than two pads per hour over a few hours is concerning. Her sister should take her to a facility that offers vacuum aspiration; she may also need rehydration or a blood transfusion depending on her status and the site's capability to administer blood transfusion.

Case study 7

A 28-year-old woman reports abdominal tenderness four days after taking misoprostol. She first noticed it when her small son was sitting on her lap. She is concerned because the pain is now severe. She has a fever and feels generally unwell. She had a mild fever and chills after taking the misoprostol, but thought this was a side effect of the medicines.

Question: *What is the likely diagnosis and what advice do you give her?*

Diagnosis: *Infection*

Discussion: These symptoms are consistent with a uterine infection or endometritis. The abdominal tenderness and persistent fever is not a typical side effect of the misoprostol. Transient fever caused by misoprostol should not last past the day the woman takes misoprostol. She should be evaluated by a clinician and given antibiotics for the infection.

Case study 8

A 17-year-old woman was eight weeks at the time she received MA. She had a day of very heavy bleeding the day she used misoprostol, but the bleeding steadily declined after the first day. She resumed her normal activities the day after using misoprostol. Two weeks later, she comes to the clinic complaining of intermittent cramping, although she feels that she is no longer pregnant. 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.

Question: *What is the likely diagnosis and what advice do you give her?*

Diagnosis: *Tissue trapped in the cervical os*

Discussion: Occasionally a large clot or tissue can get trapped in the cervical os. This can be painful, and can result in persistent cramping. The quickest and simplest treatment is to see if you can draw the tissue out of the cervix using a ring forceps or similar grasping instrument. If the tissue cannot be removed easily, vacuum aspiration is recommended

Case study 9

A 21-year-old woman with three small children requested a MA at about seven weeks LMP. By pelvic examination, her uterine size was about eight weeks. Her husband calls you three hours after she took misoprostol, very upset that she is bleeding so heavily. He knew she was having an abortion with pills but he is frightened that this is dangerous for her. You ask to speak to the woman. She tells you that she is bleeding like a very heavy period. She soaked two pads for an hour and is now saturating one pad per hour. She noticed large clots and had intense cramps for about an hour. Then she took ibuprofen, which helped. She feels she expelled the pregnancy and now her bleeding and cramping are diminishing. Her husband's anxiety is worrying her, but she herself does not think what is happening is different from the experience she was told to expect.

Question: *What is the likely diagnosis and what advice do you give her?*

Diagnosis: *Normal MA process, spousal anxiety*

Discussion: The woman is having a normal MA. Her husband is anxious for her. This is common, especially if the husband (or friend, mother or other support person) was not present in the clinic to hear information about the range of experience with MA. Reassure the woman and ask her if she wants you to speak to her husband. If she gives you permission to speak to her husband, talk to him, explaining the normal process of MA and the warning signs that should prompt seeking care. Reassure him that what his wife is experiencing is completely normal and that it means that the medicines almost certainly worked, and that the bleeding and cramping are decreasing. All these are good signs. Reassure him that either he or his wife can call again if they have questions or concerns. During initial counseling in the health center, having a husband or support person join the woman to listen to the counseling information can prevent unnecessary anxiety and increase the level of support the woman receives at home.

Case study 10

A 16-year-old woman seeking a medical abortion came to your clinic with her mother and after counseling and consent, received mifepristone. Her mother planned to be home to support her on the day she took misoprostol. The young woman's father, the mother's husband, was expected to be away for at least a week. He unexpectedly returned home the day before the young woman was supposed to take the misoprostol. They are both very worried that the father will find out that the young woman

was pregnant and will be very angry and perhaps even become violent with them or the young woman's boyfriend. The young woman calls to ask what she should do.

Question: *What is the likely diagnosis and what advice do you give her?*

Diagnosis: *Possible danger of domestic violenc*e

Discussion: Because of the father's unexpected return, and the misgivings about his reaction to the young woman's pregnancy and abortion, their home is no longer a safe place for her to take the misoprostol. Discuss various alternatives with the young woman, and if she gives permission to bring her mother into the conversation, include her mother in the conversation as well. Alternatives may be:

- If the father works or will reliably be out of the house for several hours, take the misoprostol at that time.
- Ask if there's another supportive and discreet family member, such as an aunt or grandmother, where the young woman may take the misoprostol and spend the day.
- If feasible, offer the young woman the choice of coming to the clinic to take the misoprostol there and spend several hours at the clinic until the pregnancy has passed.
- If feasible, offer the young woman the choice of MVA.

