Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration

Facilitator's Guide

Refresher Training Module for Health Care Providers Implementing the MISP

Inter-agency Working Group on Reproductive Health in Crises Training Partnership

Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration: A Refresher Course for Health Care Providers

This training guide is published by the Inter-agency Working Group (IAWG) on Reproductive Health in Crisis in partnership with Ipas. The content has been adapted from *Ipas's Woman-Centered, Comprehensive Abortion Care* manuals. It is intended to be used by clinical trainers leading a refresher course for clinicians already familiar with intrauterine procedures, including manual vacuum aspiration.

Disclaimer: *Clinical Updates in Reproductive Health* provides Ipas's most up-to-date clinical guidance. Recommendations in *Clinical Updates in Reproductive Health* supersede any clinical guidance in Ipas curricula that differs from the guidance provided in this publication. The guide is available on the Ipas website, www.ipas.org

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ISBN: 1-933095-89-X
CAT: MVACRT-E16

Suggested citation: Ipas. *Uterine evacuation in crisis settings using manual vacuum aspiration: A refresher course for health care providers. Chapel Hill, NC: Ipas.*

Acknowledgements

Ipas is grateful to the IAWG for its collaboration on this refresher course.

The authors especially acknowledge Bill Powell for his clinical expertise and for overseeing the development of this publication.

In addition, the authors would like to thank the following people for their contributions:

Talemoh Dah, Nigeria
Jeannine Herrick, USA
Jill Moffett, USA
Diane Morof, USA
Monica Oguttu, Kenya
Jennifer Kiefer Soliman, USA

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Training Guide Overview

Introduction

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. The MISP has five objectives[1]:

1. Ensure the health sector/cluster identifies an organization and a SRH coordinator to lead and coordinate the implementation of the MISP.
2. Prevent and manage the consequences of sexual violence.
3. Reduce HIV transmission.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Plan for comprehensive SRH services, integrated into primary health care as the situation permits.

Neglecting the MISP in humanitarian settings has serious consequences: preventable maternal and newborn deaths; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV.

Nurses, midwives, and doctors working in emergencies provide the clinical services needed to achieve objectives 2, 3, and 4 of the MISP. These services include the clinical management of survivors of sexual violence and basic emergency obstetric care, while ensuring effective infection control practices at all times in all clinical settings.

The IAWG has designed a series of short clinical outreach refresher trainings in order to reinforce the previously acquired knowledge and skills of health care staff tasked with providing these priority services. This *Uterine Evacuation in Crisis Settings* module is one of the refresher training modules.

Description

The *Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration, Facilitator's Guide* is intended to be used by clinical trainers leading a refresher course for clinicians already familiar with intrauterine procedures, including manual vacuum aspiration (MVA). This refresher course is intended for in-person workshops in crisis settings with limited resources. Course components include discussions and activities that promote the sustainability of onsite MVA services. The course also provides ways to address ongoing training needs in crisis settings that have high staff turnover. Simulated practice with pelvic models is built into the course but it does not include a clinical practicum.

Purpose

This training includes PowerPoint slides and activities designed to help health care workers refresh the knowledge and practical skills they need to provide first trimester uterine evacuation using Ipas MVA Plus® and EasyGrip Cannulae®.

Please note that this course focuses on the MVA procedure, rather than comprehensive abortion or postabortion care. It also does not cover use of medications for uterine evacuation. For broader training materials on comprehensive abortion and postabortion care, refer to the Ipas *Woman-Centered, Comprehensive Abortion Care Trainer's Manual (2nd ed.)* and other Ipas curriculae, available at www.ipas.org.

[1] The MISP will be revised in 2017. Please be aware that this content is subject to modification

Intended Participants

This training program is designed for health care workers, including midwives, nurses and other mid-level providers, general practice physicians, and obstetricians/gynecologists who will provide first trimester uterine evacuation in crisis settings and have previous experience with MVA and other intrauterine procedures. The program provides the basic information necessary for provision of care and includes resources for further study.

Participant Prerequisites

At minimum, participants should:

- Demonstrate knowledge of the female reproductive system;
- Know how to take a medical history and conduct a physical exam;
- Accurately assess the gestational age of an early pregnancy using a bimanual exam;
- Recognize and manage or refer women for treatment of complications due to incomplete abortion;
- Recognize symptoms of ectopic pregnancy; and
- Have previous exposure to uterine evacuation with MVA.

Organization of the Facilitator's Guide

This guide is divided into eight units:

- One introduction/assessment unit
- Six workshop units
- One course evaluation/closing unit

Each unit focuses on one component of MVA service delivery, and includes five elements:

1. **Time:** An estimate of how long it should take to complete the unit;
2. **Objectives:** Specific objectives to be met by the end of each unit;
3. **Preparation:** Instructions regarding information or materials to be prepared ahead of time;
4. **Materials:** Copies of all learner materials for distribution and answer keys for trainers; and
5. **Instructions:** 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.

Trainers are encouraged to adapt the units to fit local training needs and objectives.

Note to Trainer: If PowerPoint presentations are not possible, trainers can copy the slides onto transparencies or use photocopies as handouts.

Accompanying Flash Drive

The accompanying Flash Drive includes several resources to be used in the workshop activities, including all handouts and PowerPoint slide presentations. The Flash Drive also includes text and picture-based pocket cards to help women recognize normal side effects and complications, and sample certificates of completion which can be personalized by trainers in Microsoft Word®.

The training materials will also be available on the IAWG website: www.iawg.net

Documentation and Certification

Trainers should document attendance as well as pre- and post-test results, and present certificates of completion as appropriate.

Competency Assessment/Participant Evaluation

Trainers should assess each participant's knowledge and skills to determine competency. The pre- and post-tests serve as knowledge assessments. The *Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist* (available on the IAWG website and Flash Drive) can be used to assess skills during simulated practice.

Ipas recommends that an informal process evaluation be conducted at the end of each workshop day to assess participant satisfaction with the topics and activities. At the end of the course, participants should complete the final evaluation to provide feedback for future trainings.

Trainer Considerations and Advance Preparation

Requirements

All trainers should meet the following criteria:

- Be a clinician skilled in uterine evacuation with MVA, capable of training on all elements of the course;
- Ideally, be a member of the Ipas Global Trainers Network (follow current clinical guidelines, use Ipas clinical training curricula, employ effective teaching methodologies based on adult learning principles, and serve as an effective presenter and facilitator); and
- Have facilitated numerous trainings on uterine evacuation and postabortion care (PAC) using MVA.

Recommended Preparation

Before teaching the course, trainers are advised to:

- Review the *Ipas Effective Training in Reproductive Health & Course Design and Delivery Reference Manual*;
- Review the *Ipas Uterine Evacuation with Manual Vacuum Aspiration (MVA): A Training Manual for Conducting Short Courses*;
- Review the *Ipas Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training* (available on the Flash Drive); and
- Review *Ipas Abortion Attitude Transformation: Introduction to Abortion Values Clarification and Attitude Transformation*.

These and other publications can be downloaded at **www.ipas.org/Publications/Index.aspx** or by contacting training@ipas.org.

Characteristics of an Effective Training

The following characteristics are necessary for a training course to be effective.

- Clearly communicate the purpose of the training to both trainers and learners.
- State exactly what learners are expected to do at the end of the course.
- Use training methods that build on participant's existing skills and experience, enabling them to meet the objectives.
- Present new knowledge and skills in a relevant context.
- Actively engage learners in the process.
- Use an effective mix of training methods to meet the needs of different learning styles.
- Offer learners the opportunity to practice applying new knowledge and skills.
- Provide learners with constructive feedback on their performance.
- Allow enough time for learners to meet the objectives of the training.
- Offer trainers and learners the opportunity to evaluate the course, measuring the extent to which trainers and learners met the training objectives, and accept feedback from learners to make improvements to the course.

From: *Ipas, Women-Centered Prostabortion Care: Reference Manual, Second Edition. Chapel Hill. 2013.*

Site Assessment

If possible, trainers should visit the site before the course. During the site visit, trainers should assess the following:

- Staffing protocols – including mentoring relationships and clinical supervision, turnover rate, and available training resources;
- Availability of a projector and electricity for a laptop;
- Current and expected future caseload for MVA services;
- Type of facility, level of training, and experience of staff in providing MVA services;
- Availability of MVA kits and how instruments are processed and stored;
- Which staff offer uterine evacuation and related services such as patient assessment, counseling, family planning, and reproductive health linkages;
- Whether instrument processing supplies from the site can be used at the training;
- Whether supplies – including pelvic models – should stay at the site after the training for additional clinical simulation practice (if yes, then budget to accommodate this); and
- How quality of patient care is monitored and which (if any) data systems are in place.

Collaborate with site leaders to establish the following work plans for use during the training:

- A work plan to monitor the quality of care for uterine evacuation using MVA and postabortion contraceptive services; and
- A work plan to integrate MVA services in the crisis setting, ensure sustainability (supply/resupply), and support ongoing training, mentoring, and facilitated supervision, if necessary.

Trainers should also collaborate with site leaders to establish supply/resupply of MVA instruments and related supplies. Visit www.mvacalculator.org for information on planning and calculating instrument supply.

Participant Assessment

It is important to assess the experience of participants prior to finalizing the training. Only providers who have already been trained in uterine evacuation using MVA are eligible for the rapid refresher course.

If you find that there is a need for a basic MVA training for clinicians with no experience:

- Budget for an extended training;
- Create a pre-training prior to the refresher course; and
- Provide opportunities for facilitated supervision using MVA.

Alert: Important recommendations for before and after the training

This module is designed to be a 2 or 3-day clinical refresher training for already trained health care service providers in humanitarian contexts. The IAWG-TPI conducted research about the barriers and facilitators to its implementation during the pilot phase, and have the following recommendations **for trainers and program managers**:

- Before the training:
  - Limit the selection of participants to those who meet the specified prerequisite qualifications in this facilitator's guide.
  - Assess qualified participants' learning needs to prepare for how best to address knowledge gaps. To do so, use the pre-test included in the *Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration* module or interview participants.

- Based on identified trainees' needs, provide additional training resources to expand the training as needed.
- Ensure that participants become certified in the MISP Distance Learning Module (available at http://iawg.net/minimum-initial-service-package/) prior to the training, if possible.

- After the training:
  - Discuss and possibly organize a log book and calendar of opportunities for trainees to practice their skills at their institution.
  - Regularly schedule ongoing supportive supervision for providers as soon as the security situation allows.

For more information, please see the following guidance note: *Sexual and Reproductive Health Clinical Outreach Refresher Trainings (S-CORTs): Operational considerations and programmatic guidance for SRH trainers, program managers, and coordinators.*

Sensitivity and Flexibility in a Crisis Setting

Sensitivity and flexibility are crucial in a crisis setting. When planning this training, keep the following things in mind:

- Minimize the time providers spend away from their duty stations.
- Be sensitive to the long hours and double shifts health care providers may be working.
- Remember that some participants may have long travel times.
- Be prepared for participants who have a mix of abilities and experience – some may be very new to the current setting.
- Attendees will most likely be a range of health care providers, including nurses, midwives, doctors, and clinical officers.
- Be sensitive to the emotional needs of health care providers/participants in a crisis setting.
- Some providers may be experienced using MVA for uterine evacuation but inexperienced doing so in a crisis setting.

Training Supplies for Demonstration and Clinical Simulation

When conducting clinical simulation, make sure to have the following supplies:

- Pelvic model(s)
- Ipas MVA Plus® instruments
- Ipas EasyGrip® cannulae
- Specula in various sizes
- Dilators
- Tenaculae
- Sponge holding forceps
- Gloves
- Syringes and needles
- Samples of contraceptive methods

Note to Trainer: In crisis settings, refresher courses typically take place on site. Be sure to bring all supplies to the training, including paper certificates, copies of handouts, and additional resources in paper format. Bring paper copies of slides and flip chart paper as a backup.

Abortion Law in the Region

Because regional abortion laws vary, it is important to know the legal and policy climate in the specific region where you are working.

- Prepare some PowerPoint slides, a flip chart, or a handout that explains the current laws and policies that can affect providing abortion care.
- Facilitate a short discussion and have participants think through various scenarios.
- Advocate for participants to provide abortion services to the fullest extent of the law.
- Review the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010 Revision for Field Review* (pp 147, 153-4).

Adapt Training for PAC

Women in crisis settings may also require postabortion care (PAC). To adapt this training for PAC:

- Avoid the use of the terms abortion and elective abortion. Instead, use the terms uterine evacuation, treatment of incomplete abortion, and postabortion care.
- Remember that PAC encompasses treatment for both spontaneous abortion (miscarriage) and complications from induced abortion (which could be elective by a medical professional, self-induced, or forced). Encourage participants to use very sensitive language and gentle clinical care.
- Women seeking PAC may have related clinical complications such as excessive bleeding, infection, or cervical or uterine perforation. Encourage participants to be very sensitive to a woman's situation, since in addition to her need for treatment for incomplete abortion, she may be feeling pain, discomfort, and fear.

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

Training Objectives:

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

1) Articulate their own comfort levels discussing, advocating for, and providing uterine evacuation services.
2) Explain what the current abortion law is in their setting and how it relates to which services are provided.
3) Explain why uterine evacuation with MVA is an essential part of reproductive health services in crisis settings.
4) Describe the various uterine evacuation options and explain why MVA is especially critical in crisis settings.
5) Describe the safety, efficacy, and possible complications of MVA.
6) Explain how medical abortion and misoprostol for incomplete abortion may be useful options for some women in crisis settings with MVA backup.
7) Provide procedure options counseling for women seeking uterine evacuation.
8) Obtain informed consent prior to uterine evacuation.
9) Describe the features of the Ipas MVA Plus instrument and Ipas EasyGrip cannulae.
10) Process Ipas MVA instruments in accordance with local regulations and with locally availably products/systems.
11) Create a pain management plan with the woman that is sensitive to her situation.
12) Describe the steps of providing uterine evacuation with Ipas MVA Plus.
13) Resolve common technical problems.
14) Identify how to recognize signs and symptoms of complications and provide basic medical management.
15) Be able to simulate a uterine evacuation procedure using Ipas MVA Plus on a pelvic model.
16) Discuss medical eligibility for select methods of postabortion contraception, including emergency contraception (EC).
17) Provide referrals to other reproductive health services.
18) Have an established plan to monitor the quality of on-site uterine evacuation services.
19) Have an established plan to ensure sustainability of uterine evacuation and postabortion contraception services on site.
20) Understand and contribute to a work plan to ensure the supply and resupply of instruments and related supplies, assure the sustainability of MVA services, and provide for ongoing training/mentoring needs.

Sample Refresher Course Agenda

Note to Trainer: This is only an example of a rapid refresher course on using MVA for uterine evacuation. You may need to adjust the order of some content and the time allowed based on your setting and the experience level of the participants.

UNIT	OBJECTIVE	TIME	CONTENT	TRAINING METHOD
	Day 1 total: 8 hours			
1		15 min	Welcome Trainer introduction(s) Ice breaker	Paired interview
1		15 min	Course agenda Participant expectations Course objectives (optional) Housekeeping/parking lot	Brainstorm
1		15 min	Knowledge pre-test	
2	3	15 min	Uterine evacuation is an important element of reproductive health (RH) in crisis settings because: • maternal mortality is linked to unsafe abortion; • of a lack of security; • of a high risk of sexual violence; • of disruption in contraceptive and other health services; and • women may want to delay childbearing during a crisis	Interactive presentation and group discussion (Why might a woman need uterine evacuation in a crisis setting?)
2	1	30 min	Values clarification	Group activity (Comfort Continuum)
2	2	15 min	Review abortion law	Read case studies aloud, large (or small) group process
3	4, 5	15 min	Uterine evacuation methods and why manual vacuum aspiration (MVA) is necessary in crisis settings Safety and efficacy of MVA Possible complications of MVA	Presentation Handout: *Uterine Evacuation Treatment Options Chart*
	Break 15 min			
3	6	15 min	Using misoprostol to treat incomplete abortion in crisis settings Using medical abortion for first trimester uterine evacuation	Facilitated discussion Colored paper activity
3	7, 8	30 min	Uterine evacuation method options counseling Informed consent	Presentation Case studies

UNIT	OBJECTIVE	TIME	CONTENT	TRAINING METHOD
4	9	30 min	Instrument facts and features	
	Lunch 1 hour			
4	10	45 min	Processing Ipas MVA Plus and Ipas EasyGrip Cannualae	Presentation Instrument processing video
4	12	1 hour	Uterine evacuation with the Ipas MVA Plus Review MVA steps	Procedure video
4	15	1 hour	Demonstration Simulated practice	Pelvic models
	Break 15 min			
4	13	15 min	Technical problems during MVA	Demonstration/ "What if" activity
		15 min	Summarize and close for Day 1	Daily process evaluation
	Day 2 : 4 hours			
		30 min	Welcome participants back Overview of Day 2 Respond to any questions from Day 1 Re-energize Review MVA steps	
5	11	15 min	Pain management plan	Case studies
5	15	1 hour	Simulated practice with pelvic models	
6		15 min	Post-procedure care and follow-up care	
	Break 15 min			
6	16	45 min	Postabortion contraceptive counseling and services	Positive/negative trainer demonstration
6	14	1 hour	Management of complications	
6	17	15 min	Linkages to family planning, reproductive health, sexually transmitted infections, and more	
	Lunch 1 hour			
7	18, 19	30 min	Using a monitoring plan to ensure quality of care and to sustain MVA and postabortion contraceptive services	Worksheet activity
7	20	15 min	Review a work plan to integrate MVA into crisis setting immediately: • Supply/resupply of MVA instrument	

UNIT	OBJECTIVE	TIME	CONTENT	TRAINING METHOD
			and related supplies • Create systems of sustainability • Create mentor relationships and facilitated supervision if necessary	
8		30 min	Closing activities	Review course objectives Review participant expectations Summary points Daily process evaluation Course evaluation
8		15 min	Knowledge post-test	
8		15 min	Certificate of completion	

Introduction

Unit 1: Course Overview

Time
45 minutes

Objectives
By the end of this unit, participants should be able to:
- Be familiar with one another, the course overview, and the course objectives.