Module 7: Service Provision

Time

One hour, 30 minutes

Module objectives

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

- Describe the factors that need to be in place to ensure high-quality, woman-centered medical abortion care within the health system
- Identify and prioritize key aspects of high-quality MA services in their own setting, including needed changes and how to accomplish them
- Describe the benefits and challenges of using MA at home (or in a safe place) and in clinic settings
- List several barriers to accessing MA care and ways to overcome those barriers

Advance preparations

- Prepare flipchart with Module 7 Objectives
- Copy handout worksheet: Preparing a Site to Provide MA
- If appropriate, gather information about local resources for MA providers, including professional associations and distributors of mifepristone and misoprostol. Distribute this information to participants at the end of the session.

Instructions and materials

A. MA service provision considerations (45 minutes)

Materials:

- Blank flipchart paper and stand, markers, tape
- Presentation materials for groups (e.g., poster board, flipchart paper, markers, note cards, blank paper, magazines with images depicting women, scissors, etc.)
- Pre-prepared flipchart: Module 7 Objectives (list)
- Worksheet: *Preparing a Site to Provide MA Services*

1. Post and review flipchart: Module 7 Objectives

2. Ask participants to name the different service provision elements to consider when providing woman-centered MA.
   - Show slide: *Service Provision Elements*
     — Adequate facilities
     — Sufficient supplies
     — Trained staff
     — Functional referral systems
     — Quality assurance mechanisms
   - Ask participants to look at the "Providing Woman-Centered Medical Abortion" section in Module 7: Service Provision of the *Medical Abortion Study Guide*, Second Edition
   - Ask for different volunteers to read each section aloud; for each section, invite participants to comment on and discuss the following:
     — *Are there any service-delivery elements that are missing from the list?*
     — *Are there things on the list that are unnecessary in your setting and if so, why?*
   - For the section on "Staff Knowledge, Attitudes and Skills":
     — Remind participants that provider attitudes should be positive, helpful and non-discriminatory toward all women seeking MA, regardless of their age, marital or HIV status. Values clarification can help improve provider attitudes.
   - Ask participants to explain the linkage between good record-keeping and confidentiality. Adult and young women alike have the right to confidentiality and identify confidentiality as a key component of high-quality care.

3. Hand out the worksheet: *Preparing a Site to Provide MA Services*
   - Ask participants to take 15 minutes to think about the MA elements that are or are not currently in place in their own sites, taking notes on the worksheets. **(Note:** *If several participants work at the same site, they should complete the worksheet as a team.)*
   - Ask participants (or teams) to select two changes and improvements that their sites need to make immediately in order to begin or improve MA services.
   - Ask participants to list on a flipchart the specific steps and support needed to make the selected changes.
   - Post the flipcharts on the walls around the room.
   - Invite participants to walk around and look at each other's ideas.

Reconvene the group (after 5-10 minutes) and spend about five minutes discussing common themes. *(***Note***: You may want to have participants circulate during a break.)*

- Encourage participants to share any further ideas.

B. Taking MA at the clinic or at home (30 minutes)

1. Ask participants where MA services are generally offered in their setting:
   - *Do women take misoprostol at the clinic? If so, do they stay there until they abort or do they go home?*
   - *Do women take misoprostol at home or in some other safe place?*

2. Show slide *Taking MA Outside the Clinic*:
   - For some women who wish to take misoprostol outside the clinic, home is not the preferred setting
   - Example: for many young women, home is not private
   - Identify an alternative safe place outside the clinic, such as a friend or relative's home

3. Explain that participants will use a debate format to explore the challenges and benefits of providing MA services exclusively in the clinic versus allowing women to complete the MA process at home or in another safe place.
   - Place four chairs in the center of the room (two pairs facing each other).
   - Divide participants into two debate teams. Inform one team that they will argue in favor of providing MA only in the clinic (Clinic Team). The other team will argue in favor of only home use of MA (Home Team). Clarify that home use here also includes other safe place outside the clinic.
   - Give the teams 10 minutes to prepare their arguments. Instruct each team to select two representatives to present the team's arguments to the group.
   - Let the teams know that they can refer to Module 8 of the *Medical Abortion Study Guide,* Second Edition for information on home and clinic use of misoprostol.
   - After 10 minutes, ask the four representatives (two per team) to sit in the facing chairs in the center of the room.
   - Toss a coin or use some other method to decide which team will go first.
   - Allow each team three minutes for their opening arguments, and two "rebuttal" responses of two minutes each.
   - After two rebuttal rounds of debate, thank the teams and have them return to their seats.
   - Point out that there is no "winner" of this debate because there are good arguments on both sides.