Advance Preparation
- Bring copies of the *Knowledge pre-test.*
- Prepare flip chart paper with the *Course Agenda* and schedule, and blank flip chart paper.
- Prepare a *Course Agenda* handout with detailed information of the eight units, subtopics and schedule.
- Prepare pairs of matching cards for the icebreaker activity.
- Prepare flip chart with a list of icebreaker questions.

Materials
- Copies of the *knowledge pre-test,* one per participant
- Bell
- Copies of the *Course Agenda,* one for each participant
- Flip chart paper
- Matching cards

Instructions
1) Welcome
Greet participants warmly.
Welcome them to the refresher course for providing uterine evacuation for women in crisis settings using manual vacuum aspiration (MVA). This is a refresher course for health care providers who are already familiar with MVA.

2) Trainer(s) introduction
Introduce yourself and give a brief summary of your qualifications. Mention that you are passionate about providing women with high quality clinical care for uterine evacuation and that you are enthusiastic about working with the group. Thank participants for attending the course despite hectic schedules, exhaustion, and difficult circumstances.

3) Icebreaker
Pass out a random card to each participant. Make sure there are an even number of participants – the trainer can take a card if necessary. The cards can be matching words, photos, pictures, or symbols. Ask participants to walk around the room and find their match. Once they find their partner, ask them to spend two minutes interviewing each other (no notes!). Once the two minutes have ended, ring a bell and ask them to switch. After two more minutes, ask participants to introduce their partner to the whole group in 30 seconds or less.

Prepare and post a flip chart paper with these (or your own) questions:
- What is your name and where are you from?
- Who misses you at home?

- Have you worked in a crisis setting before and where?
- What is a comfort from home that you miss?
- Have you treated women in the past who could have benefited from a woman-centered approach to MVA?
- What is the greatest gift you have ever received?

Note to Trainer: To get a better idea of learners' professions, post signs such as "Doctor," "Nurse," "Midwife," and "Clinical Officer" around the room. Ask participants to stand under the one that best describes them.

4) Participant expectations

- Ask participants what they hope to learn in the course and write down their expectations on the flip chart.
- Review the expectations and identify those likely to be met.
- Point out any expectations that may be beyond the scope of the course.
- Keep the list to review with participants at the end of the course and ensure that realistic expectations were met.

5) Course agenda

- Post the prepared flip chart titled "Course Agenda"on the wall and review the schedule. Refer to the agenda throughout the course to stay on topic and on time.
- **Distribute the handout:** *Course Agenda* (available on the IAWG website and Flash Drive).
- Refer back to the participant expectations posted on the wall and circle what will be covered in this course and indicate what may have to be addressed separately.

6) Course objectives

- **Show and discuss slide:** *Course objectives*

Note to Trainer: This is optional, since the objectives for each unit will be reviewed at the start of each unit. Other options include passing out a handout with the objectives listed (available on the Flash Drive and IAWG website), or having participants take turns reading the objectives out loud.

7) Housekeeping/Parking lot/Ground rules

Tell participants where the restrooms are and encourage them to leave the training room quietly, if needed. Mention that there will be morning and afternoon breaks with a lunch in between.

- Post a blank flip chart sheet and draw a car at the top. Explain that during the course, any questions that can't be addressed at that time will be put in the "parking lot."
- Throughout the course the trainer will refer back to these questions and address them when they are most relevant.

Post a flipchart entitled "Ground Rules":

- Explain that ground rules 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 ground rules. Write their suggestions on the flip chart.
- Possible ground rules may include participating, listening respectfully, speaking one at a time, turning off cell phones and pagers, and maintaining confidentiality.

8) Knowledge pre-test

- **Distribute the handout:** *Knowledge pre-test* (available on the IAWG website and Flash Drive) and tell participants they have about 15 minutes to complete it. Ask them to write their names at the top and collect all tests at the end of the allotted time.

Workshop Units

Unit 2: Uterine Evacuation in Crisis Settings

Time
1 hour

Objectives
By the end of this unit, participants should be able to:
- Explain why uterine evacuation with MVA is an essential part of reproductive health services in crisis settings.
- Articulate their own comfort levels discussing, advocating for, and providing uterine evacuation services.
- Explain what the current abortion law is in their setting and how it relates to which services are provided and how.

Advance Preparation
- Research current abortion laws and policies in your setting and prepare a 15-minute presentation on the topic.
- Put the current written law on a PowerPoint slide, write it on a flip chart sheet, or prepare a handout.
- Read through the following sections from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010 revision:
  - Section 3.1 Needs Assessment (p 147)
  - Section 4 Human Rights & Legal Issues (p 153)
  - Section 4.1 Challenges and Opportunities (p 154)
- Note anything applicable to your training setting and share with participants.
- Make large signs titled: "Not at all," "A little," and "A lot."Post them in different places in the room.

Materials
- Flip chart
- Handout: *Abortion Law Handout*, one per participant
- Trainer handout: *Comfort Continuum Statements*

Instructions
1) Uterine evacuation is an important element of reproductive health in crisis settings

On a blank sheet of flip chart paper write the following numbers:

5

22,000,000

1

13%

99%

42,000,000

Ask:

How many pregnancies across the world end in abortion (induced, spontaneous, safe, unsafe, etc.)?

- Circle 42,000,000 on the flip chart. The World Health Organization (WHO) estimates that 42 million pregnancies end annually in abortion.

How many worldwide abortions are performed each year that are considered unsafe?

- Circle 22,000,000 on the flip chart. Worldwide, there are an estimated 22 million unsafe abortions performed every year. Emphasize that in our current year, about half of all abortions in the world are still being performed by people who lack the necessary skills and/or are in an environment lacking minimum medical standards for the procedure.

Draw a circle. What percent of maternal deaths are caused by unsafe abortion?

- Circle 13 percent. Draw (but don't fill in) 13 percent in the circle on the flip chart. Globally, unsafe abortion accounts for 13 percent of maternal deaths.

Look at that 13 percent in the pie chart. What percentage within that 13 percent do you think takes place in the developing world?

- Fill in the triangle of 13 percent, leaving just one tiny sliver unfilled. Draw an arrow from the 13 percent out of the circle and write: 99 percent in the developing world.

Do you know a woman who could have been part of that 99 percent?

- **Show and discuss slide:** *Making pregnancy safer*
  - Provision or referral for safe abortion services.
  - Timely and appropriate management of unsafe and spontaneous abortion for all women.

Explain:

Making pregnancy safer includes the provision of, or referral for, safe abortion services to the full extent allowed by the law. It also includes timely and appropriate management of unsafe and spontaneous abortion for all women.

Ask:

Why might women and girls in crisis settings be at an increased risk of unintended pregnancy and unsafe abortion? Write responses on the flip chart. Ensure that they include:

- Women may have lost their contraceptive method during displacement.
- Families may want to delay childbearing until their security and livelihoods are assured, and do not have access to contraceptives due to the disruption in health services.
- The risk of sexual violence is often increased in conflict and natural disaster settings.

Explain:

In 2003, the WHO issued technical guidance to strengthen the capacity of health systems to provide safe abortion care and postabortion care (PAC), and that this guidance was updated and reissued in 2012. **On the flip chart sheet write:** "PAC" and the number five ("5"). Ask participants to raise their hand if they are familiar with the term. Ask a volunteer to provide an explanation.

PAC is a global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. Ask participants if they know what the number five (5) indicates. Tell them PAC has five elements.

- **Show and discuss slides:** *Elements of PAC*
  1. **Treatment** of incomplete and unsafe abortion and complications that are potentially life-threatening.
  2. **Counseling** to identify and respond to women's emotional needs, physical health needs, and other concerns.

3. **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or practice birth spacing.
4. **Reproductive and other health services**, preferably provided on-site or via referrals to other accessible facilities in providers' networks.
5. **Community and service provider partnerships** for the prevention of unwanted pregnancies and unsafe abortion, mobilization of resources to help women receive appropriate and timely care for complications from abortion, and assurance that health services reflect and meet community expectations and need.[2]

Explain and ask:
Ask participants if they are familiar with the term CAC. Ask a volunteer to provide an explanation. Circle the number one (1) on the flip chart sheet. Explain that CAC stands for comprehensive abortion care. It includes all the elements of PAC with one important addition: safe induced abortion for all legal indications.

On a new sheet of flip chart paper, write the number one (1). Now write 22,000,000. Tell participants that adding this one element to reproductive health services would improve the health and possibly save the lives of 22 million women each year. Now, write:

PAC + CAC = ↓ maternal death.

Together, PAC and CAC contribute to reductions in maternal mortality.

2) Values clarification

Introduce the Comfort Continuum Activity. A trainer handout for the activity is available on the IAWG website and Flash Drive. Explain that this activity asks participants to reflect on their level of comfort discussing, explaining options, and providing uterine evacuation.

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

Using the trainer handout, read the statements aloud one at a time. Ask participants to physically move to the point along the continuum that best represents their feelings. Encourage participants to be honest and to resist being influenced by where others are standing.

Note to Trainer: You do not have to read all the statements, just choose those that are most relevant.

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

[2] Adapted from the Postabortion Care Consortium Community Task Force. Essential Elements of Postabortion Care: An Expanded and Updated Model, *PAC in Action #2 Special Supplement* (September 2002)
Additional Resource: Corbett, M., Turner, K. Essential Elements of Postabortion Care: Origins, Evolution and Future Directions. *International Family Planning Perspectives*, 29(3), (2003). 106-111.

As you facilitate a brief discussion about the different responses and comfort levels in the room, refer to the reasons given for choosing a certain place on the continuum. 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 for providing uterine evacuation services?
- Did you feel differently about providing uterine evacuation for incomplete abortion or spontaneous abortion (miscarriage) vs. induced abortion? How did other people feel about this?
- Would your response about providing contraceptives have been different for married women? Why or why not?
- What observations do you have about the group's overall level of comfort with providing uterine evacuation services to the fullest extent of the law? Focus on the group as a whole, not individuals' responses.

Emphasize the impact providers' attitudes have on their provision of services and women's experience and satisfaction with those services.[3]

3) Review of abortion law

Present the current law on abortion for the crisis setting where you are working.

> **Note to Trainer:** If you prepared a handout or a short PowerPoint Presentation about the law, present it here.

Read the following three scenarios aloud and facilitate a discussion about how each woman can be treated within the fullest extent of the law. If time allows, divide participants into small groups to discuss. Appoint someone in each group to report key points back to the larger group, then facilitate a large group discussion. Recommendations and strategies will vary based on each setting.

Be sure to address situations where safe abortion may be legal, but there are additional requirements regarding consent, counseling, and the period of time when it is permissible. Carefully go over any requirements. Feel free to create scenarios that best address the legal complexities and/or represent the physical, social, and emotional challenges of your specific setting.

Scenario 1: A 16-year-old girl comes to the clinic, she is ten weeks from her last menstrual period (LMP), which is confirmed with bimanual exam. She is crying and is clearly distraught. She is alone and does not want her family – who is living in cramped quarters at the crisis setting – to find out that she is pregnant. They have been living in this settlement for over six months. She claims that she was forced into sex on her way to the bathroom about three months ago, that her periods have stopped, and that she has been throwing up a lot. She fears that she will be beaten if the pregnancy is discovered.

Scenario 2: A 25-year-old woman comes to the clinic pleading for her uterus to be emptied. It has been nine weeks since her LMP, confirmed by bimanual exam. She has her four malnourished children with her. Her husband has been taken by enemy forces and has been missing for over a month. She has no means to support her children. She claims that if the clinic can't help her she will have to do it herself, as she knows she

[3] Activity adapted from: Chapman, Kimberly and Katherine Turner. *Abortion attitude transformation: A values clarification toolkit for global audiences.* Chapel Hill, NC: Ipas. 2008.

can't support another child and fears she won't survive childbirth in these conditions (her last birth was very difficult with complications). She is the only person on whom her children can depend.

Scenario 3: A 28-year-old humanitarian worker presents with an eight-week pregnancy, confirmed by bimanual exam. She is very quiet, tense, and sad. She says that the pregnancy is the result of a casual relationship and is unintended. She wants to stay at the settlement for another year and work to improve conditions. She has no intentions of becoming a mother under the circumstances.

- **Show and discuss slide:** *Clinical applications for MVA*
  1. Treatment of incomplete or missed abortion
  2. Endometrial biopsy
  3. First trimester abortion (menstrual regulation)

Explain:
In every country in the world there are at least two clinical applications for MVA: treatment of incomplete or missed abortion (miscarriage) and endometrial biopsy.

- **Show and discuss slide:** *Abortion is legally permitted*

Explain:
In most countries, abortion is legally permitted to save the woman's life, preserve her health, and/or for other indications. Most women live in countries where induced abortion is permitted, with or without restrictions.[4]

- **Show slide:** *Grounds on which abortion is permitted - percentage of countries (n=195)*

Explain:
According to a 2007 study of abortion policies in 195 countries, conducted by the United Nations Development Program (UNDP):

- 97 percent permit abortion to save the woman's life;
- 67 percent permit abortion to preserve physical health and 64 percent permit it to preserve mental health;
- 48 percent permit safe abortion for rape or incest;
- 45 percent for fetal impairment;
- 34 percent for economic or social reasons; and
- 28 percent upon request.

[4] Source: CRLP 2007. Ipas Uterine Evacuation with Manual Vacuum Aspiration (MVA): A Training Manual for Conducting Short Courses (p 3).

Unit 3: Uterine Evacuation Methods

Time
1 hour

Objectives
By the end of this unit, participants should be able to:
- Describe the various uterine evacuation options and explain why MVA is especially critical in crisis settings.
- Describe the safety, efficacy, and possible complications of MVA.
- Explain how medical abortion and misoprostol for incomplete abortion may be useful options for some women in crisis settings with MVA backup.
- Provide procedure options counseling for women seeking uterine evacuation.
- Obtain informed consent prior to uterine evacuation.

Advance Preparation
- Bring two pieces of different colored paper for each participant. For example, if you have 20 participants, bring 20 sheets of red and 20 sheets of blue.

Materials
- Handout: *Uterine Evacuation Treatment Options Chart*, one per participant
- Blank flip chart paper and markers

Instructions
1) Review the various method options for uterine evacuation
- **Show and discuss slide:** *Uterine evacuation methods*
  - Uterine evacuation removes the contents of the uterus.
  - Recommended methods for providing first-trimester uterine evacuation:
    - Vacuum aspiration
    - Medical methods
    - Expectant management for incomplete abortion

- **Show and discuss slide:** *Obsolete method: Sharp curettage (SC)*
  - According to the WHO: "Dilatation and curettage (D&C) is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods."
  - International Federation of Gynecology and Obstetrics (FIGO) supports vacuum aspiration and medical methods over SC.
  - Health systems should replace SC with vacuum aspiration and medical methods.
  - SC has increased blood loss, pain and procedure time compared to vacuum aspiration.

Ask:
Let's start with vacuum aspiration. What is vacuum aspiration, either manual (MVA) or electric vacuum aspiration (EVA)?
- Vacuum aspiration removes the contents of the uterus through a cannula attached to a vacuum source that is either electric or manual.

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

➺ **Show and discuss slide:** *Ipas MVA Plus with Ipas EasyGrip cannulae*

Ask:
What is MVA?

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

➺ **Show and discuss slide:** *EVA machine*

Ask:
What is EVA?

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

➺ **Show and discuss slide:** *Vacuum aspiration (MVA or EVA)*
- Vacuum aspiration is extremely safe.
- It is associated with few complications, especially when performed in the first trimester.
- Most studies show success in 98 to 100 percent of cases, including for incomplete abortion.
- It is less costly when performed on an outpatient basis under local anesthesia.

➺ **Show and discuss slide:** *Medical methods*

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

➺ **Show and discuss slide:** *Expectant management*
- Expectant management refers to the process of allowing the uterus to evacuate the products of conception spontaneously over time without provider intervention. This is used in cases of inevitable abortion. Access to quick emergency care is recommended.

2) Safety, efficacy, and acceptability of MVA

Ask:
Why is vacuum aspiration acceptable to women?

➺ **Show and discuss slide:** *Acceptability of Vacuum Aspiration for Women*
- Women can remain awake during the procedure.
- They don't have to stay overnight if done on an outpatient basis.
- MVA is quiet.

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

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

- ❖ There is a lower risk of complications.
- ❖ Less cervical dilatation is required.
- ❖ It can be performed as an outpatient procedure.
- ❖ There is a decreased need for anesthetic drugs compared to SC.

➺ **Show and discuss slide:** *Value of MVA in crisis settings*

- ❖ MVA is appropriate for use in primary care facilities.
- ❖ MVA is an appropriate technology for low-resource/crisis settings.
- ❖ It is easy to use, clean, and process; requires no electricity.
- ❖ Can be performed by mid-level providers with no difference in complication rates compared to doctors.

3) Possible complications of MVA

Explain:

MVA has been shown to have a very low risk of infection or injury. However, as with any medical procedure, there are warnings and precautions.

Read the following paragraphs aloud:

As with any uterine evacuation method, one or more of the following may occur during or after the procedure: vagal reaction, incomplete evacuation, uterine or cervical injury or perforation, pelvic infection, or acute hematometra. Some of these conditions can lead to secondary infertility, serious injury, or death. Before performing uterine evacuation, any life-threatening conditions should be addressed immediately. These include: shock, hemorrhage, cervical or pelvic infection, sepsis, perforation, or abdominal injury, as may occur with incomplete or clandestine abortion.

However, uterine evacuation is often an important component of definitive management in these cases. Once the patient is stabilized, the procedure should not be delayed. A history of blood dyscrasia may be a factor in the woman's care. Uterine evacuation should not be performed until the size and position of the uterus and cervix have been determined. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and to perform intrauterine procedures, including MVA.

4) Medical methods for uterine evacuation

Post a blank sheet of flip chart paper.

Ask:

In some cases, women may prefer medical methods for uterine evacuation if the option is available.
Why do you think some women may prefer medical methods to vacuum aspiration?

◆ Record responses on a blank sheet of flip chart paper.

➺ **Show and discuss slide:** *Acceptability of medical methods for women*

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

Explain:
Misoprostol can be used to treat uncomplicated incomplete abortion for uterine sizes less than 13 weeks. Medical abortion – which includes a combination of mifepristone and misoprostol, or misoprostol only where mifepristone is unavailable – can be used up to 13 weeks from LMP. Emphasize that it is important to always have MVA as a back-up method on site or by referral in case medication methods fail.

Case Study Activity

Instructions:
Hand out two different colored sheets of paper to each participant. Choose a color and ask participants to write "misoprostol" in big letters on that piece. Have them write "mifepristone + misoprostol" in big letters on the other color. Ask participants to hold up the piece of paper they think is most appropriate for a woman who has expressed a preference for medical methods for uterine evacuation.

Case Study 1:
A 16-year-old female is 10 weeks LMP. She is experiencing vaginal bleeding and cramps.

ANSWER: She has most likely had an incomplete abortion and should use MISOPROSTOL ONLY for treatment of incomplete abortion.

Case Study 2:
A 25-year-old female is nine weeks LMP and is pregnant, confirmed by a bimanual exam and pregnancy test.

ANSWER: She can have MIFEPROSTONE AND MISOPROSTOL together for an elective abortion.

Case Study 3:
A 37-year-old female can't remember her last period. She notes that she has a foul odor coming from her vagina, a high fever, and abdominal pain. A bimanual exam finds she has a uterine size of about 11 weeks and a very tender pelvis and abdomen.

ANSWER: NEITHER. She may have a pelvic infection and most likely has an incomplete abortion. She is not eligible for a medical method for uterine evacuation.

Case Study 4:
An 18-year-old female is throwing up and is nine weeks LMP.

ANSWER: She can have MIFEPROSTONE AND MISOPROSTOL together for an elective abortion – she is pregnant.

Case Study 5:
A 22-year-old female has had vaginal bleeding for over two weeks with some cramping. Her uterine size is about 10 weeks.

ANSWER: She most likely has an incomplete abortion and should use MISOPROSTOL ONLY for treatment.

Explain:
In all of these cases, it is necessary to have MVA back-up in place in case of complications. For more information about eligibility, routes of administration, regimens, and expected side effects and complications for medical methods for uterine evacuation, see www.ipas.org. Explain to the participants that this training will only focus on MVA.

5) Uterine evacuation methods options counseling

Pass out the handouts: *Uterine Evacuation Treatment Options Chart* and *Advantages/Disadvantages of Medical Intervention Versus Vacuum Aspiration Chart* (both are available on the IAWG website and Flash Drive).

Ask:
What are the factors in deciding which method to use?

- **Show and discuss slide:** *Factors in choosing a method*
  - Staff skills
  - Equipment, supplies, and drugs available
  - The woman's clinical condition
  - The woman's personal preference

Case Study Activity

Instructions:
Read the following case studies to the group and ask them for reasons why they think each woman might choose a specific method of uterine evacuation. Depending on the size of the group, you may want to divide into small groups, triads, or pairs to facilitate more conversation. **Ask participants:** what other questions would you ask the women in the following situations to help them decide which method would be best?

Case Study 1: A 28-year-old mother of three young children presents with an incomplete abortion, ten weeks LMP. She is very distraught because she thought everything in the pregnancy was going fine and then suddenly her morning sickness stopped and the bleeding began. She just learned that the pregnancy is no longer viable and she brought two of her young children with her to the clinic.

Case Study 2: A 17-year-old student presents with an incomplete abortion, eight weeks LMP. She knew she was pregnant for about a week and doesn't want to talk about why she is having vaginal bleeding and some cramping. She lives with her parents but is alone at the clinic. She seems nervous about a procedure, since the speculum used in her exam was a new experience for her. She also didn't bring much money with her to the clinic.

Case Study 3: A 19-year-old mother of one child (one year old) is pregnant, nine weeks LMP, and does not want another child at this time. She is accompanied by her older sister. She seems like she is in a hurry to get home to be with her child. She admits to taking some medicines last week but doesn't think they worked.

Group Process
In each of these cases the woman might choose one method over another. It's important not to make assumptions about what would be more convenient, less painful, or less costly to a patient, and to ask clarifying questions.

Case Study 1: The woman may prefer to take misoprostol because staying at the clinic to wait for a vacuum aspiration might take longer. She also might be concerned that she would have pain or bleeding – she has no one with her to help her with her children or to get home. Alternatively, she may be more concerned about having to come back and may think that MVA treats her condition quickly and effectively.

Case Study 2: The woman seems very nervous about a pelvic exam so misoprostol might cause her less anxiety. She has support at home and no one with her to support her through a procedure in the office. However, she may be more scared about having more severe bleeding and cramping at home, with no clean bathrooms nearby, and may prefer to have everything taken care of today.

Case Study 3: Having a medical abortion might allow the woman to get home more quickly. However, she may not have a lot of trust in pills or be concerned that her pregnancy is getting further along.

6) Informed consent

- **Show and discuss slide:** *Obtain informed consent*

Ask:

What do you think voluntary, informed consent means? Take a few answers. Responses should include:

- Full information on options.
- Discussion of benefits, risks, and alternatives to the procedures discussed.
- Free decision making without pressure or coercion.

Explain:

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

Ask:

What circumstances might limit a woman's ability to give true voluntary, informed consent? Take a few answers. Responses should include:

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

- **Show and discuss slide:** *Procedure choice*
  - What are the differences between methods.
  - What will be done during and after the procedure.
  - What is she likely to experience.
  - How long will it take.
  - Which pain management options she can choose.
  - What are the expected effects, side effects, risks, and potential complications.
  - Explain aftercare and follow up, if needed.

Emphasize:

Pain medication should not be delayed once consent has been obtained, and treatment is never contingent on a woman's acceptance of contraception.

Unit 4: Manual Vacuum Aspiration Refresher

Time

3 hours, 30 minutes

Objectives

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

- Describe the facts and features of the Ipas MVA Plus and Ipas EasyGrip cannulae.
- Describe processing MVA instruments in accordance with local regulations and with locally availably products/systems.
- Describe the steps of providing uterine evacuation with Ipas MVA Plus.
- Resolve common technical problems.
- Be competent simulating a uterine evacuation procedure using Ipas MVA Plus on a pelvic model.

Advance Preparation

Arrange to ship or carry with you the supplies listed below, ensuring they make it through customs and other potential barriers in time for the training. Assess which method(s) of instrument processing will be used and tailor Section 2 accordingly.

Materials

Bring all necessary supplies to explain facts, features, and processing of MVA instruments, as well as simulate uterine evacuation. Bring at least two of everything, more if possible.

- Pelvic model(s)
- Ipas MVA aspirators (and product insert)*
- Ipas EasyGrip Cannulae
- Specula (various sizes including small)
- Dilators
- Tenaculae
- Sponge holding forceps
- Gloves
- Samples of worn aspirators and cannulae that need to be replaced (if possible)

**If possible, bring one aspirator per participant, or at least one per site.*

Note to Trainer: Ensure that all the processing chemicals/containers/machines that the crisis setting uses for instrument processing are available for demonstration. Refer to handout: *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training* for lists of equipment and supplies for training Sections 3 and 4.

Instructions

1) Facts and features of Ipas MVA and Ipas EasyGrip Cannulae

Distribute an aspirator set to each participant. If you are providing sets to each site rather than each participant, have participants share the sets. Allow them a few minutes to inspect and handle the aspirator and cannulae. Tell participants to follow along using the aspirator in their sets.

Distribute the handout: *Tips for Using the Ipas MVA Plus*

- **Show and discuss slide:** *Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae*
  - Woman-centered, appropriate technology.
  - Safe and effective for abortion-related care.
  - Can be used in decentralized health care settings.

- **Show and discuss slide:** *Woman Care Global*

Explain:
Tell participants that the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae are now manufactured and distributed globally by Woman Care Global. Woman Care Global (WCG) is a nonprofit organization working with partners around the world to improve the lives of women by providing access to affordable, quality reproductive health products.

Demonstrate:
Use your aspirator set to show the participants the instrument parts while presenting the slides below.

- **Show and discuss slide:** *Parts assembled*

Point to each part of the aspirator on the slide as you describe it:
- Plunger with handle creates the vacuum.
- Valve buttons control the release of the vacuum.
- 60cc cylinder holds the products of conception (POC).
- Collar stop with retaining clip prevents the plunger from coming out.

The Ipas MVA Plus aspirator provides the same amount of vacuum as an EVA machine. Hold up the cannulae and point to each aspect as you mention it.

- **Show and discuss slide:** *About the cannulae*
  - Same dimensions and apertures (openings) as Karman cannulae.
  - Slightly more rigid.
  - Permanently affixed base with wings.
  - Sizes 4, 5, 6, 7 and 8mm have two opposing apertures.
  - Sizes 9, 10 and 12mm have one larger, single-scoop aperture.
  - Dots on each cannula at 1cm intervals indicate the location of the main aperture.

Explain:
Ipas EasyGrip cannulae have permanent bases that act as built-in adapters. The cannulae connect directly to the Ipas MVA Plus aspirator without requiring a separate adapter.

- **Show and discuss slide:** *Selection of cannulae*
  Depends on uterine size and amount of dilation:
  - Uterine size 4–6 weeks LMP: suggest 4–7mm
  - Uterine size 7–9 weeks LMP: suggest 5–10mm
  - Uterine size 9–12 weeks LMP: suggest 8–12mm

Explain:
It is important to use a cannula appropriate to the size of the uterus and amount of cervical dilation present. Using a cannula that is too small may result in retained tissue or loss of suction.

Instruct participants to follow along with the aspirator in their sets. Use your fully assembled aspirator with cannula attached for the demonstration. Ask a volunteer to disassemble the aspirator. Point to the steps on the slide as you describe how to disassemble the instrument while the volunteer follows your directions.

- **Show and discuss slide:** *Disassembling the aspirator*
  - Remove cannula by twisting its base and pulling it out of the valve.
  - Pull cylinder and remove from the valve.
  - Press cap-release tabs to remove the cap.
  - Open hinged valve by pulling open the clasp.
  - Remove the valve liner.
  - Disengage collar stop by sliding it under the retaining clip, or remove completely.
  - Pull plunger completely out of the cylinder.
  - Displace O-ring by squeezing its sides and roll it down into the groove below.

- **Show and discuss slide:** *Remove O-ring*

Explain:
Participants should never use a sharp object to remove the O-ring, as that could damage the ring.

- **Show and discuss slide:** *MVA parts disassembled*

Ask:
Start with the now fully disassembled aspirator. Ask for another participant to demonstrate the steps of instrument assembly using the disassembled instrument. Ask the participant to follow the steps described in the slide.

- **Show and discuss slide:** *Assembling the Ipas MVA Plus*
  - Place valve liner in the valve by aligning the ridges.
  - Close the valve; ensure that it snaps into place.
  - Snap cap onto the end of the valve.
  - Push cylinder into the base of the valve.
  - Place O-ring into the groove near the tip of the plunger.

- **Show and discuss slide:** *Assembling the Ipas MVA Plus (cont.)*
  - Spread one drop of lubricant around the O-ring with your finger.
  - Squeeze the plunger arms, push fully into the cylinder.
  - Move plunger in and out to lubricate.
  - Insert the collar stop tabs into the holes in the cylinder.

- **Show and discuss slide:** *When assembling the aspirator*
  - Introduce the plunger straight into the cylinder.
  - Do not introduce the plunger at an angle.

- **Show and discuss slide:** *Steps to lubrication*

Explain:
It is important to only use one drop of lubricant because over-lubricating can interfere with the vacuum capability. Silicone lubricant (which is not sterile) is provided, but other non-petroleum based lubricant can be used. We will learn how to prepare the aspirator for use by creating a vacuum with it. This is also called "charging" or "preparing" the aspirator.

Tell participants to follow along with the aspirator in their sets. Point to the parts on the slide as you describe how to prepare the instrument.

- **Show and discuss slide:** *Creating a vacuum*
  - Begin with the valve buttons open, plunger all the way in, and collar stop locked in place.
  - Close the valve by pushing the buttons down and forward until they lock.
  - Pull the plunger back until the plunger arms catch on to the wide sides of the cylinder.
  - Both arms must be extended and secured over the edge of the the cylinder.
  - Incorrect positioning of the plunger's arms can allow the plunger to slip back into the cylinder.

Explain:
Never grasp the charged aspirator by the plunger arms because it could lose vacuum or eject its contents.

- **Show and discuss slide:** *Check aspirator for vacuum*
  - Charge the aspirator.
  - Leave it charged for several minutes.
  - Push the buttons to release the vacuum.
  - A rush of air indicates the vacuum was retained.

- **Show and discuss slide:** *Checking why vacuum fails*
  - Check that it is properly assembled.
  - Inspect the O-ring for proper positioning and lubrication.
  - If the O-ring is damaged, replace it.
  - Ensure that no foreign bodies are present.
  - Check that the cylinder is firmly seated on the valve.
  - Charge and test again.

Explain:
Tell participants to look at their aspirator sets. Show participants the Ipas MVA Plus product insert that comes with every aspirator and includes information about the instrument.

Demonstrate instrument assembly and preparation again, this time asking participants to follow along with their instruments. Ensure that all participants have properly assembled and prepared their aspirators.

Determine if anyone is having difficulty with assembly, especially with inserting the plunger O-ring. Show the participants the correct position of the plunger arms over the edge of the cylinder. Ensure that all participants have now properly charged their aspirators. If necessary, coach individual participants. Tell them to leave their instruments charged and not to release the vacuum until they are instructed.

Demonstrate how to release the valve buttons. Ask one participant at a time to release the vacuum in their aspirators. Ensure that all participants have properly tested their aspirators. If they did not hear the rush of air indicating vacuum release, check to determine why they failed to create a vacuum.

Describe what you are doing to each part as you disassemble your aspirator, following the steps outlined previously. Ask participants to disassemble their devices while you walk around the room coaching them. Ensure that all participants have properly disassembled their aspirators. Finally, have them practice assembling, charging, and disassembling their instruments while you walk around coaching them.

2) Maintaining Ipas instruments

- **Show and discuss slide:** *Ipas MVA Plus aspirator care and processing*
  - Must be soaked, cleaned, and high-level disinfected (HLD) or sterilized between patients.
  - Does not have to be high-level disinfected or sterile at the time of use (like a speculum).
  - Should be put in a decontamination soak promptly after use to ease removal of tissue.

Explain:
The MVA aspirator does not directly touch the woman's body. However, when it is used, the cylinder fills with blood. There is the potential risk that some contaminants from a previous woman could be introduced to another woman if the MVA aspirator is not fully processed (soaked, cleaned, and sterilized or HLD) between each use. Therefore, after cleaning, the Ipas MVA Plus must undergo HLD or sterilization between patients to remove contaminants. Once processed, the aspirator may be kept in a clean container. We will go into more detail on these points later in this module.

- **Show and discuss slide:** *Number of times the instruments can be used*
  - Varies according to how they are used and maintained.