4. Summarize key points from the debate, including the following:
   - Home and clinic settings both have benefits and challenges for MA service provision.

- When possible, it is recommended that clinics offer women with LMPs up to 9 weeks both options and allow them to choose where they would like to undergo the MA process.
- Having both options available has the potential to increase women's access to MA services.
- In some settings, protocols and policies may restrict women's options.
- If participants' sites offer MA in only one of the two settings, it is still helpful to know the benefits and challenges of both models in the event that protocols eventually change.

C. Barriers to MA access (15 minutes)

1. Ask participants to think back to their responses to the reflection questions in Module 7 of the *Medical Abortion Study Guide,* Second Edition and brainstorm challenges or barriers women may face when seeking MA services. Ensure that participants consider young women's unique barriers. Please see the Additional Resources: Young Women section of the *Medical Abortion Study Guide,* Second Edition, for more information.
   - List the group's responses on flipchart paper. Be sure responses include:
     — Restrictive laws or ignorance or narrow interpretation of legal indications that limit access
     — Shortage of trained providers and equipped sites
     — Policies limiting which providers are allowed to provide MA
     — Restrictions on how and where medications can be administered and women can undergo MA
     — Negative provider attitudes
     — High cost
     — Unavailability of medicines
     — Myths and misperceptions about MA
     — Restrictions based on age or marital status
     — Third party consent requirements for young women
     — Social stigma against abortion
2. Divide participants into small groups and assign each group two or three of the listed barriers.
   - Ask the groups to discuss several ways to overcome their assigned barriers and assign a spokesperson.
   - After five minutes, ask a spokesperson from each group to report back.
   - Summarize the key points.
3. Solicit final questions and comments and thank participants for their participation.

Module 7: Materials

1. Preparing a site to provide MA services worksheet *(for participants)*

For participants

Preparing a site to provide MA services worksheet

Service Delivery Components	Currently at Your Facility	What to Change (if necessary)	What is Needed to Make the Change
Facilities and health services			
Medication and supply management			
Staff knowledge, attitudes and skills			
Client information			
Record keeping and confidentiality protocols			
Monitoring and evaluation			

Module 8: Clinical Practicum

Time

Five to six hours

Module objectives

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

- Describe the characteristics of a functioning clinic providing MA services
- Describe competent clinical and counseling skills of practicing providers
- Demonstrate skills for providing high-quality MA services (as outlined in the Medical Abortion Skills Checklists)

Advance preparations

- Several weeks before the training, identify a site or sites where participants can complete a hands-on clinical practicum to practice MA skills in a functioning clinic setting. Considerations for selecting a practicum site are listed in the Appendices.
- Prepare flipchart with Module 8 Objectives.
- Prepare practicum schedule and participant assignments on a flipchart.
- Copy the Medical Abortion Skills Checklists (in Module 4) according to regimen to be used.
- Prepare additional activities for practice (such as role-plays and case studies).
- Prepare a flipchart titled *One Word.*

Instructions and materials

A. Practicum overview (15 minutes plus facility tour)

Materials:

- Pre-written flipchart: Module 8 Objectives (list)
- Practicum schedule written on a flipchart

- Handouts (according to regimen to be used):
  - — *Medical Abortion Skills Checklist I: Mifepristone and Misoprostol Regimen*
  - — *Medical Abortion Skills Checklist 2: Misoprostol-only Regimen*
- Additional activities for practice if no clients are available

1. Post and review flipchart: Module 8 Objectives

2. Post flipchart and describe the practicum schedule and participants' assignments.
   - If participants will be divided into practice groups, form the groups and instruct them on how their groups will function (for example, how they will rotate roles in the group).
   - Explain that trainers will observe practicum participants and complete the Medical Abortion Skills Checklist (#1 or #2 according to regimen used) for each participant. *(***Note***: In some settings it is acceptable for practicum participants to complete a checklist on fellow participants they are observing and then give that person their feedback after the skills practice is over.)*
   - Explain when and where the trainers will give feedback. Note that while individual feedback ideally should be given immediately after each skills practice, this may vary.
   - After the practicum, trainers should meet privately with each participant to provide overall feedback on their skills.
   - Tell participants that alternative activities will be available at times when there is no opportunity to practice with actual clients, such as when the caseload is low. *(***Note***: Prepare in advance role-plays and case studies for participants to practice when no clients are available; ensure participants have the materials needed to do this so that time is not wasted.)*

3. Tour the practicum facility with the group.
   - Refer participants to their worksheet from Module 7 (Preparing a Site to Provide MA Services) to guide their observations.
   - Call attention to relevant aspects of the site, including:
     - — Staffing
     - — Counseling areas and exam rooms
     - — Location of toilets
     - — Site factors or protocols that may impact participants' clinical practice
   - Solicit and discuss any outstanding questions, comments or concerns.