- **Show and discuss slide:** *Replace Ipas MVA Plus Aspirator when…*
  - The cylinder is cracked or brittle.
  - Mineral deposits inhibit plunger movement.
  - The valve is cracked, bent, or broken.
  - The buttons are broken.
  - The plunger arms do not lock.
  - The aspirator no longer holds a vacuum.

Ask:
What steps should you follow if the vacuum fails? Use an assembled instrument to demonstrate and describe what to do when the vacuum fails:

- Check that it is properly assembled.
- Inspect the O-ring for proper placement and lubrication.
- If the O-ring is damaged, replace it.

- Ensure no particles are present.
- Check that the valve is firmly seated on the cylinder.
- Charge and test again.
- If the vacuum is still not retained, use another aspirator.

Explain:
Now that we are knowledgeable about maintaining the aspirator, let's discuss maintenance of the cannulae. In the United States and some other countries, Ipas cannulae are labeled for single use only. In settings where instrument reuse is permitted by local regulations, Ipas EasyGrip cannulae are reusable devices.

- **Show and discuss slide:** *Ipas EasyGrip cannulae care and processing*
  - Manufacturer-sterilized with ethylene oxide.
  - Should be sterilized or HLD before reuse.
  - After use, process promptly to ease cleaning.

Ask:
Why should the cannulae be either sterile or high-level disinfected (HLD) before use?
- The cannulae should be sterile or HLD before use because they come in contact with the sterile uterus.

- **Show and discuss slide:** *Discard and replace cannula if:*
  - It is brittle.
  - Tissue cannot be removed with cleaning.
  - It is cracked, twisted, or bent, especially near the aperture.

Ask:
Pass around the worn aspirators and cannulae that you brought as samples of devices that should be replaced. Ask learners to explain why each should be replaced.

3) Instrument processing

Note to Trainer: You may want to create Instrument Processing Practice Stations for participants to work in pairs practicing the method that is used in the crisis setting. Show the 17-minute Ipas video *Processing the Ipas Instruments* and quickly review and answer questions with the following content.

Explain:
We process instruments to protect our clients and ourselves. Proper instrument processing also prevents the spread of infection from the health care facility to the wider community.

- **Show and discuss slide:** *Standard precautions when processing*
  - Consider all blood and body fluids to be infectious.
  - Always wear gloves when handling any body fluids except sweat.
  - Use protective barriers when a part of the body may be exposed to body fluids: gloves, gown, face protection.
  - Guard against puncture injuries from sharp instruments.
  - Wash hands immediately before and after contact with contaminated items, even if gloves are worn.

- **Show and discuss slide:** *Ipas MVA Plus aspirator and Ipas EasyGrip cannulae processing*
  - Reusable in settings where instrument reuse is permitted by local regulations.
  - There are many processing options.

- **Show and discuss slide:** *Difference between disinfectants and antiseptics*
  - Disinfectants are strong germicides used to clean equipment.
  - Antiseptics are weak germicides used to clean the body.

Pass out the handout: *Instrument Processing Skills Checklist* (available on the IAWG website or Flash Drive). Allow participants a minute to look at it and ask them to follow along as you present the information. Explain that although participants may not process instruments themselves, they should use this checklist to ensure the quality of instrument processing.

- **Show and discuss slide:** *Four steps for processing instruments*
  1. Decontamination soak
  2. Cleaning
  3. Sterilization or high-level disinfection
  4. Storage

Step 1: Decontamination Soak

- **Show and discuss slide:** *Why soak instruments before cleaning?*
  - It makes cleaning easier by keeping the instruments wet.
  - The use of chlorine solution assists with disinfection.
  - It removes some material.
  - Items are still not safe to handle with bare hands.

- **Show and discuss slide:** *Steps in decontamination soak*
  - Fill a plastic container with solution.
  - Can use 0.5% chlorine solution.
  - Wearing gloves, submerge instruments completely.
  - Then draw solution into the cannula and aspirator.
  - Soak instruments until they are ready to clean.
  - Use gloves or forceps to remove.

Ask:

What are some possible mistakes you might make in the soaking process?

- Not wearing gloves.
- Not fully submerging the instruments.
- Allowing the instruments to dry.

Explain and ask:

You must wear barriers when handling instruments after soaking. Have a set of barriers that are worn for instrument cleaning (face protection, gloves, gown, apron). Ask for a volunteer to come up and demonstrate the barriers worn for cleaning MVA by briefly putting on all the barriers, then removing them.

Step 2: Cleaning

- **Show and discuss slide:** *Cleaning*
  - The WHO says cleaning is the most important step to ensure the proper final decontamination of instruments.
  - Wash all surfaces in warm water and detergent.
  - Use probe or cloth to remove any trapped material.
  - Clean all crevices and the inside of the cylinder, valve, and plunger.
  - Use a soft brush – nothing sharp or pointed.
  - Don't splash.
  - Clean until no blood or tissue is visible, then rinse.
  - Allow the items to dry.

Explain:
The instrument must be disassembled before cleaning. If tissue is trapped in the tip of a cannula, flush water through the cannula repeatedly or use a cotton tipped probe, soft brush, or soft cloth to gently remove material.

Ask:
What are some mistakes that commonly occur while cleaning?
- Not wearing barriers.
- Not fully cleaning the instrument.
- Using antiseptics instead of detergent.

Explain:
Do not use sharp items to remove the O-ring. Squeeze or use a blunt instrument to gently displace it. Instruments must be completely clean before further processing. Discard the instrument if you are unable to remove blood or tissue during cleaning. We will now discuss processing options.

- **Show and discuss slide:** *Ipas MVA Plus aspirator*
  - Must be HLD or sterilized between patients.
  - This prevents potential bloodborne pathogens from being transmitted between patients in case of problems during the procedure, where aspirator contents may make contact with a woman's body.
  - The aspirator does not need to remain HLD or sterilized before the next patient.

- **Show and discuss slide:** *Ipas EasyGrip cannulae*
  - Must be HLD or sterilized between patients.
  - Must be HLD or sterile at the time of use.

Step 3: Processing Options

- **Show and discuss slide:** *Common options for processing Ipas MVA Plus and Ipas EasyGrip cannulae*

Explain:
Processing options include:
- Boiling
- Glutaraldehyde (Cidex)

- 0.5% chlorine solution
- Steam autoclave

➪ **Show and discuss slide:** *Option: Boiling (HLD)*

- Place in water at a rolling boil – items do not need to be fully immersed.
- Boil for 20 minutes.
- Remove using HLD or sterile gloves or forceps.
- Dry with sterile cloth, if desired.
- Cool before use.

➪ **Show and discuss slide:** *Boiling MVA instruments*

Ask:

What mistakes can be made when boiling the instruments?

- The water is not actually boiling.
- The instruments were not boiled for a sufficient amount of time.

➪ **Show and discuss slide:** *Option: Glutaraldehyde (sterilization)*

- Fully immerse and ensure that the solution fills the instruments.
- Soak according to manufacturer's instructions – most recommend 10 hours.
- Remove with sterile forceps or gloves.

➪ **Show and discuss slide:** *Option: Glutaraldehyde (sterilization) (cont.)*

- Rinse with sterile water.
- Dry with a sterile towel, if desired.
- Change the solution when it expires.

➪ **Show and discuss slide:** *Option: Glutaraldehyde (HLD)*

- Fully immerse and ensure that the solution fills the instruments.
- Soak according to manufacturer's instructions – recommendations range from 20 to 90 minutes.
- Remove using HLD, sterile gloves, or forceps.

➪ **Show and discuss slide:** *Option: Glutaraldehyde (HLD) (cont.)*

- Rinse with sterile or boiled water.
- Dry with a sterile cloth, if desired.
- Change solution when it expires.

➪ **Show and discuss slide:** *HLD disinfectant soak and rinse*

Ask:

What mistakes might be made during sterilization or HLD using chemicals?

- Items were not submerged or filled.
- Cannula opening was obstructed.
- Instrument was not disassembled.
- Solution expired or was incorrectly mixed.
- Not enough time was allowed for sterilization/HDL.
- Instruments were not rinsed.

- **Show and discuss slide:** *Option: Steam autoclave (sterilization)*
  - Wrap clean, disassembled items in paper or linen.
  - Arrange items so steam penetrates all surfaces.
  - Ensure instrument openings are not obstructed and parts do not touch.
  - Cool before use.

- **Show and discuss slide:** *Paper wrap*
  - It is very important to autoclave the instruments properly to avoid damaging them.

- **Show and discuss slide:** *Steam autoclave: caution*
  - Process at 121°C (250°F) with 106 kPa (15lbs/in2) pressure for 30 minutes.
  - Be sure the autoclave is set to these parameters.
  - Do not use other autoclave settings or "flash" the instruments.
  - Higher temperature settings can damage instruments.

Ask:

What mistakes can be made when steam autoclaving MVA instruments?

- Temperature, pressure, or time allowed is not correct.
- The autoclave was set on higher settings.
- The items were not wrapped or arranged properly for steam contact.
- The cannula opening was obstructed.
- The instrument was not properly disassembled.

Step 4: Store or use immediately

- **Show and discuss slide:** *How to store MVA instruments*
  - Ideally, reprocess cannulae every day if boiled or soaked.
  - Storing items that are even slightly wet invites microbial growth.
  - Keep just a few cannulae in each container.
  - Avoid touching cannulae tips; grasp cannulae by the base.
  - Store instruments in an environment that preserves the level of processing desired.

Explain:

After the instrument has been processed, it has to be reassembled (including lubrication). Test the vacuum before use or storage.

4) Uterine evacuation with the Ipas MVA Plus

Have participants first watch the instructional video *Manual Vacuum Aspiration Technique Using the Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae* (on the IAWG website and Flash Drive) and then discuss each step of the procedure.

- **Show and discuss slide:** *Steps of the MVA procedure*
  1. Prepare instruments.
  2. Assist the woman.
  3. Perform cervical antiseptic prep.
  4. Perform paracervical block.
  5. Dilate cervix.

- **Show and discuss slide:** *Steps of the MVA procedure (cont.)*
  6. Insert the cannula.
  7. Suction uterine contents.
  8. Inspect the tissue.
  9. Perform any concurrent procedures.
  10. Take immediate post-procedure steps, including instrument processing.

Explain:
These are the general steps for the MVA procedure. The exact sequence will vary slightly based on local circumstances.

- **Show and discuss slide:** *Step 1: Prepare instruments*
  - Check that the aspirator retains a vacuum.
  - Have more than one aspirator available.

Explain:
You will want to have more than one aspirator available in case of technical problems or copious products of conception (POC). Ensure that all necessary equipment and supplies are available.

- **Show and discuss slide:** *Create a vacuum*

- **Show and discuss slide:** *Step 2: Prepare the woman*
  - Ensure pain medication is given at the appropriate time.
  - Administer antibiotics.
  - Ask the woman to empty her bladder.
  - Help her onto the table.
  - Ask for her permission to start.
  - Wash your hands and put on appropriate barriers.
  - Perform a bimanual exam.
  - Select and insert speculum.

Explain:
Research has shown that routinely providing antibiotics to women undergoing MVA reduces infection.

- **Show and discuss slide:** *Pre-procedure provision of antibiotics*
  - Administer prophylactic antibiotics to all women.
  - Prophylactic: reduces the risk of infection.
  - Administer therapeutic antibiotics to women with signs and symptoms of infection.
  - Monitor for an allergic reaction.

- **Show and discuss slide:** *Wear barriers for MVA procedures*

- **Show and discuss slide:** *Perform bimanual exam*

Explain:
The woman should empty her bladder before she gets on the table because a full bladder makes the pelvic exam difficult to perform.

Ask:

Why conduct a bimanual exam now?

- To confirm previous findings regarding the size and position of the uterus.

It may be helpful to take a few minutes to reassure the woman before the procedure. Why might this be important in crisis settings?

- In many cases women have been subjected to harsh living conditions, or emotional and possibly physical trauma.

What are some ways you can provide comfort to a woman throughout the procedure?

- Every woman is different. Before beginning it may be helpful to brainstorm with the woman about things that might help bring her comfort during the procedure. Some possibilities might include:
  - Assign a nurse, counselor, or the woman's loved one to talk with her during the procedure, offering comforting words of reassurance and encouragement.
  - Assign a nurse, counselor, or the woman's loved one to help the woman through some imagery exercises – picturing a favorite place, home, or just a pretty sunset.
  - Offer some distraction tactics to take her mind off the procedure; have her think about a happy place, a happier time, her work before living in the crisis setting, loved ones, or holidays, for example.
  - Offer comfort by holding her hand or patting her shoulder.
  - Play music that she enjoys.

- **Show and discuss slide:** *Step 3: Perform cervical antiseptic prep*
  - Follow the No-Touch Technique.
  - Use antiseptic sponges to clean cervical os, cervix and, if desired, vaginal walls.
  - Do not retrace areas previously cleaned.

- **Show and discuss slide:** *Antiseptic cervical preparation*

Ask:

What is the No-Touch Technique?

- Handling instruments so that the part that will enter the sterile uterus does not touch any other surface, including gloved fingertips or vaginal walls.
- Emphasize that the No-Touch Technique is important because infection can start when vaginal or other flora is introduced into the uterus during the procedure. The No-Touch Technique must be used throughout the procedure.

Why is the cervical antiseptic prep important?

- During the procedure, microorganisms in and around the vagina are very often transferred through the os into the uterus, or by the block needle to deep cervical tissue, where they can cause infection.

Why not retrace with the sponges?

- Retracing with the sponge can cause contamination by carrying microorganisms from unswabbed areas onto already-cleaned areas.

- **Show and discuss slide:** *Step 4: Perform paracervical block*
  - Recommended for all MVA procedures.
  - Usually 10 to 20mL of 0.5-1.0 percent lidocaine (always less than 200mg).
  - Always aspirate (pull back on the plunger) slightly before injecting to prevent intravascular injection.

Explain:
Most women experience pain when the cannula is inserted through the os, as well as when the os contracts after the evacuation. Since paracervical block aids in preventing pain and is unlikely to cause harm, it is recommended that it be administered to all women needing uterine evacuation. Paracervical block is safe and easy to do, and may be done by mid-level providers. It is important to aspirate before injecting to be sure the needle is not in a vessel, which can cause very serious problems.

- **Show and discuss slide:** *Administering paracervical block*
  - Start with 20mL of 1 percent lidocaine (buffered or unbuffered).
  - Inject 2mL of anesthetic where tenaculum will be placed (12 o'clock).
  - Place tenaculum.
  - Apply slight traction to move the cervix, exposing the transition from cervical to vaginal tissue.
  - The remaining 18mL are injected in equal amounts at the cervicovaginal junction at 2, 4, 8 and 10 o'clock. The injection is continuous from superficial to deep to superficial to a depth of 3cm.
  - Always aspirate (pull back on the plunger) before injecting to prevent injecting into a vein.
  - Wait three minutes before dilating the cervix.

- **Show and discuss slide:** *Paracervical block*

- **Show and discuss slide:** *Step 5: Dilate cervix*
  - Dilatation is required in most but not in all cases.
  - Women with inevitable or incomplete abortion may require minimal or no dilatation.
  - The cannula should fit snugly in os.
  - Use a gentle operative technique.
  - Use progressively larger cannulae or mechanical dilators.
  - After 12 to 14 weeks, cervical preparation with osmotics or misoprostol should be routinely used.

Explain:
Using a gentle operative technique is important during dilatation to avoid creating a false passage, cervical tear, or perforation, especially as cervical tissue will be softened with pregnancy.

- **Show and discuss slide:** *Step 6: Insert cannula*
  - Gently apply traction to the cervix.
  - Rotate the cannula while gently applying pressure.
  - Insert cannula just past internal os.
  - Alternatively, insert cannula slowly until it touches the fundus, then draw it back.

- **Show and discuss slide:** *Insert cannula into the uterus*

Explain:
A cervical tear can occur if the cervical traction is too strong. A uterine perforation can occur if the cannula is inserted too far through the os.

- **Show and discuss slide:** *Attach the aspirator*

- **Show and discuss slide:** *Step 7: Suction uterine contents*
  - Attach the charged aspirator to the cannula.
  - Release buttons to start suction.

- Gently rotate cannula 180 degrees in each direction.
- Use a gentle "in and out" motion.
- Do not withdraw cannula opening beyond external os.

Explain:
Throughout the procedure, remain alert to signs that may indicate perforation and stop suction immediately if they appear.

➺ **Show and discuss slide:** *Release buttons*

➺ **Show and discuss slide:** *Evacuate uterine contents*

Ask:
Why should you not withdraw the cannula opening out beyond the external os?
◆ The vacuum will be lost.

Though it is necessary, what is the risk with using an "in and out" motion?
◆ There is a risk of uterine perforation.

➺ **Show and discuss slide:** *Signs that the uterus is empty*
- There is red or pink foam without tissue passing through the cannula.
- There is a gritty sensation over the surface of the uterus.
- The uterus is contracting around the cannula.
- There is increased uterine cramping or pain.

➺ **Show and discuss slide:** *When the procedure is finished*
- Depress buttons down and forward to close the valve, then disconnect cannula from the aspirator.

OR
- Withdraw cannula and aspirator from the uterus without depressing buttons.
- Keep instruments ready to evacuate again after inspecting POC, if needed.

➺ **Show and discuss slide:** *Use care to disconnect cannula*
- Ipas EasyGrip cannulae fit firmly into the valve of the aspirator.
- Use care when disconnecting cannula from the aspirator.

➺ **Show and discuss slide:** *Detach cannula from aspirator*

➺ **Show and discuss slide:** *Step 8: Inspect tissue*
- Empty contents of the aspirator into a container.
- Look for POC: villi and decidua should be visible.

➺ **Show and discuss slide:** *Inspect tissue for:*
- Quantity and presence of POC
- Complete evacuation
- Molar pregnancy

➺ **Show and discuss slide:** *Detailed tissue inspection*

Explain and ask:
If the visual inspection is not conclusive, the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory. What might it mean if the POC inspection shows less tissue than expected or the tissue sample is inconclusive?

➺ **Show and discuss slide:** *Possible reasons that no POC visible*
- ❖ A spontaneous abortion has already completed itself.
- ❖ Uterine cavity still contains POC.
- ❖ The patient has an ectopic pregnancy.
- ❖ Uterine anatomical variation prevented evacuation.

➺ **Show and discuss slide:** *Possible reasons for less than expected POC*
- ❖ Incomplete procedure; re-evacuation necessary.
- ❖ Incorrect estimation of length of pregnancy.

Explain:
The MVA procedure is almost done if the exam of the POC is satisfactory. In some circumstances, the POC may then be collected to be sent for pathologic examination. In all cases, POC are handled as infectious material. If significant bleeding continues or other issues are identified, the provider should intervene as needed. We will cover this when we discuss complications in another unit.

➺ **Show and discuss slide:** *Step 9: Perform any concurrent procedures*
- ❖ If POC inspection results are satisfactory:
  - ✦ Wipe the cervix with a swab to assess additional bleeding.
  - ✦ Perform concurrent procedure.

Ask:
What concurrent procedure might be done?
- ◆ Intra-uterine device (IUD) insertion
- ◆ Contraceptive implant insertion
- ◆ Contraceptive injection and sterilization
- ◆ Repair of cervical tear

➺ **Show and discuss slide:** *Step 10: Immediately post-procedure*
- ❖ Process or discard instruments.
- ❖ Remove barriers and wash your hands.
- ❖ Reassure the woman that the procedure is finished.
- ❖ Help her into a comfortable position.
- ❖ Ensure she is escorted to the recovery area.
- ❖ Record information about the procedure.

Ask:
What questions do you have about the steps for performing the uterine evacuation procedure before we proceed to a demonstration?

5) Demonstration and simulated practice

Refer to *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training* for guidance on how to set up and conduct an effective pelvic model demonstration and practice. Pelvic model practice should simulate clinical practice as closely as possible, including infection prevention and client interaction. All participants should achieve simulated competence on a pelvic model before they perform the procedure on women.

Perform a demonstration of the uterine evacuation procedure on a pelvic model for the entire group.

- **Distribute the handout:** *Uterine Evacuation Procedure With Ipas MVA Plus Skills Checklist.*
- Ask a volunteer to stand next to you and read each step of the checklist aloud as you demonstrate.
- Ask another volunteer to sit at the head of the procedure table and act the part of the woman.
- Ask participants to follow along on their copy of the checklist as they watch the demonstration.

Note to Trainer: Ensure that the demonstration is realistic. As you perform every step of the procedure, use standard precautions and speak to the volunteer "woman" as you would speak to an actual woman.

Ask:

What questions do you have about this demonstration of the procedure?

- Answer questions and incorporate into a discussion of possible adverse events as they might occur.
- Tell participants they will now practice the procedure themselves.

Instructions:

- Divide participants into groups of four.
- Each group is to perform a simulated practice of the uterine evacuation procedure at the pelvic model stations.
- Ask one participant to be the provider and perform the procedure while another participant plays the observer, reading the checklist aloud. Another participant should play the role of the woman and another volunteer the support person.
- At the end of each demonstration, the provider should first give feedback describing their experience.
- The support person, the woman, and the observer should then give the provider feedback about skills that were performed well and areas for improvement.
- Participants should switch roles until all have had the opportunity to practice performing the procedure, using the checklist to observe, acting as the woman, and practicing the support role.
- While participants are practicing, rotate to each pelvic model station to observe, listen, address issues that arise, correct technique as needed, and ensure that roles are being followed.

Evaluation:

Evaluate each participant's performance using the checklist when they indicate that they are ready.

- Other participants can continue practicing while you conduct evaluations.
- All participants must be evaluated as competent with simulated practice on a pelvic model before they can perform the procedure on actual women.
- Make arrangements for participants who fail to reach competency at this time to have additional practice and another evaluation.

Ask:
What final questions do you have about the procedure?

- Answer all questions.

6) Solving technical problems using MVA

Note to Trainer: Participants should have Ipas MVA Plus and Ipas EasyGrip Cannulae instruments to practice the various steps in this section. Work one-on-one, in pairs, in triads, or in small groups. Demonstrate each step for these problems so participants can visualize what to do. Participants should then practice doing each step themselves.

Be sure participants have the handout (distributed earlier): *Tips for using the Ipas MVA Plus,* which includes "Solving technical problems during the MVA procedure" on the back page.

Ask:
What technical problems have you experienced with MVA in the past?

- Record responses on a flip chart. Reassure participants that you will go through all the problems they have mentioned, along with other possibilities, so that they will feel prepared to troubleshoot when providing uterine evacuation.
- Explain that the most common technical problem seen with MVA instruments is loss of vacuum.
- During most MVA procedures, the vacuum remains constant until the aspirator is approximately 80 percent (or 50mL) full. Still a decrease in vacuum may occur before the aspiration is complete for several reasons.

Why might vacuum decrease unexpectedly during the procedure?

- **Show and discuss slide:** *Reasons for decrease in MVA vacuum*
  - The aspirator is full.
  - The cannula is withdrawn past os.
  - The cannula is clogged.
  - The aspirator is incorrectly assembled.

Ask:
What do you do if the aspirator is full?

- **Show and discuss slide:** *When the aspirator is full*
  - Close the valve buttons.
  - Detach the cannula and leave in os.
  - Replace the aspirator

  OR
  - Empty aspirator into a container by pressing buttons and pushing the plunger into the cylinder.
  - Establish a new vacuum, attach the aspirator to the cannula and resume.

Explain and ask:
Many clinicians keep a second prepared aspirator on hand during the procedure and switch aspirators if one becomes full. What should be done if the cannula is accidentally withdrawn past the os?

- **Show and discuss slide:** *When cannula is withdrawn past os*
  - Remove the cannula and aspirator; don't touch vaginal walls.
  - Detach and empty the aspirator.
  - Reestablish the vacuum.
  - Reinsert the cannula if it has not been contaminated.
  - If contaminated, insert another sterile or HLD cannula instead.
  - Reconnect aspirator to the cannula, release the vacuum and resume.

Ask:

Ask for a volunteer to demonstrate these steps for the entire group. What should be done if the cannula becomes clogged?

- **Show and discuss slide:** *When cannula is clogged*
  - Ease the cannula back toward, but not through, the external os

  OR
  - Depress buttons and withdraw the aspirator and cannula out of the uterus, avoiding contamination.
  - Remove the tissue clogging the cannula, using sterile or HLD forceps.
  - Reinsert the cannula using the No-Touch Technique.
  - Reattach the aspirator and continue aspiration.

Explain and ask:

- Never try to unclog the cannula by pushing the plunger back into the cylinder.
- Ask for a volunteer to demonstrate these steps for the entire group.
- Ask the group: What should be done if the vacuum is lost?

- **Show and discuss slide:** *If aspirator does not hold vacuum*
  - Reassemble and test the aspirator.

Ask:

What questions do you have about technical problems during the procedure?

- Answer the questions.

Unit 5: Pain Management and Simulated Practice

Time
1 hour, 45 minutes

Objectives
By the end of this unit, participants should be able to:
- Create a pain management plan with the woman that is sensitive to her situation.
- Be competent simulating a uterine evacuation procedure using Ipas MVA Plus on a pelvic model.

Advance Preparation
Arrange to ship or carry with you the supplies listed below, ensuring they make it through customs and other potential barriers in time for the training.

Note to Trainer: These are the same advance preparation recommendations as those in Unit 4, since the simulated practice with pelvic models is continued in Unit 5.

Materials
Bring all supplies for simulated uterine evacuation. Bring at least two of everything, more if possible.
- Pelvic model(s)
- MVA
- Cannulae
- Specula (various sizes including small)
- Dilators
- Tenaculae
- Sponge holding forceps
- Gloves
- Syringes and needles

Note to Trainer: Refer to handout: *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training* for lists of equipment and supplies.

Instructions
1) Pain management plan

Explain:
Managing the woman's pain and anxiety is a vital component of high-quality, abortion-related care.

- **Show and discuss slide:** *Pain management during MVA*
  - Recommended by the WHO for all women undergoing uterine evacuation by any method.
  - Should address physical, procedural, and psychosocial factors associated with pain.

- Minimizes procedural risk.
- A woman determines the action plan with her provider, based on individual needs and preferences.
- Women's responses to pain vary, but all women should be offered pain management.
- Providers consistently underestimate the amount of pain a woman experiences.
- Young women may report higher levels of pain than older women.

Explain and ask:
All women who present for abortion-related care should be offered pain management and be provided it without delay. What particular factors might be taken into consideration when helping the woman develop a personalized pain management plan?

- **Show and discuss slide:** *Physical factors associated with increased pain with vacuum aspiration*
  - Nulliparity
  - Higher gestational age
  - Dysmenorrhea
  - Young age

- **Show and discuss slide:** *Procedural factors associated with pain with vacuum aspiration*
  - Cervical dilatation
  - Uterine manipulation
  - Clinical technique

- **Show and discuss slide:** *Psychosocial factors associated with increased pain with vacuum aspiration*
  - Anxiety
  - Depression

Explain and ask:
Addressing the woman's psychosocial state is part of providing high quality woman-centered care. In a crisis setting, the woman may be feeling high levels of anxiety and intense emotions for a host of reasons. Ask the participants to name a few of these possible reasons. Be sure most on the list below are named.

- Displacement from home and personal possessions
- Separation from loved ones
- Grieving the death of loved ones
- Food/safe water insecurity
- Fear of violence
- Fear of inability to provide for dependents
- Lack of privacy
- Lack of clean, sanitary bathroom facilities
- Lack of adequate or safe housing
- Post-traumatic stress symptoms from witnessing or experiencing traumatic events
- Lack of sleep

Additionally, the circumstances surrounding how she became pregnant, her decision to terminate a pregnancy, or her inability to carry a pregnancy to term may be compounded by living in a crisis setting. This anxiety can affect how she perceives and copes with pain and discomfort associated with uterine evacuation.

- **Show and discuss the slide:** *Addressing pain from cervical dilatation*
  - Anesthetic: paracervical block using lidocaine
  - Non-steroidal analgesics (ibuprofen or naproxen)
  - Conscious sedation

- **Show and discuss the slide:** *Addressing pain from uterine manipulation*
  - Gentle operative technique
  - Non-steroidal analgesics (ibuprofen or naproxen)
  - Conscious sedation

Explain and ask:
Providing conscious sedation increases the expense, complexity and potential risks of an abortion procedure. The increased need for monitoring requires facility investments in training and equipment to deliver conscious sedation safely. What pharmacological interventions might be provided to alleviate anxiety?

- **Show and discuss slide:** *Pharmacological means of addressing anxiety*
  - Anxiolytics relieve anxiety for some women.
  - Non-steroidal analgesics relieve pain, which can reduce anxiety.
  - Conscious sedation.

- **Show and discuss slide:** *Timing of oral medications*
  - Drugs must be most effective at the time of the procedure.
  - Administer drugs 30 to 45 minutes before the procedure.

- **Show and discuss slide:** *Addressing pain from psychosocial factors*
  Support measures in addition to pain medications include:
  - A calm environment
  - Respectful interactions and communication
  - A companion during the procedure
  - Verbal and physical support and reassurance
  - Gentle clinical technique
  - Non-pharmacological pain relief, such as a heating pad or hot water bottle

  All of these support measures supplement, but do not replace, medications.

Explain:
Providers can arrange for a female staff person to accompany the woman during the procedure, if she prefers. The companion can ask if the woman would prefer silence or distraction by talking with her or leading her through a guided visualization. She can offer to provide the woman information at each step. Facility staff can create a calming environment by de-medicalizing the procedure areas as much as possible and providing appropriate music, lighting, and décor. Music is effective for pain management during vacuum aspiration and may be helpful for uterine evacuation with medical methods as well. All these methods of pain management can also address any preexisting pain the woman may have when she comes for abortion-related care.

Distribute the handout: *Pharmacological Approaches to Pain Management During MVA.* Give participants a minute to review the chart.

Explain and ask:

We will now create a list of locally available drugs and usual practices.

- Ask participants to name anxiolytics that are locally available, and write their answers in the space on the flipchart.
- Ask participants to name the drugs that are locally available for paracervical block, and write their answers in the space on the flipchart.
- Ask participants to name oral non-steroidal anti-inflammatory drugs or narcotic analgesics that are locally available. Write their answers in the spaces on the flipchart.
- When the list is complete, ask participants to describe nonpharmacological support measures that could be locally provided to address pain. Write their answers in the spaces on the flipchart. This will result in a comprehensive list of locally-available drugs and non-pharmacological support measures for MVA pain management to use in the case study activity.

Show and discuss slide: *Helping the woman develop a pain management plan*

- Discuss the type of pain she may experience during uterine evacuation.
- Discuss options available to reduce pain.
- Describe available medications, their effects, and their potential side effects.
- Offer support measures that can be used in addition to pain medication.
- Ask her to state her preferred support measures.
- Help her decide on a pain management plan.

Explain:

When developing a pain management plan, the woman is the decision maker. Providers should not impose their own preferences but instead offer available medication and support options, and help the woman decide what she prefers. A woman has the right to refuse pain medications once she has been fully informed about her options. In the following case study activity, be sure to address each concern expressed by the woman when helping her develop her pain management plan.

2) Pain management case studies

Have participants complete the *Pain Management Plan Case Studies* activity.

Instructions:

- Divide participants into small groups.
- Distribute the *Pain Management Plan Case Studies* handouts.
- Ask each small group to write a pain management plan that addresses the concerns expressed by the woman in each of the case studies. Each group will develop a plan for each case study.
  - The groups should use the list of locally available drugs and support measures for the MVA pain management plan that was just created.
  - Be sure participants address any preexisting pain, the woman's individual needs, and the factors previously noted.
- Have each group briefly report on one of the case studies, asking other groups to comment only if their responses were different.
  - Correct or comment on responses as needed using the key.

Explain:

Once you have assessed the woman, helped her develop a pain management plan, obtained her informed consent, and administered pain medication at the appropriate time, you are ready to proceed with the uterine evacuation procedure using Ipas MVA Plus instruments.

3) Simulated practice with pelvic models

Note to Trainer: Continue where you left off the day before with Unit 4, Section 4.

Unit 6: After Uterine Evacuation

Time
1 hour, 15 minutes

Objectives
By the end of this unit, participants should be able to:
- Identify and explain how to recognize signs and symptoms of complications.
- Discuss medical eligibility for select methods of postabortion contraception, including emergency contraception.
- Provide referrals to other reproductive health services.

Advance Preparation
- Arrange to ship or carry contraceptive methods with you to ensure they make it through customs and other potential barriers in time for the training.

Materials
- Samples of contraceptive methods approved for use by women after having had a uterine evacuation

Instructions
1) Post-procedure care

Explain:
Once the MVA procedure is finished, the woman will require high-quality post-procedure care.

- **Show and discuss slide:** *Post-procedure care*
  - Is care provided after uterine evacuation is completed.
  - Any physical complications are addressed.
  - The woman is informed about her condition and self-care.
  - The woman is provided with a contraceptive method, if desired.
  - Ends when she is discharged.

- **Show and discuss slide:** *Elements of post-procedure care*
  - Physical monitoring
  - Other physical health issues
  - Pain management
  - Emotional monitoring and support

- **Show and discuss slide:** *Elements of post-procedure care (cont.)*
  - Contraceptive counseling and provision
  - Scheduling follow-up care if she desires and providing referrals
  - Providing discharge instructions

Distribute the *Post-Procedure Care Skills Checklist.* Ask participants to follow along with the checklist as you discuss the elements of post-procedure care.

- **Show and discuss slide:** *Physical monitoring*
  - Take the woman's vital signs immediately.
  - Ensure that she is resting comfortably.
  - Review her chart for information about her condition, history, and baseline vital signs.
  - Ensure recovery from the procedure and medications.
  - Evaluate bleeding and cramping at least twice.

- **Show and discuss slide:** *Physical monitoring (cont.)*
  - Detect and manage complications:
    - Significant physical decline
    - Dizziness, shortness of breath, fainting
    - Severe vaginal bleeding
    - Severe abdominal pain, cramping
    - Enlarged and tender uterus

- **Show and discuss slide:** *Taking vital signs*

Explain:
Tell participants that they can evaluate bleeding and cramping from the woman's description or from observation. Cramping and bleeding should decrease over time; severe cramping and bleeding is not normal.