- Release participants to their practicum assignments.

B. Supervised Clinical Practice (4-5 hours)

1. Use skills checklists to observe competency of participants in providing MA services.

2. Supervise learner groups and ensure that all is functioning smoothly; if there are times when no clients are available, monitor alternate activities for learner practice.

C. Post-practicum debriefing (30 minutes)

Materials:

- Flipchart: *One Word* (leave blank)

1. Welcome participants back to the workshop and thank them for completing the practicum.

2. Post the flipchart titled, *One Word*
   - Ask participants to think silently of one word that captures their practicum experience.
   - Ask participants to come to the front and write their word on the flipchart.
   - Ask for volunteers to briefly speak about their word with the group.

3. Facilitate a discussion about the practicum, using some of the following questions:
   - *What went well?*
   - *What was challenging?*
   - *Was there a particularly interesting case?*
   - *What surprised you?*
   - *What did you learn?*
   - *What would you do differently?*
   - *How can you apply what you did in the practicum to your own work situation?*
   - *What challenges or barriers might you face?*
   - *What are some strategies to deal with those challenges?*
   - *Were young women served?*
   - *Did providers face any challenges providing high-quality services to young women?*

- *What barriers or challenges did young women face in accessing services?*
- *How does the facility involve or link with the community, for example by holding community education events or coordinating with community groups or health workers?*
- *What information did women receive about what to expect during MA?*
- *What information and medications did women receive for pain control?*
- *How well did the facility provide contraceptive counseling and methods?*
- *What types of contraception were offered?*
- *What method choice (MA or MVA) were women offered?*
- *What protocols were in place for MA?*

4. Provide feedback and identify next steps:
   - Summarize common themes and highlight unique points from participants' discussion.
   - Share what you and the other trainers observed about the practicum.
   - Ask for and answer any last questions about the practicum.
   - Ask participants to identify their most important next steps towards gaining MA skills.
   - Provide participants with specific recommendations for implementing and improving their skills when they return to their work sites. *(***Note***: This can also be done individually with participants who may need to focus on particular areas of improvement.)*

5. Solicit final questions and comments and thank participants for their participation.

After the workshop:

- Provide feedback on each participant's skills to their site supervisor, if appropriate.
- Arrange follow-up visits with participants to support them in using their new skills and to help them problem-solve. Follow-up should occur as soon as possible after the workshop, preferably within a month.
- Provide opportunities for refresher courses and site-visit exchanges between participants.

Module 9: Final Assessement and Closing

Time

One hour, 30 minutes

Module objectives

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

- Determine whether their expectations and the workshop objectives were met
- Demonstrate knowledge level acquired through a post-test
- Give feedback about the MA workshop to the organizers

Advance preparations

- Gather all the module objectives, expectations and parking lot flipcharts and post at front of room
- Copy the MA Pre/Post-test and Answer Key (in Module 1 materials)
- Copy Final Evaluation Forms
- Consider how to close the workshop. The closing circle described in Activity B is one example. The closing ceremony may be conducted in whatever manner is appropriate to local practices.
- Prepare certificates of completion or competency according to local practices (on CD-ROM in Word®)

Instructions and materials

A. Review expectations, objectives and parking lot (10 minutes)

Materials:

- Completed flipcharts from previous modules:

  — Expectations

  — Module Objectives

  — Parking Lot

1. Review the expectations flipchart and determine whether all

expectations were met or not. If any were not met, discuss with participants if and how they can be met outside the course.

2. Have participants examine the module objectives flipcharts and express whether they felt they were met or not. If not, discuss ways they could be met outside the course.

3. Review the parking lot flipchart and address any outstanding issues.

B. Post-test and evaluation (50 minutes)

Materials:

- Blank flipchart paper and stand, markers
- Handouts:
  - — *Medical Abortion Pre/Post-test*
  - — *Medical Abortion Pre/Post-test Answer Key*
  - — *Final Evaluation Form*

1. Explain that participants will complete a post-test and final evaluation.
   - Distribute the post-tests and give participants approximately 30 minutes to complete the test.
   - After 30 minutes collect the tests.
   - Distribute the Final Evaluation Form and ask participants to complete it; during that time, grade the post-tests and record the scores.
   - Collect the final evaluations.
   - Return each participant's scored post-test along with an answer key.
   - Answer any outstanding questions from the post-test.