Ask:
Why is it important to evaluate bleeding, cramping, pain, and vital signs at least twice during the post-procedure period?

- You need a baseline evaluation and then a second evaluation to determine if there has been any change, for better or worse, in her status.

Explain:
Levels of pain, bleeding, and cramping cannot be measured in exactly the same way for all women. Although there are norms, providers must be alert to differences among women.

- **Show and discuss slide:** *Post-procedure pain management*
  - Evaluate pain level and patterns.
  - Offer choices for pain relief:
    - Analgesics, non-steroidal anti-inflammatory drugs (NSAIDs)
  - Administer and monitor pain medications.
  - Offer empathy and non-pharmacologic support, such as warm compresses, in addition to pain medications.
  - If a woman's pain increases, she needs attention.

Explain:
One way to help women assess the level of the pain they are experiencing is by using a pain scale.

- Ask the woman how her pain compares to the most painful situation in her life on a scale of one to 10 (one is least painful and 10 is most painful).
- For low-literacy women, you could draw a line with a happy face at one end and a sad face at the other, then ask them to point to where they are along the line.

- **Show and discuss slide:** *Other physical and reproductive health issues*
  - Anemia: counsel on diet, supplements
  - Rh-immunoglobulin: administer according to protocol
  - Reproductive-tract infections (RTIs), HIV, violence, infertility, or cancer screening: counsel, provide care, and/or refer

- **Show and discuss slide:** *Make referrals if necessary*

Explain:
So far we have focused on physical monitoring. The next element of post-procedure care is emotional monitoring and support.

- **Show and discuss slide:** *Emotional monitoring and support*
  - Assess and monitor the woman's emotions.
  - Respond sensitively to her emotional state.
  - Treat the woman gently.
  - Offer counseling or referrals.

- **Show and discuss slide:** *Post-procedure contraceptive counseling*
  - Ideally, provide before the procedure.
  - If the woman hasn't decided on contraception, discuss it again after the procedure when she may be better able to focus on her contraceptive needs.
  - Ensure that she receives counseling and a contraceptive method of her choice, which she understands how to use, or a referral.
  - Remember that some women may desire another pregnancy.

Explain:
We will discuss more about postabortion contraception shortly.

- **Show and discuss slide:** *Is follow-up care needed?*
  - Not required after a routine MVA procedure.
  - Make an appointment if the woman desires follow-up.
  - Tailor the appointment to the woman's condition and needs.
  - Obtain consent to send her records to the follow-up provider.

Explain:
When her condition allows, the woman can be discharged.

- **Show and discuss slide:** *The woman is ready for discharge*
  - Vital signs are normal.
  - Bleeding and cramping are diminished.
  - She is awake, alert, and able to walk unassisted.
  - She is ready to leave.

Explain:
It is important to explain to the woman what she can expect and what she can do during the recovery period.

- **Show and discuss slide:** *Normal recovery*
  - A few days of menstrual-like bleeding and cramping
  - Analgesics, baths, and compresses for cramping
  - Next menses: four to eight weeks
  - Intercourse and tampons can be used after any complications are resolved

- **Show and discuss slide:** *Provide instructions for medications*

Ask:
What other medications might be necessary to administer and explain?
- Antibiotics or other drugs, depending on the woman's condition.
- The woman should be informed about what conditions to be alert for and when to seek care, and given 24-hour contact information and emergency phone numbers, if available.

- **Show and discuss slide:** *Signs needing immediate attention*
  - Fever, chills, fainting, vomiting
  - Heavy bleeding
  - Severe pain

- **Show and discuss slide:** *Signs to monitor if they worsen over time*
  - Pain in the abdomen or distention of the abdomen
  - Odd or bad-smelling vaginal discharge
  - Prolonged cramping or bleeding
  - Delay in resumption of menstruation (more than eight weeks)
  - Dizziness

Explain:
Discharge instructions may be provided to women in writing as well in case they may forget or want to verify their understanding later.

Note to Trainer: Not all women will speak the same language as the provider. Therefore, you may need to discuss how providers can tell patients the signs for needing immediate attention with the help of a translator or by using low literacy pictures.

Distribute the handout: *Discharge Information Sheet*

Note to Trainer: As an optional activity, ask participants to practice giving discharge instructions in pairs.

- **Show and discuss slide:** *Before discharge*
  - The woman received contraceptive counseling and a method, if desired.
  - A follow-up appointment or referrals were made, if needed or desired.
  - She was provided a list of counseling and other services available at the facility or in the community.

Explain and ask:
There may be other resources in the community to which links can be provided. Ask participants to brainstorm about services available in their communities to which they could provide referrals. Write all responses on a flipchart and group responses by topic (for example, cancer-screening services) or by location (for example, in the next town).

➺ **Show and discuss slide:** *Offer contraceptive methods*

Explain:
This discharge procedure is routine for women who do not have any complications after abortion-related services. If a woman has suffered any complications:

- Give clear, evidence-based explanations of the situation.
- Include her in decision making about her treatment.
- She may need additional discharge instructions.
- Stress the importance of a follow-up visit.

Explain that the *Post-Procedure Skills Checklist* describes all the steps prior to discharge, and that it can be used to develop facility protocols and as a monitoring tool for quality assurance.

2) Follow-up care

Explain:
Routine follow-up is not necessary. If there are complications, the woman should return to the facility immediately. If the woman desires follow-up care, an optional visit may be scheduled one to two weeks after a uterine evacuation with MVA. Most women do not experience complications from the uterine evacuation procedure. Complications can occur prior to, during, or following the procedure. Those women who do have acute problems should seek immediate care at an appropriate facility.

➺ **Show and discuss slide:** *Follow-up care: Women with complications*

- Ensure that any complications have been resolved.
- Stabilize, treat, or refer women with acute problems.
- Explain what the complication was and what it might mean for the woman.

Explain:
While follow-up services vary depending on each facility's resources, there are some basic elements that may be included as part of a follow-up visit.

➺ **Show and discuss slide:** *Follow-up care elements*

1. Confirm success of the uterine evacuation.
   - Ask how she is feeling, including bleeding and any pregnancy symptoms.
   - Conduct a physical examination.
   - If needed, do or refer for ultrasound.
2. Stabilize, treat or refer for acute problems; ensure that earlier complications are resolved.
3. Perform vacuum aspiration if the uterine evacuation is incomplete.

➺ **Show and discuss slide:** *Follow-up care elements (cont.)*

4. Inform the woman of what to expect following completion or continued treatment.
5. Review any laboratory tests results.
6. Provide a contraceptive method, if desired and not already provided.
7. Refer for other medical, gynecologic, or counseling services where indicated.

3) Contraceptive counseling and services

Explain:

Offering on-site contraceptive counseling and method provision as an integrated part of abortion-related services in the unit where abortion-related care is provided, can improve contraceptive acceptance and help break the cycle of multiple unwanted pregnancies. All women receiving abortion-related care, regardless of their age, marital status, or number of children, should be offered contraceptive services. Refer participants to their handout: *Post-Procedure Care/Follow-Up Care, Contraceptive Services Skills Checklist.*

➺ **Show and discuss slide:** *Avoid assumptions*

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

➺ **Show and discuss slide:** *Return to fertility*

- ❖ How soon after a uterine evacuation can ovulation take place?

Explain:

Ovulation can take place within 2 weeks of a vacuum aspiration abortion or incomplete abortion, and as early as 8 days after medical abortion with mifepristone and misoprostol. Contraception should be provided immediately to women who want to prevent pregnancy. A common factor among women receiving abortion-related care is that they are at a critical juncture in their lives and can benefit from compassionate counseling about contraception.

➺ **Show and discuss slide:** *Preferred service-delivery model*

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

➺ **Show and discuss slide:** *Discussing contraception and uterine evacuation procedure together*

- ❖ Discuss contraceptive and uterine evacuation options at the same time.
- ❖ The uterine evacuation method has implications for whether and how certain contraceptive methods can be provided.
- ❖ Discuss the importance of providing information on contraceptive options along with information on the uterine evacuation methods and procedure. For example, for women who want an IUD, a vacuum aspiration procedure would allow her to have the IUD inserted immediately, ensuring that she can leave the facility with her method of choice. However, women who choose medical abortion and desire an IUD must return to a provider to have it inserted. Women who choose an implant can have it inserted immediately, whether they have a vacuum aspiration procedure or a medical abortion.

Explain:
There are key messages every woman receiving abortion-related care should know before leaving the facility.

- **Show and discuss slide:** *Key messages on postabortion contraception*
  - A woman can become pregnant again very quickly after a uterine evacuation (within 2 weeks, and as early as 8 days after medical abortion with mifepristone and misoprostol).
  - In general, all methods can be used immediately.
  - Where to go for contraceptive services, including emergency contraception (EC).

- **Show and discuss slide:** *"We've failed her twice"*
  "If a woman comes to a hospital with an incomplete abortion, we've already failed once to help her avoid an unwanted or a mistimed pregnancy. If she leaves the facility without having any means of preventing another pregnancy in the future that may not be wanted, we've failed her twice."
  – Cynthia Steele Verme, Postabortion Care (PAC) Consortium

Explain:
Remind participants that many women receiving abortion-related services have terminated unwanted pregnancies that resulted from contraceptive failure or from failure to use the method consistently or correctly.

- **Show and discuss slide:** *Privacy, confidentiality and informed choice*
  - Privacy and confidentiality are essential in the abortion-related care setting.
  - The woman should be counseled in an area where no one else can see and hear to ensure confidentiality.
  - Providers should follow professional protocols that protect confidentiality.

Explain:
This may be challenging in a crisis setting. Suggest speaking in low tones or going outside to have a conversation. Some women, especially adolescents, may be reluctant to acknowledge that they are sexually active. Living in confined, crowded spaces may make them more reluctant to talk openly about their contraceptive needs.

- **Show and discuss slide:** *Informed choice means*
  - Choosing a method voluntarily, without coercion or pressure.
  - Choosing from a wide range of methods.
  - Understanding the benefits and risks of each method.
  - Informed consent is obtained prior to method provision.
  - Informed consent is particularly important for permanent methods, such as sterilization.

Discussion:
Facilitate a discussion about available contraceptive methods, and supply and access issues at the crisis setting. Contraceptive counseling should begin with what will continue to be available, and should take into account the likelihood of the woman remaining at the setting or moving elsewhere within a given time. Women who may have been using one method before the displacement will need to reevaluate which method(s) will work best given their new life circumstances. Consider lack of personal storage and privacy, and discuss the risk of rape and violence, especially for adolescents.

- **Show slide:** *Ask if she would like her partner to be with her*

Explain and discuss:

- The woman should be asked privately whether or not she wants her partner included in contraceptive counseling.
- If a woman does not want her partner involved, she should be counseled and given the method privately, and no information from the visit should be shared with her partner.

- **Show and discuss slide:** *Medical eligibility for methods*
  - If there are no severe complications, all modern methods can be used immediately following a uterine evacuation, including by young women.
  - Screen for any medical precautions for particular methods.
  - All methods require adequate counseling and informed consent.

Explain:

Long-acting reversible contraceptives (LARC) have many advantages and should be offered as an option for women of all ages.

- **Show and discuss slide:** *Long-acting reversible contraceptives (LARC)*
  - LARC includes IUDs and implants.
  - For both young and adult women, LARC are more effective and have higher satisfaction feedback from users than pills.
  - LARC also often continue longer than pills or injectables.

- **Show and discuss slide:** *Integrating LARC into abortion-related services*
  - Offering LARC enhances women's access to effective contraception.
  - Women of all ages should be offered LARC as an option.
  - Providers should insert women's chosen method as soon as possible.

Explain:

There are guidelines for contraceptive methods in certain clinical situations.

- Fertility-awareness methods are not recommended until a normal menstrual pattern returns.
- Abstinence from intercourse is recommended until any complications are resolved and the chosen contraceptive method has become effective.
- If a woman has contraindications to using her desired method, such as using an IUD, immediately after a septic abortion, she should be offered an interim method until she can safely use her chosen method.

Remind participants that young women, like older women, are able to use all contraceptive methods. Also note that eligibility for contraceptive methods after postabortion care is the same as after induced abortion.

- **Show and discuss slide:** *Uncomplicated vacuum aspiration*
  - All modern contraceptive methods can be used immediately.

- **Show and discuss slide:** *Vacuum aspiration with complications: Infection*
  - IUD/intrauterine system (IUS), sterilization appropriate when infection has been resolved.
  - Avoid intercourse until the infection has been resolved.

- **Show and discuss slide:** *Vacuum aspiration with complications: Genital injury*
  - Spermicides and female barrier methods may be restricted.
  - Provider must decide whether her condition rules out a particular method.

- **Show and discuss slide:** *Vacuum aspiration with complications: Excessive blood loss*
  - Delay sterilization if the woman is too anemic.

- **Show and discuss slide:** *Supply EC pills*

Ask:

Why is it particularly important to offer EC in advance?

- It can be used as a back-up method in case of contraceptive failure (for example, condom breakage).
- It can be used after unprotected sex or when sex is non-consensual.

4) Special considerations for refugee and displaced women

Explain:

Refugee and displaced women may be dealing with many different emotional stresses related to safety and personal security issues: institutional, societal, and personal violence; displacement from family, culture, and home; lack of food; lack of access to comprehensive medical care; and insecurity about the future.

Many women may have survived violence during the initial period of displacement, while many others continue to experience violence in their present location. It is important when counseling refugee and displaced women to let them guide the counseling process. The provider must be sensitive to language differences between the provider and the woman, and have a native speaker of the woman's language translate if possible.

Ask:

Ask articipants to brainstorm some of the complexities that might be encountered while providing contraceptive counseling to women in crisis settings.

- **Show and discuss slide:** *Contraceptive methods: Special considerations*
  - High levels of sexual violence
  - Possible limited contraceptive mix
  - Increased risk of exposure to STIs/HIV
  - Adolescent girls among the most vulnerable
  - Importance of EC

Discuss the following points:

- High levels of sexual violence, including sexual coercion for food, protection, and shelter; disruption in medical and contraceptive services; and the general uncertainty of refugee life, place refugee women at an increased risk for unprotected sex and unwanted pregnancy.
- Medical settings for refugees or displaced persons may not have the full range of contraceptive supplies; providing counseling based on the methods available is most beneficial.
- In situations where flight from war, migratory population movement, repatriation, or relocation is imminent, counselors are advised to develop a protocol that addresses the long-term needs of contraceptive clients. The provider and patient can discuss the benefits and drawbacks of each method according to the woman's individual preferences and situation.

- Poverty, high population density, and limited medical provision can all contribute to the increased risk of exposure to STIs and HIV. Population migration, increased violence, and military troop movements combine with these factors to create a high risk of exposure to STIs and HIV for refugee and displaced women. Counseling around patients' needs for barrier methods is important.
- Adolescent girls are among the most vulnerable in refugee or displaced settings; every effort should be made to provide adolescents with contraceptive information and methods.
- Counselors should be aware of EC provision in the refugee or displaced setting and counsel women on the availability of EC pills, directions for use, and provision of supplies; a protocol should be developed to provide these pills in advance, where possible.

5) Other special considerations

Explain and ask:

Now we will discuss special contraceptive counseling considerations. There are certain specialized considerations providers should keep in mind when providing contraceptive counseling. Ask participants to review the information provided in their handout *Special Contraceptive Counseling Considerations* for information on how providers can meet the specific contraceptive needs of women in these circumstances. Ask a participant to read the following short case studies aloud. Discuss each one at a time.

Note to Trainer: The cases below cover three of the special populations listed in the handout. You could develop other case studies to substitute or add to those below depending which special considerations are most often seen in the local settings.

➪ **Show and discuss slide:** *Case study 1: Violence*

A 22-year-old married mother of one discloses that she is frequently beaten by her husband. The last beating occurred while she was pregnant, and she came to the facility with a lot of vaginal bleeding and cramping. She is afraid to discuss contraception for child spacing with her husband.

Ask:

What are the special contraceptive counseling considerations for this woman?

- If the woman cannot control the circumstances of her sexual activity, advise her about methods that do not require partner participation, such as injectables, implants, IUDs, and EC.
- If the violence is a result of her contraceptive use, she may consider a method that cannot be detected by others, such as an IUD, implant, or injectable.
- Advise her on how to access and use EC.
- It may be beneficial to provide EC pills in advance.
- Offer referrals for women experiencing violence.

➪ **Show and discuss slide:** *Case study 2: HIV*

A 28-year-old mother of two comes into the clinic extremely sick and learns that she is HIV-positive. Her only sexual partner has been her husband. She wants to prevent another pregnancy until she receives treatment for HIV and is feeling better.

Ask:

What are special contraceptive counseling considerations for this woman?

- Ensure that she has correct information on HIV and how to care for her health and slow the effects of the disease.
- Discuss how contraception may interact with medications for HIV and which methods may be better for her.
- Oral contraceptive pills can interact with some antiretroviral drugs, resulting in a decrease in the effectiveness of her contraception.
- Depot medroxyprogesterone acetate (DMPA) may be used with antiretrovirals without reduced efficacy.
- Women who are stable on antiretrovirals may be eligible for an IUD.
- Women who are on antiretroviral medications with oral contraception should be encouraged to use condoms to prevent HIV transmission and compensate for any reduced effectiveness of the oral contraception.