C. Closing circle (20 minutes)

1. Thank the group for their participation and contributions to the course. Acknowledge the experience and expertise in the group.

2. To formally close the workshop:
   - Have participants form a circle.
   - Ask participants to go around the circle and name one specific skill that the workshop helped them improve and one thing they will do differently as a result of the MA training.

D. Certificates (10 minutes)

Materials:

- Handout (depending on local regulations):

— *Certificates of Completion* or *Certificates of Competence*

1. Distribute the *Certificates of Completion* or *Certificates of Competence* (according to local practices and regulations).
   - Call one participant at a time.
   - Encourage applause for each person for their hard work and commitment to MA care.
   - Emphasize the investment made in each learner and the importance of them providing MA care to women when they return home.

(**Note**: *As an alternative, you can have participants say something they appreciated about and learned from another participant and then present their certificate to them).*

2. Tell participants how you can be reached for more information, support and follow-up as they implement MA services in their sites.

3. Wish participants a safe journey home.

Module 9: Materials

1. Final evaluation form *(for participants)*

2. Certificates of competency or completion (*on CD-ROM)*

For participants

Final evaluation form

Dates: _____ Location: _____

Trainers: _____

Goal

To develop health care workers' knowledge and skills to provide medical abortion to women who request and are eligible for this abortion method.

Learning objectives

By the end of this workshop, participants will be able to:

Module One

- Discuss key content from the *Medical Abortion Study Guide, Second Edition.*
- Explain the role of MA in comprehensive reproductive health services for women, including young women
- Discuss the current context of abortion services in their country, including the legal status of abortion care and barriers to access

Module Two

- Discuss eligibility, contraindications, precautions for use and special considerations for MA
- Describe the efficacy, mechanisms of action, regimens, routes and timing of the medications used for MA

Module Three

- Describe care that should be provided to a woman prior to the MA procedure
- Discuss strategies for dating pregnancy using last menstrual period (LMP) and bimanual exam
- List the signs and symptoms of ectopic pregnancy
- Assess clinical eligibility for MA
- Describe the MA process, including expected effects, possible side effects and strategies for managing them
- Describe strategies for prevention and management of pain associated with MA
- Recognize warning signs

Module Four

- Provide unbiased options counseling to women seeking MA services
- Discuss with women the benefits, risks and alternatives to abortion, the consequences of not receiving abortion care, and details of planned procedure, then obtain informed consent

- Articulate their own comfort levels discussing, advocating for and providing MA services, including for young women
- Discuss how their personal level of comfort providing MA services relates to societal norms about abortion and MA
- Offer emotional support and woman-centered counseling to women seeking MA services
- Provide postabortion contraceptive counseling
- Help women manage MA side effects, identify warning signs and know when to make a follow-up care plan

Module Five

- Describe the purpose and key components of follow-up care
- Discuss methods for determining if a woman is still pregnant after taking MA
- Describe management approaches for problematic bleeding
- Demonstrate skills in providing follow-up to women by telephone
- Explain ways in which outreach workers can provide support

Module Six

- Demonstrate an ability to identify and manage MA problems, complications and emergencies
- Describe elements of a good emergency response system

Module Seven

- Describe the factors that need to be in place at sites to ensure high-quality, woman-centered care
- Identify and prioritize key aspects of high-quality MA services in their own setting, including needed changes and how to accomplish them
- Describe the benefits and challenges of using MA at home (or in a safe space) and in clinic settings
- List several barriers to accessing MA care and ways to overcome those barriers

Module Eight

- Describe the characteristics of a functioning clinic providing MA services
- Describe competent clinical and counseling skills of practicing providers
- Demonstrate skills for providing high-quality MA services (as outlined in the *Medical Abortion Skills Checklists)*

Module Nine

- Summarize key points from the *Medical Abortion Study Guide, Second Edition* and workshop
- Determine whether their expectations and the workshop objectives were met
- Demonstrate knowledge level acquired through a post-test
- Give feedback about the MA workshop to the organizers

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.