Show and discuss slide: *Condoms for both females and males*

Ask:

What does dual-method use mean?

- Using male or female condoms to prevent STIs/HIV with another contraceptive method to prevent pregnancy, or using condoms to prevent both pregnancy and disease, with EC as a back-up method.

Show and discuss slide: *Case Study 3: Young Women*

A 16-year-old woman is sexually active with her boyfriend. They use withdrawal because she doesn't feel comfortable asking him to use condoms. She wants to use something more effective but is afraid her family might be upset if they see her taking birth control pills. She has tried to get injectables in the past, but has been denied by a nurse at the health center because she isn't married.

Ask:

What are special contraceptive counseling considerations for this woman?

- Learn what her privacy needs are and identify the barriers she may face in using different contraceptive methods, to help her choose the most appropriate option for her.
- Some young women may want to become pregnant immediately and do not require contraception. As with all women, ask what her immediate and longer-term reproductive plan is.
- Include basic information on her menstrual cycle, fertility, and how pregnancy occurs and is prevented, if needed.
- Fully explain how any contraceptive she is interested in works, including efficacy, potential side effects, and long-term clinical implications of any side effects, to allay fears about contraceptives causing illness or future permanent infertility.
- Offer to have her leave the facility with at least one dose of EC, in addition to her contraceptive method of choice.
- Clinical eligibility guidelines are the same as for adult women.
- Young women are more likely to experience regret after sterilization.
- Methods that don't require a daily regimen may be more effective for some young women, and LARC – such as IUDs and implants – has been found to be more effective and young women report higher satisfaction with LARC than pills in preventing future pregnancies.
- An IUD would have particular benefits for her because it would not be obvious to her family (no scar).
- For all LARC there are no resupply concerns and there is no chance of improper use on her part.

6) Managing complications

Explain:

This module addresses complications that may occur before, during, or after vacuum aspiration. Pain management is an essential part of managing complications.

- **Show and discuss slide:** *Abortion is a safe procedure*

  "When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure." – WHO, 2012

Explain:

As long as effective methods are used, abortion is usually safe. However, even in the most skilled hands, procedural complications can occur.

- **Show and discuss slide:** *Types of complications*
  - Presenting
  - Procedural
  - Pregnancy-related

Ensure that the following information is covered:

- Complications may develop individually or several at the same time.
- Presenting complications are those that a woman has prior to the uterine evacuation procedure.
- Procedural complications can occur during the provision of uterine evacuation, during the recovery period, or late, though they are rare when uterine evacuation is performed using effective methods.
- Pregnancy-related or gynecological complications may require specific clinical consideration and management.
- Pregnancy-related conditions may be discovered during the clinical assessment or may not become evident until during or after the uterine evacuation.
- Most women who present for postabortion care are stable and need routine management, but some may present in distress and need urgent treatment.

- **Show and discuss slide:** *Frequency of adverse events*

Adverse events	Frequency
Any adverse event after first-trimester vacuum aspiration procedure	<1%
Serious adverse event after first-trimester vacuum aspiration procedure	<0.1%

Explain:

Discuss the chart, noting that complications do occur, but they are rare. These numbers come from a large case series in experienced facilities, so complication rates may be higher in facilities with less experienced providers or a lower case volume.

- Any adverse event after first-trimester vacuum aspiration is less than one percent (8.46/1000).
- Serious adverse events after first-trimester vacuum aspiration are less than 0.1 percent (0.71/1000).

- **Show and discuss slide:** *Frequency of death*
  - First trimester vacuum aspiration procedure – 1/1,000,000 (0.0001%)

Discuss, noting that the frequency of death is very low.

- **Show and discuss slide:** *Assessment and management of complications*

  The provider needs to:
  - Do a rapid initial assessment and management of shock if the woman is presenting for postabortion care.
  - Continually assess the woman for complications.
  - Manage complications by providing pain management, then treating immediately or stabilizing and referring.

Explain:

Several types of complications may infrequently occur with vacuum aspiration. These include: incomplete abortion, infection, continuing pregnancy, hemorrhage, cervical, uterine or abdominal injuries, and ectopic pregnancy. We will first discuss these procedural and pregnancy-related complications and then discuss presenting complications later.

- **Show and discuss slide:** *Signs and symptoms of incomplete abortion: Immediate*
  - Heavy vaginal bleeding
  - Less tissue than expected
  - Sometimes severe abdominal pain

- **Show and discuss slide:** *Signs and symptoms of incomplete abortion: Delayed*
  - Uterine tenderness
  - Fever, pain, infection
  - Elevated white blood cell count

- **Show and discuss slide:** *Causes of these signs and symptoms*
  - Retained pregnancy tissue after uterine evacuation
  - Uterine infection (endometritis), especially likely if reproductive tract infection present

- **Show and discuss slide:** *Treatment of incomplete abortion*
  - Usually treat with vacuum aspiration.
  - May use misoprostol or expectant management with close monitoring.
  - If the woman has heavy bleeding or signs and symptoms of infection, use immediate vacuum aspiration.

Explain:

Treatment of incomplete abortion is usually vacuum aspiration, whether the initial uterine evacuation method was vacuum aspiration or medical methods. Another possible complication of vacuum aspiration or medical methods is infection.

- **Show and discuss slide:** *Signs and symptoms of uterine infection*
  - Lower pelvic or abdominal pain
  - Bleeding
  - Fever and chills
  - Uterine or lower abdominal tenderness on exam
  - Cervical motion tenderness

Ask:

If a woman has signs of infection, what should the provider do?

- Establish antibiotic coverage.
- Perform/re-perform vacuum aspiration for retained tissue, if indicated.

Explain and ask:

The next complication we'll discuss is continuing pregnancy. This is rare after uterine evacuation with vacuum aspiration when performed by a trained provider. If any of you has seen a woman experiencing a continuing pregnancy, please tell us about her signs and symptoms.

- **Show and discuss slide:** *Signs and symptoms of continuing pregnancy*
  - On vacuum aspiration, smaller amount of POC than expected
  - Persistent pregnancy symptoms
  - Less vaginal bleeding than expected
  - Uterine size increasing after uterine evacuation

Ask:

Describe the cause of these signs and symptoms.

- **Show and discuss slide:** *Continuing pregnancy*
  - Also known as "failed abortion."
  - Pregnancy continues due to:
    - Ineffective uterine evacuation
    - Failure to evacuate gestational sac
    - Extrauterine pregnancy
  - Early gestational age (less than six weeks), operator inexperience, and uterine anomalies may make it more difficult to evacuate gestational sac using vacuum aspiration.

Explain:

Examining the aspirate immediately after uterine evacuation can decrease the risk of failed vacuum aspiration. Vacuum aspiration is the recommended treatment for continuing pregnancy.

- **Show and discuss slide:** *Hemorrhage*
  - Rare after a safe abortion
  - May occur because of an incomplete abortion, infection, or uterine atony

Explain:

Uterine atony is one cause of hemorrhage.

- **Show and discuss slide:** *Signs and symptoms of uterine atony*
  - Copious vaginal bleeding
  - Large, boggy, softened uterus

- **Show and discuss slide:** *Factors contributing to uterine atony*
  - Uterus loses muscle tone, cannot stop bleeding
  - More common in multiparous and later pregnancies

Ask:

What are some methods for managing hemorrhage?

- Vacuum aspiration
- Fluid and blood replacement and oxygen administration
- Uterotonics or intrauterine tamponade may also be used
- When uterine atony is the cause of hemorrhage, bimanual uterine massage may be effective

- **Show and discuss slide:** *Steps for management of hemorrhage*
  - Conduct bimanual massage
  - Give uterotonics therapies
  - Proceed with uterine aspiration
  - Perform intrauterine tamponade
  - Perform hysterectomy if bleeding cannot be stopped by other measures

Explain:

Management should be done step by step to control bleeding. Providers should move quickly to the next step if bleeding is not controlled. Hysterectomy should be done only as a last resort.

- **Show and discuss slide:** *Uterotonics for bleeding or stabilization*

  After uterine aspiration:
  - Methylergonovine 0.2mg intramuscularly or intracervically, not for women with hypertension
  - Misoprostol 200-800mcg orally, rectally, or sublingually
  - Oxytocin 20 units in 1L IV at a rate of 60 drops per minute
  - Intrauterine tamponade

Explain:

These therapies may be given for bleeding or to stabilize a patient for transfer after vacuum aspiration or postpartum hemorrhage.

- **Show and discuss slide:** *Signs and symptoms of cervical, uterine, or abdominal injury*

  During procedure:
  - Excessive vaginal bleeding
  - Sudden excessive pain
  - Instrument passes further than expected
  - Aspirator vacuum decreases
  - Fat or bowel in aspirate

- **Show and discuss slide:** *Signs and symptoms of cervical, uterine, or abdominal injury (cont.)*

  Post-procedure:
  - Persistent abdominal pain
  - Rapid heart rate
  - Falling blood pressure
  - Pelvic tenderness
  - Fever, elevated white blood cell count

Explain:
Cervical, uterine, or abdominal injuries may occur during vacuum aspiration procedures, although they are rare.

- **Show and discuss slide:** *Causes of cervical, uterine, and abdominal injury*
  - Minor cervical lacerations from tenaculum or dilator, or anything inserted in the vagina during an unsafe abortion.
  - Uterine perforation caused by:
    - Excessive force used to dilate (such as with stenotic cervix)
    - Unusual uterine position (for example, very retroverted)
    - Actual uterine size different than expected

- **Show and discuss slide:** *Management of cervical or vaginal laceration*
  - Ensure adequate pain control and proper positioning and lighting.
  - Apply antiseptic solution to the cervix and vagina.
  - Check for more than one laceration.
  - Stop the bleeding by:
    - Clamping a ring forceps over the tear
    - Applying silver nitrate, or
    - Suturing with continuous absorbable suture
  - Repair with laparotomy any deep tears or sutured lacerations that continue bleeding.
  - Vaginal packing may be used for emergent treatment of bleeding.

- **Show and discuss slide:** *Management of uterine perforation*

  If:
  - Perforation occurred during aspiration
  - Woman is stable
  - No other signs of intra-abdominal injury, and
  - Evacuation is complete

  Then you may admit her and closely observe for signs and symptoms of intra-abdominal injury or hemorrhage.

Explain:
This is appropriate only if the perforation occurred during the uterine aspiration and the provider feels confident that there were no other injuries.

- **Show and discuss slide:** *Management of uterine perforation (cont.)*

  If the woman is unstable or has signs of intra-abdominal injury:
  - Shock management as indicated
  - Laparotomy or laparoscopy to diagnose and manage, or
  - Stabilize and transfer her

  If evacuation is not complete:
  - Complete evacuation with laparotomy or laparoscopy and repair any damage, then inspect abdominal cavity carefully for injuries

  OR
  - If laparotomy/laparoscopy is not available, prepare for transfer to a higher-level facility.

Explain:
If the uterus or cervix is beyond repair or bleeding cannot be controlled, a hysterectomy may be necessary. Hematometra is another complication of vacuum aspiration. It refers to the accumulation of blood clots in the uterine cavity.

- **Show and discuss slide:** *Signs and symptoms of hematometra*
  - Enlarged, firm, tender uterus
  - Pelvic pressure
  - Intense cramps and pain
  - Lightheadedness
  - Mild fever
  - Scant vaginal bleeding

Explain:
Re-evacuation with vacuum aspiration will usually resolve the condition. Now we're going to discuss vasovagal reaction.

- **Show and discuss slide:** *Signs and symptoms of a vasovagal reaction*
  - Fainting, loss of consciousness
  - Cold or damp skin
  - Dizziness
  - Nausea
  - Moderate drop in blood pressure, pulse

Explain:
Explain that fainting can occasionally occur during vacuum aspiration.
- This is a vagal reaction to stimulation during the procedure.
- Typically it lasts about 10 seconds and does not require intervention.

- **Show and discuss slide:** *Cause of vasovagal reactions*
  - Result of vagal nerve stimulation during vacuum aspiration.
  - Explain that a vagal reaction is not a true complication, but rather a side effect.
  - Point out that it can be very distressing when a woman experiences a vagal reaction if the staff are not aware of what is going on.

Ask:
How is a vasovagal reaction treated?
- Most symptoms pass quickly as the woman regains consciousness and no further treatment is necessary.
- Occasionally, smelling salts will be needed to revive the woman.
- In very rare cases, atropine injection will be necessary if the reaction is prolonged.

Note to Trainer: Many participants may be confused about vagal reaction and may mistake it for a more serious condition. Ensure that participants understand that a vagal reaction is not shock and is usually self-limiting without requiring intervention. Vagal reaction may occur with IV insertion, intramuscular injection, vacuum aspiration or the sight of blood. It is fainting and is self-limited rather than a seizure that might require intervention.

Explain:
Let's now discuss undiagnosed ectopic pregnancy. Again, this is not a complication of the uterine evacuation, but rather a condition that was in place before it. Women should be screened for ectopic pregnancy before uterine evacuation with medical methods or vacuum aspiration, but sometimes it is not detected. How does ectopic pregnancy complicate abortion-related care?

- **Show and discuss slide:** *Ectopic pregnancy*
  - Is usually detected during clinical assessment.
  - Can go undiagnosed, even after uterine evacuation with medical methods, as POC not examined.
  - Medications used in uterine evacuation with medical methods will not treat an ectopic pregnancy.
  - Is a life-threatening condition – refer or treat immediately.

- **Show and discuss slide:** *Possible signs and symptoms of ectopic pregnancy*
  - After vacuum aspiration: no villi or decidua are seen when POC are examined.
  - Sudden, intense, and persistent lower abdominal pain or cramping, sometimes with:
    - Irregular vaginal bleeding or spotting
    - Palpable adnexal mass
  - Fainting, shoulder pain, rapid heartbeat, or lightheadedness (from internal bleeding). Internal bleeding is not necessarily accompanied by vaginal bleeding.

Explain:
A ruptured ectopic pregnancy is a gynecologic emergency that can be life threatening and requires immediate surgical intervention. A woman with a suspected ectopic pregnancy should be treated or transferred as soon as possible to a facility that can confirm diagnosis and begin treatment.

We will now review severe presenting complications that occur before uterine evacuation. When a woman presents for postabortion care, it is essential to assess her health and condition immediately. Pain management is an essential part of management of complications.

Ask:
Do the majority of women presenting for postabortion care require emergency treatment? What signs and symptoms are they most likely to have? What treatment is required in this case?

- Ensure that participants understand that, most women have light to moderate bleeding and no complications, and uterine evacuation may be the only treatment required.

What are the causes of the complications that women may present with in postabortion care?

- **Show and discuss slide:** *Causes of complications in postabortion care*
  - Injury from an abortion procedure
  - Incomplete uterine evacuation
  - Infection

Ask:
How should informed consent be handled if the woman needs emergency care?

- Ensure that responses include: when a woman presents with a life threatening emergency, complete clinical

assessment and voluntary informed consent may be deferred until actions have been taken to save the woman's life.

What is the first step in providing care to a woman presenting for postabortion care?

- Ensure that responses include: perform a rapid initial assessment and obtain voluntary informed consent, if possible.
- Note that a clinical assessment should be done as the provider begins to treat the complications.

With which severe complications may women present?

- **Show and discuss slide:** *Possible presenting severe complications*
  - Shock
  - Hemorrhage
  - Sepsis
  - Intra-abdominal injury

Explain:
Shock can develop in any patient at any time during postabortion care and requires immediate action.

7) Rapid initial assessment and management of shock

Ask:
What is usually a key part of treatment for women presenting with signs and symptoms of pelvic infection, sepsis or hemorrhage due to incomplete abortion?

- Prompt uterine evacuation, usually with vacuum aspiration.

Explain:
Recognizing shock is the first step in providing care to a woman who has told you or who you believe requires postabortion care. Although most women presenting for postabortion care are ambulatory and do not need emergency treatment, some require emergency care and shock must be addressed immediately. To check for shock, use your ABCs.

- **Show and discuss slide:** *The "ABC" signs*
  Any member of the facility staff can quickly check:
  - **A**irway
  - **B**reathing
  - **C**irculation
  - **C**onsciousness
  - **C**onvulsions (whether she's having them) to identify if she needs urgent care.

Ask:
Ask participants to identify some signs of shock. Take a few answers and then show slide.

- **Show and discuss slide:** *Signs of shock*
  - Low blood pressure (SBP < 90mm HG)
  - Fast pulse
  - Pallor or cold extremities

- Decreased capillary refill
- Dizziness or inability to stand
- Low urine output (< 30mL per hour)
- Difficulty breathing
- Impaired consciousness, lethargy, agitation, confusion

Explain and ask:
Shock can develop at any time during postabortion care, especially if underlying injuries were not detected during the initial assessment. Once shock is stabilized, it will be necessary to determine the underlying cause. Shock in postabortion care patients is usually either hemorrhagic or septic. How do you stabilize for shock?