5 = strongly agree 4 = agree 3 = neutral 2 = disagree 1 = strongly disagree

	Rating	Comment
1. The course fulfilled its goal and objectives (see above).		
2. The course was well organized.		
3. The trainers were responsive to participants' needs.		
4. The trainers used effective training methods.		
5. The training materials (handouts, slides, worksheets, tests, etc.) were effective.		
6. There were adequate opportunities for discussion		
7. The physical facilities were conducive to learning and sharing.		
8. The logistical arrangements were satisfactory.		
9. I have a better understanding of MA because of this workshop.		
10. I will provide high-quality, woman-centered MA services after this training, including to young women		

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

General comments and suggestions:

References

This manual provides the "how to train" guidance for the clinical content found in the Ipas Medical Abortion Study Guide, Second Edition. Clinical content in this Training Guide is only referenced if specifically mentioned in the Training Guide. Please refer to the Study Guide for all other clinical references.

Bernstein, P., & Kandinow, L. (2004). Use of misoprostol for labor induction in patients with asthma. Retrieved 20, March 2013, from http://www.medscape.com/viewarticle/491697

Cable, E. E., Pepe, J. A., Donohue, S. E., Lambrecht, R. W., & Bonkovsky, H. L. (1994). Effects of mifepristone (RU-486) on heme metabolism and cytochromes P-450 in cultured chick embryo liver cells, possible implications for acute porphyria. *European Journal of Biochemisty, 225*(2), 651-657.

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., Varela, L., Velazco, A., Tanda, R., & Sánchez, C. (1999). Vaginal misoprostol for abortion at 10-13 weeks' gestation. *The 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., et al. (2001). Misoprostol for abortion at 9-12 weeks' gestation in adolescents. *The European Journal of Contraception and Reproductive Health Care, 6*(1), 39-45.

Davey, A. (2006). Mifepristone and prostaglandin for termination of pregnancy: contraindications for use, reasons and rationale. *Contraception, 74*(1), 16-20.

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.

Herrick, J., Turner, K., McInerney, T., & Castleman, L. (2004). *Woman-centered postabortion care: Reference manual*. Chapel Hill, NC: Ipas.

Ipas. (2013). *Woman-centered postabortion care: Reference manual*, second edition. K.L. Turner & A. Huber (Eds.) Chapel Hill, NC: Ipas.

JHPIEGO. (2001). Planning for a training course: Selecting a clinical site for a clinical skills course. Baltimore, MD: JHPIEGO Trainer News.

Kobrynski, L. (2007). Anaphylaxis. *Clinical Pediatric Emergency Medicine, 8*(2), 110-116.

Kulier, R., Kapp, N., Gülmezoglu, A. M., Hofmeyr, G. J., Cheng, L., & Campana, A. (2011). Medical methods for first trimester abortion. *Cochrane Database Systematic Reviews*(11), CD002855.

Land, J. A., & Arends, J. W. (1992). Immunohistochemical analysis of estrogen and progesterone receptors in fallopian tubes during ectopic pregnancy. *Fertility Sterility, 58*(2), 335-337.

McInerney, T., Baird, T. L., Hyman, A. G., & Huber, A. B. (2001). *Guide to providing abortion care*. Chapel Hill, NC: Ipas.

McSmith, D., Borjessen, E., Villa, L., & Turner, K. L. (2011). *Abortion attitude transformation: Values clarification activities adapted for young women*. Chapel Hill, NC: Ipas.

Mittal, S., Agarwal, S., Kumar, S., & Batra, A. (2005). Comparison or oral versus vaginal misoprostol & continued use of misoprostol after mifepristone for early medical abortion. *Indian Journal Medical Research, 122*(2), 132-136.

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.

Plan International. (2007). *Because I am a girl: The state of the world's girls 2007*. London: Plan International

Sitruk-Ware, R. (2006). Mifepristone and misoprostol sequential regimen side effects, complications and safety. *Contraception, 74*(1), 48-55.

Sitruk-Ware, R., & Spitz, I. M. (2003). Pharmacological properties of mifepristone: toxicology and safety in animal and human studies. *Contraception, 68*(6), 409-420.

Spitz, I. M., & Bardin C. W. (1993). Mifepristone (RU 486)--a modulator of progestin and glucocorticoid action. *New England Journal of Medicine, 329*(6), 404-412.

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.

von Hertzen, H., Honkanen, H., Piaggio, G., Bartfai, G., Erdenetungalag, R., Gemzell-Danielsson, K., et al. (2003). WHO multinational study of three misoprostol regimens after mifepristone for early medical abortion. I: Efficacy. *BJOG, 110*(9), 808-818.

von Hertzen, H., Piaggio, G., Huong, N. T., Arustamyan, K., Cabezas, E., Gomez, M., et al. (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.

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 ed.). Geneva: World Health Organization (WHO).

World Health Organization., Ahman, E., Shah, I., & Butler, P. (2007). Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003 (pp. 43). Geneva: World Health Organization.

Appendices

A. Sample schedule and agenda

The modules included in this *Training Guide* were designed to allow trainers to tailor a workshop agenda to participants' needs. Below is a suggested three-day training schedule that includes a clinical practicum. The didactic part of this workshop could be completed in two days if no clinical practicum is completed at that time. Alternatively, the training may be delivered one module at a time over several weeks, or trainers may select from the modules they determine are most relevant to participants' needs. Lastly, trainers could combine online learning with Ipas University (*www.ipasu.org*) with a short face-to-face workshop and clinical practicum.

An agenda template is included on the CD-ROM to allow trainers to personalize a schedule. Suggested times are approximate and may change based on clinical regimens to be taught as well as any additional activities.

For more assistance with designing an MA workshop to meet your needs, please feel free to contact *training@ipas.org.*

DAY ONE

Module Title	*Time*
1. Overview of Medical Abortion	2 hours, 10 minutes
2. Medical Abortion Regimens	1 hours, 10 minutes
3. Clinical Care	3 hours

DAY TWO

Module Title	*Time*
4. Informed Consent, Information and Counseling	3 hours
5. Follow-up Care	1 hour, 30 minutes
6. Problems, Complications and Emergencies	1 hour, 15 minutes
7. Service Provision	1 hour, 30 minutes

DAY THREE

Module Title	*Time*
8. Clinical Practicum	5-6 hours
9. Final Assessment, Closing and Evaluation	1 hour, 30 minutes

B. Four corners activity

(**Note**: *This activity provides an excellent opportunity to recognize and respect various opinions and values. It is recommended that trainers with experience in leading values clarification activities facilitate it.*)

Time

45 minutes

Advance preparations

- Prepare four signs for Four Corners activity and post one sign in each corner of the room.
- Review and, if necessary, adapt the handout Four Corners Statements to make them more relevant to the participants or workshop content.

A version of this activity has been adapted to address issues specific to abortion care for young women. Please see "Additional Resources, Values Clarification" in the *Medical Abortion Study Guide,* Second Edition.

Instructions and materials

Materials:

- Pre-prepared signs:
  - — Strongly Agree
  - — Agree
  - — Disagree
  - — Strongly Disagree
- Handout: *Four Corners Statements*

1. Introduce the Four Corners activity.
   - Explain that the activity asks participants to think honestly about their beliefs about MA and to defend other people's views about MA.
   - Give each participant a Four Corners Statements handout.
   - Ask participants to complete the handout and turn the sheet over when they are done; instruct participants not to write their names on the handout.
   - When everyone is done, request that participants crumple their handout into a ball.
   - Ask participants to stand in a circle, throw their ball into the circle, pick up a different ball, and toss it to another participant.
   - *Instruct participants to represent the responses on the handout they picked up for the remainder of the activity, even if the responses conflict with their personal beliefs.* **(Note***: If participants get their own handout back, they should act as though someone else completed it.)*

- Point out the four signs placed around the room (*Strongly Agree, Agree, Disagree, Strongly Disagree*).
- Make sure that the groups understand the difference between "*agree*" and "*strongly agree*," and between "*disagree*" and "*strongly disagree*."

2. Begin the Four Corners discussion.
   - Tell participants they will discuss the statements one at a time.
   - Read the first statement aloud and ask participants to move to the sign that matches the response circled on their handout.
   - Invite participants to look around the room and notice the range of opinions held. There may be different-sized groups in each corner, or one or more unoccupied corners. *(***Note***: If there are corners with no one in them or just one person, one of the trainers can join or represent that corner.)*
   - Give the groups two minutes to discuss (within their group) the strongest reasons why people might hold that opinion. Ask each group to appoint a spokesperson.
   - After two minutes, ask the spokesperson from each group to convincingly represent the belief (for example, "I strongly agree with this statement because…"). Tell them to act as if they were an actor, even if they disagree with how the statement was marked, and to always represent the viewpoint with respect because it was someone's opinion.
   - Start with "*Strongly Agree*" and proceed, in order, to "*Strongly Disagree*."
   - Read the next statement and continue with the activity until you have discussed several statements. *(***Note***: It is not necessary to discuss <u>all</u> the statements – which may be too time-consuming – just discuss the ones most relevant to the participants' circumstances.)*