Note to Trainers: This is not covered in depth in this material. Participants may be relying on other clinical training for these responses.

Answers should include:
- Ensure that the airway is open
- Elevate the legs
- Give oxygen
- Give rapid bolus crystalloid (lactated ringers [LR] or normal saline [NS])
- Give second liter if vital signs remain abnormal
- Transfuse if vital signs remain unstable
- Keep warm
- Place urinary catheter
- Monitor fluid intake and output, including ongoing blood loss
- Get laboratory tests, including blood type and crossmatch, hematocrit and hemoglobin, blood cultures and chemistry tests, if available
- Monitor and record vital signs every 15 minutes
- Prepare for an emergency transfer if the woman cannot be treated in the facility

Show and discuss slide: *Stabilization for shock*
- Ensure that the airway is open – turn the head to the side to prevent aspiration.
- Elevate the legs to increase return of blood to the heart.
- Give oxygen – five L/minute by mask or nasal cannula.
- Give rapid bolus crystalloid (LR or NS) by one or two large bore IVs, reassess after one liter.
- Give a second liter if vital signs remain abnormal.
- Transfuse if vital signs remain unstable after two liters of IV fluid.

Show and discuss slide: *Stabilization for shock (cont.)*
- Keep the woman warm.
- Place a urinary catheter.
- Monitor fluid intake and output, including ongoing blood loss.
- Get laboratory tests – blood type and cross match, hematocrit and hemoglobin, blood cultures, and chemistry tests, if available.
- Monitor and record vital signs every 15 minutes.
- Prepare for an emergency transfer if the woman cannot be treated in the facility.

8) Secondary assessment for underlying causes of shock

Explain:

Once shock is stabilized, identify and treat the underlying cause immediately. In order to determine the underlying cause of shock, and identify other complications, the provider must now do a more complete, but urgent clinical assessment.

- **Show and discuss slide:** *Assessing the underlying cause*

  Take history:
  - From the woman if she is conscious, otherwise from anyone accompanying her.
  - If possible determine: gestational age and type of abortion procedure.

  Perform a physical exam: vital signs, heart, lung, abdominal, and pelvic exam
  - Abdominal distension, rigidity, guarding, and rebound
  - Sources of bleeding during speculum exam
  - Size and consistency of uterus, cervical motion tenderness, and uterine tenderness during bimanual exam

- **Show and discuss slide:** *Physical exam considerations*
  - Pelvic exam
    - Good positioning and lighting to identify and treat bleeding
    - Any instruments or anesthetics that may be needed are prepared and available
  - Pain medication for women who are uncomfortable or may need a procedure
  - Speculum exam
    - Repair any lacerations during the exam
    - Inspect cervical os and remove any visible products of conception with ring forceps

Ask:

What are the usual causes of shock in postabortion care patients?

- Take two or three answers.
- Ensure that participants know that hemorrhage and infection/sepsis are the usual causes of shock in postabortion care patients.

- **Show and discuss slide:** *Hemorrhagic shock*

  Hemorrhagic shock is the result of severe blood loss, caused by:
  - Incomplete abortion
  - Uterine atony, or
  - Laceration and/or perforation (intra-abdominal injury)

Explain:

We have already covered the management steps for shock and these specific causes. Review those steps as needed. Now we're going to look at sepsis.

- **Show and discuss slide:** *Septic shock*

  Septic shock is the end result of infection, caused by:
  - Incomplete abortion
  - Intra-uterine infection, or
  - Intra-abdominal injury

Explain:
Infection may occur after a uterine evacuation procedure if the abortion was incomplete, infection prevention was not followed, or if the woman had a pelvic infection at the time of uterine evacuation. Intrauterine infection (also called endometritis) can become a more generalized infection (sepsis or septic shock) if it is untreated. A woman with sepsis should be hospitalized. First, let's review the signs and symptoms of an intrauterine infection.

- **Show and discuss slide:** *Signs and symptoms of intrauterine infection (endometritis)*
  - Lower pelvic or abdominal pain
  - Fever and chills
  - Uterine or lower abdominal tenderness on bimanual exam
  - Cervical motion tenderness
  - Unusual or bad smelling vaginal or cervical discharge

- **Show and discuss slide:** *Diagnosis of sepsis*
  Suspected infection plus:
  - Hypotension (SBP <90mmHg) plus
  - One or more of the following:
    - Pulse >100 per minute
    - Respiratory rate >24 breaths per minute
    - Abnormal temperature (<36°C or >38°C)

- **Show and discuss slide:** *Management of sepsis*
  - Shock management as indicated
  - Broad-spectrum IV or IM antibiotics until afebrile for 48 hours
  - Then oral antibiotics for a total of at least seven days of treatment
  - Tetanus toxoid and tetanus antitoxin if there was an unsafe abortion and the vaccination history is unknown
  - For incomplete abortion – immediate uterine evacuation
  - For suspected intra-abdominal injury – laparotomy with injury repair
  - For women not responding to treatment – hysterectomy may be necessary

Explain and ask:
The recommended broad-spectrum antibiotics are Ampicillin 2g IV every six hours, plus either gentamicin 5mg/kg body weight IV every 24 hours or metronidazole 500mg IV every eight hours.

Refer participants to the handouts: *Management of Complications (CAC) Skills Checklist* and *Management of Complications (PAC) Skills Checklist* (available on the IAWG website and Flash Drive). Ask if participants have any questions about management of complications.

Unit 7: Service Delivery

Time
30 minutes

Objectives
By the end of this unit, participants should be able to:
- Describe monitoring and its importance in improving abortion-related services.
- Identify characteristics of effective monitoring systems.
- Describe indicators, information sources, and methods of gathering information.
- Describe the general steps for establishing a monitoring system for abortion-related services.
- Understand and contribute towards a work plan to ensure supply and resupply of instruments and related supplies, sustainability of MVA services, and ongoing training/mentoring needs.

Advance Preparation
- Label flipchart: "Monitoring."
- Be familiar with any monitoring practices in the participants' facilities.
- Be prepared with examples of monitoring for abortion-related service.
- Make copies for each participant of the *Monitoring Scenario* and *Monitoring Abortion-Related Services worksheet*, and *Handout: Examples of abortion services monitoring.*

Materials
- Flip chart paper
- Handouts, one copy of each per participant

Instructions

Note to Trainer:
- Content and methods for this unit will vary depending on the setting and stage of the monitoring/sustainability plan.
- Prior to teaching this unit, the trainer should assess how the quality of patient care is monitored and what (if any) data systems are in place.
- Trainers should work with site leaders to establish a written monitoring work plan and a sustainability work plan.

The monitoring plan should monitor the quality of care for uterine evacuation. The sustainability plan should provide instructions on how to integrate MVA services in the crisis setting, ensure sustainability, and support ongoing training, mentoring, and facilitated supervision, if necessary.

Some settings will have just started to create a monitoring/sustainability plan, and the focus will be on getting provider input at the training. In other cases, a plan may already be in effect and should be reviewed. It may be beneficial to get provider input/feedback to highlight any areas of the plan that need improvement. If the site has just created its first written plan, the training is a great opportunity to introduce it to staff.

Go through the overview of monitoring plans below using the handout: *Monitoring Abortion-Related Services* (available on the IAWG website and Flash Drive). Walk participants through the written plan if one was drafted prior to the training. The information that participants provide on their worksheets can be collected to either begin or help improve the plan. This may also be a good time to review their role in monitoring services at their site and to go over any forms or procedures. **Training time should be adjusted to meet the needs of each site**.

Begin by reviewing where this particular site is in the process of creating a monitoring/sustainability plan. In all crisis settings that provide uterine evacuation services with MVA, it is important to have a plan in place that all health care providers and staff support, actively engage with, and continuously revisit for improvements.

- **Show and discuss slide:** *Elements of a monitoring/sustainability plan for uterine evacuation services in crisis settings*
  - Monitor the quality of uterine evacuation services on site.
  - Ensure the sustainability of uterine evacuation services.
  - Ensure the sustainability of on-site postabortion contraception services.
  - Ensure the supply and resupply of instruments and related supplies.
  - Ensure the sustainability of MVA services.
  - Meet ongoing training/mentoring needs.

Note to Trainer: It may be helpful to post a piece of flipchart paper with these six elements for participants to refer to throughout this unit.

Ask:
I'd like to ask each of you what you think of when you hear the word "monitoring." What words or phrases come into your mind when you hear "monitoring?"

- **Show and discuss slide:** *What is monitoring?*
  Monitoring is:
  - Examining all aspects of care, including client satisfaction.
  - Tracking services over time to identify strengths and weaknesses.
  - Using data to provide feedback and make adjustments to improve quality.
  - An ongoing process.

- **Show and discuss slide:** *Why is monitoring important?*
  - Indicates if services are effective or need improvement.
  - Provides information that impacts service delivery and policies.
  - Improves services for clients and workers.
  - Assesses if changes achieve desired effects.
  - Keeps abortion-related services operating at a high standard.

Explain:
Monitoring can range from simple and inexpensive to more complex, formalized approaches. A simple approach may be for providers to monitor a few of their own service delivery indicators, while more formalized approaches usually involve assessment and monitoring across a wide range of service delivery components. One of the more formal monitoring approaches is COPE® for Comprehensive Abortion Care (CAC), which is an ongoing quality

improvement process and set of tools used by health care staff to proactively and continuously assess and improve the quality of CAC they provide. There are many other effective approaches as well.

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

- **Show and discuss slide:** *Why is monitoring especially important in crisis settings?*
  - High staff turnover can affect the quality of services provided.
  - Women may not return for continuous health care services unless they had a positive experience.
  - There may not be other health care options available, so ensuring high quality services is critical.

- **Show and discuss slide:** *Effective monitoring*
  - Is integrated into routine work.
  - Uses simple indicators.
  - Is participatory and open.
  - Is conducted ethically.
  - Is not punitive.
  - Includes recipients of the services, including young women, in the entire process.

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

- **Show and discuss slide:** *Monitoring is a continuous process*

Ask:
What information are you currently collecting about your services that could be used for monitoring? Take two responses. Ask participants for examples of how they currently monitor services in their facility. Examples may include:

- Gathering information from log books.
- Reviewing medical records.
- Assessing inventory of supplies and equipment.
- Talking with clients.

Explain:
Compiling and assessing this information helps to determine where services are effective and where they need improvement. Point out that monitoring is a critical component of high-quality service delivery.

- **Show and discuss slide:** *Monitoring includes all health care staff*

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

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

- Planning
- Information gathering

- Analysis
- Action planning

Distribute the *Monitoring Abortion-Related Services* worksheet.

Explain:
Each step for effective monitoring will be discussed. Tell participants to think about the considerations in the worksheet as each step listed below is discussed:

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

➪ **Show and discuss slide:** *Planning*

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

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

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

Ask:
In the *Monitoring Scenario* we read earlier, which planning steps did the clinic director and committee take?

- They formed a committee.
- They appointed a person to collect information.
- They determined information sources.
- They informed staff and clients; invited suggestions.

Ask participants to complete the first row of the *Monitoring Abortion-Related Services* worksheet on the planning step, specifying who to involve, specific considerations, potential challenges, and solutions to challenges in their own settings. In planning a monitoring system, it is important to consider specific indicators to measure progress.

➪ **Show and discuss slide:** *Indicators*

- Are measurements that help quantify activities and results.
- Can help describe overall quality.

Examples:

- Number and type of procedures performed
- Number and type of complications

- Percentage of women desiring contraception who receive methods
- Number of women served by age

Explain:
It is important to pick indicators that are actually under staff control; otherwise the process can be very demotivating. Refer participants to the additional indicators listed in the handout: *Examples of Abortion Services Monitoring.*

➺ **Show and discuss slide:** *Information gathering*

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

Ask:
In the monitoring scenario, which information-gathering steps did the monitoring committee take?

- They reviewed the clinic logbooks monthly.
- They reviewed a sample of medical charts quarterly.
- They put a suggestion box in the clinic for employees and clients.

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

Note to Trainer: Hold up the *MVA Skills Checklist* from the MVA refresher module or a different checklist from another module as an example.

Give participants time to complete the "Information Gathering" row on the *Monitoring Abortion-Related Services Worksheet.*

➺ **Show and discuss slide:** *Analysis*

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

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

Ask:
In the *Monitoring Scenario*, which analysis steps did the monitoring committee take?

Responses should include:
The committee:
- Compiled information from the logbook, chart review, and suggestion box.
- Discussed what the information meant.
- Determined strong and weak aspects of services.

Give participants time to complete the "Analysis" row on the *Monitoring Abortion-Related Services Worksheet*.

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

- **Show and discuss slide:** *Action planning (cont.)*
  - Discuss the plan with staff and community members who may help to implement.
  - Present findings and proposed solutions to staff and get feedback.
  - Share positive findings and improvements with staff and the community, when appropriate.
  - Recognize staff who have helped improve services.

- **Show and discuss slide:** *Possible solutions*
  - On-the-job training
  - Reorganization of services
  - Changes to hours of operation
  - Changes to supplies procurement
  - Strengthened referral systems

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

Give participants time to complete the "Action Planning" row on their *Monitoring Abortion-Related Services Worksheet*. Invite participants to use the *Monitoring Abortion-Related Services Worksheet* as a starting place for implementing or improving a monitoring system at their facilities.

Note to Trainer: Ensure that a designated person knows how to contact a local MVA distributor and how to use the www.mvacalculator.org to calculate how many and how often to order supplies based on caseload. Crisis settings are unique in that the population may not remain steady and large groups may move into the community without much notice.

Closing

Unit 8: Evaluation and Closing

Time
1 hour

Objectives
By the end of this unit, participants should be able to:
- Explain how the training met their expectations and course objectives.

Advance Preparation
Make copies of all handouts and fill out participants' names on certificates of completion.

Materials
- Flip chart paper
- Handout: *Course Evaluation*, one per participant
- Handout: *Knowledge post-test*, one per participant
- Certificates of completion, one per participant

Instructions

1) Review course objectives and revisit participant expectations

➸ **Show and discuss slide:** *Course Objectives*

Go through all objectives, reminding participants of activities and methods used to increase knowledge, build skills, and change or strengthen attitudes. Revisit the flip chart paper with the participant expectations listed. Ensure that all expectations have been addressed.

2) Process evaluation

Thank participants for their attention and participation in the refresher course. Conduct a short process evaluation for how the last day of the training went. Refer to the trainer handout: *Daily Evaluation* (available on the IAWG website and Flash Drive).

Note to Trainer: As an optional activity, draw a line down the center of a piece of flip chart paper. Write a (+) on the left and a (–) on the right side. Ask participants what went well today or about the training-related elements for which they are thankful. Record responses on the (+) side. Ask participants what could have been done better or things they would like to see improved. Record responses on the (–) side.

Distribute handout: *Course Evaluation* (available on the IAWG website and Flash Drive). Ask participants to take 10 minutes to fill it out and provide feedback on which areas of the overall training went well and which would benefit from changes or improvement.

3) Post-test

Distribute the *Post-test* (available on the IAWG website and Flash Drive), which covers content from the entire refresher ourse. Ask participants to take 15 minutes to fill it out. Explain that the post-test will help assess their increase in knowledge in key content areas. The results, along with their participation and skills practice with the pelvic models, will help assess their readiness to provide uterine evacuation using MVA with live patients.

4) Closing ceremony

Present each participant with prepared certificates of completion (available on the IAWG website and Flash Drive) and shake their hand.

Master List of Handouts/Resources
(available on the IAWG website and Flash Drive)

1. Ipas Woman-Centered, Comprehensive Abortion Care Trainer's Manual (2nd ed.)
2. Ipas Woman-Centered, Comprehensive Abortion Care Reference Manual (2nd ed.)
3. MVA Refresher Course PowerPoint Presentation
4. Sample Refresher Course Agenda
5. Course Objectives
6. Knowledge Pre-test
7. Comfort Continuum Statements
8. Uterine Evacuation Treatment Options Charts
9. Advantages/Disadvantages of Medical Intervention Versus Vacuum Aspiration Chart
10. Training tips for using pelvic models in manual vacuum aspiration (MVA) clinical training
11. Tips for Using the Ipas MVA Plus
12. Processing the Ipas Instruments Video
13. Instrument Processing Skills Checklist
14. Manual Vacuum Aspiration Technique Using the Ipas MVA Plus Aspirator and Ipas EasyGrip Cannulae Video
15. Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist
16. Pharmacological Approaches to Pain Management During MVA
17. Pain Management Plan Case Studies Handout
18. Discharge Information Sheet
19. Post Procedure Care Skills Checklist
20. Follow-up Care Skills Checklist
21. Contraceptive Services Skills Checklist
22. Special contraceptive counseling considerations
23. Management of Complications (CAC) Skills Checklist
    a. Management of Complications (PAC) Skills Checklist
24. Monitoring Abortion-Related Services
25. COPE for Comprehensive Abortion Care: A Toolbook to Accompany the COPE Handbook
26. Monitoring Abortion-Related Services Worksheet
27. Examples of Abortion Services Monitoring
28. www.mvacalculator.org
29. Course Evaluation
30. Knowledge Post-test
31. Certificate of Completion

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