3. Ask participants to return to their seats and reflect on the activity and the specific statements made. Key questions include:
   - *What was it like to represent beliefs about MA that were different from your own?*
   - *What was it like to hear your beliefs represented by others?*
   - *How might a provider's beliefs influence their provision of MA services?*

4. Lead a discussion about the types and origins of abortion method biases and how they affect the care and treatment women receive. Key issues to discuss include:
   - **Who controls the abortion procedure – women or providers?**

MA can help some women feel more in charge of their bodies and retain more control over the abortion experience. However, some providers, may feel uncomfortable about giving up the control they have when they perform a vacuum aspiration procedure on a woman, particularly with younger women. They may not see women as being capable of managing an abortion without their intervention. Other providers may feel more comfortable with women controlling the experience because of their own discomfort initiating the abortion process. These providers may feel that when women take the pills themselves they are not the ones initiating/causing the abortion. Other providers may just trust women to maintain control of the abortion process.

- **How do perceptions of MA as more natural, simulating a miscarriage, less like a human**

intervention influence behaviors towards women seeking abortion? This can be influenced by women and providers' discomfort with induced abortion.

- **How do biases of abortion procedures influence the counseling process and informed consent?** If counselors prefer one method over the other, they may not help a woman decide what is best for her based on her individual needs.

5. Conclude the activity by summarizing the key points and encouraging participants to consider these issues further throughout the workshop and clinical practicum.

Handout: Four Corners Statements*

Instructions: *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 paper. Turn the paper over when you are done.*

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

1. Medical abortion (MA) is preferable to vacuum aspiration (VA) because women are able to have more control over the abortion experience.	SA	A	AD	SD
2. MA is better than VA because it is more like a natural process.	SA	A	AD	SD
3. MA is less acceptable than VA because of the longer bleeding time with MA.	SA	A	AD	SD
4. MA gives women too much burden for managing the expelled pregnancy.	SA	A	AD	SD
5. Providers should always assess whether the MA worked because women cannot determine this themselves.	SA	A	AD	SD
6. Adolescents are good candidates for MA and should have the same right to information and care as older women do.	SA	A	AD	SD
7. MA should be made easily available to women even if a few women end up using improper dosages.	SA	A	AD	SD
8. A woman who took MA pills but has an ongoing pregnancy should be able to continue the pregnancy if she chooses to.	SA	A	AD	SD
9. The misoprostol-only protocol for first-trimester MA should be used where mifepristone isn't available, even though the failure rate is higher.	SA	A	AD	SD
10. Community health workers should be allowed to provide MA if they are properly trained.	SA	A	AD	SD

** Adapted from: Turner, Katherine L. and Kimberly Chapman Page. (2008). Abortion attitude transformation: A values clarification toolkit for global audiences. Chapel Hill, NC, Ipas.*

C. Guidance for choosing a practicum site

Excerpted from: *Wegs, Christina, Katherine Turner and Betsy Randall-David. (2003). Effective training in reproductive health: Course design and delivery. Reference Manual. Chapel Hill, NC: Ipas.*

Selecting a clinical training site: Special considerations

Is there an adequate caseload?

Determine the caseload available at the site for the clinical procedure being taught. There should be sufficient clients to provide all participants with adequate opportunities to practice what they have learned. If no single site has adequate clients to accommodate all the participants, an alternative must be provided in the training plan. Learners may need to return to the site at another time, or trainers may need to divide participants into smaller groups that can go to other sites. A clinical trainer skilled in the clinical procedure being taught must be present at each clinical site every time a clinic practice session takes place.

Will a clinical training hinder the provision of services at the site?

Learners should be able to take part in clinical training without sacrificing the quality of services at the training site. Trainers and participants should not interfere with client flow and provider service provision. The training plan should accommodate this aspect of clinical learning at the site.

Are all essential supplies and equipment available at the site?

A clinical site must have enough supplies readily available to allow the clinical training to take place while continuing to provide regular services to clients. Trainers may need to provide part or all of the supplies needed for the clinical training. The trainer should determine the need for supplemental supplies in advance so that supplies can be procured prior to the training.

Is the site already providing appropriate services?

Clinical staff at the site should model correct service provision to participants and assist them as they practice.

Is the site similar to those in which the participants work?

If the clinical training site is similar to participants' work places, learners are able to practice applying new skills using the resources that they will have in their real work environments, increasing the chances they will be able to put their new skills into practice in their own work sites.

(McInerney et al. 2001; JHPIEGO, 2001)