UTERINE EVACUATION IN CRISIS SETTINGS USING MEDICATIONS AND MANUAL VACUUM ASPIRATION

PARTICIPANT WORKBOOK

Clinical Outreach Refresher Training Module for Health Care Providers Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises Training Partnership Initiative with Ipas

ACKNOWLEDGEMENTS

This training guide is published in partnership with the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and Ipas. The content has been adapted from Ipas's *Woman-Centered, Comprehensive Abortion Care* manuals and based on IAWG's 2018 *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings*. It is intended to be used by clinical facilitators leading a refresher course for clinicians already familiar with intrauterine procedures including manual vacuum aspiration.

These training materials were developed in 2017 through an ongoing collaboration among IAWG members through the efforts of the Training Partnership Initiative. The project was first made possible thanks to generous funding provided by USAID's Office of Foreign Disaster Assistance (OFDA). In 2020, funding from the Netherlands Ministry of Foreign Affairs allowed for this module to be updated to align with the 2018 revised *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*.

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Disclaimer: *Clinical Updates in Reproductive Health* provides Ipas' 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. Available on the Ipas website, www.ipas.org.

LIST OF ABBREVIATIONS

BP	Blood pressure
CAC	Comprehensive abortion care
D&C	Dilation and curettage
DMPA	Depot medroxyprogesterone acetate
EC	Emergency contraception
ECP	Emergency contraceptive pill
EVA	Electric vacuum aspiration
FIGO	International Federation of Gynecology and Obstetrics
HIV	Human immunodeficiency virus
HLD	High-level disinfection
IARH	Inter-Agency Emergency Reproductive Health (Kit)
IAWG	Inter-Agency Working Group (on Reproductive Health in Crises)
IEC	Information, education, and communication
IM	Intramuscular
IUD	Intrauterine device
IV	Intravenous
LARC	Long-acting reversible contraceptive
LMP	Last menstrual period
LR	Lactated ringers
MISP	Minimum Initial Service Package (for Sexual and Reproductive Health)
MVA	Manual vacuum aspiration or aspirator
NS	Normal saline
NSAIDs	Non-steroidal anti-inflammatory drugs
PAC	Postabortion care
POC	Products of conception
Rh	Rhesus
RTI	Reproductive tract infection
S-CORT	Sexual and reproductive health clinical outreach refresher training
SAC	Safe abortion care
SC	Sharp curettage
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
VCAT	Values clarification and attitude transformation
WHO	World Health Organization

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INTRODUCTION

THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health is a priority set of lifesaving activities to be implemented at the onset of every emergency. The 2018 MISP has six objectives and another priority activity:

1. Ensure the health sector/cluster identifies an organization and a sexual and reproductive health coordinator to lead and coordinate the implementation for the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive sexual and reproductive health services, integrated into primary health care as soon as possible.

Other priority: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Neglecting the MISP for Sexual and Reproductive Health in crisis 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 physicians working in emergencies provide the sexual and reproductive health services needed to achieve the objectives of the MISP. IAWG has designed a series of short clinical outreach refresher trainings (S-CORTs) in order to reinforce previously acquired knowledge and skills of health care staff tasked with providing these priority services. *Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration* is one of these modules. It was designed to be either a stand-alone training in uterine evacuation with medical methods, or to be combined with the module on *Uterine Evacuation in Crisis Settings Using Medications*. When combined, the modules provide a training on both uterine evacuation technologies for the crisis setting. Please visit www.iawg.net/scorts to access all trainings in the series and more information on their use.

UNIVERSAL ACCESS: ENSURING SERVICES THAT ARE FREE OF STIGMA AND DISCRIMINATION

Words matter when describing and caring for individuals who need access to health care information and services and, in particular, the services presented in the S-CORT series. Language can have a significant impact on sexual and reproductive health and wellbeing as well as access to related information and services. At times, the terminology used in guidance, programs, and policies can be discriminatory, stigmatizing, or dehumanizing. Conscious of the tensions that can arise when trying to use inclusive and appropriate language and, at the same time, be concise and efficient, especially in publications, the language used in the S-CORT series was guided by the following considerations:

- **On gender**. Throughout the S-CORT series, the terms "women," "girls," and, at times, the gender-neutral "person," "people," "client," "patient," or "individual" refer to those who use the services presented in the S-CORT. However, the authors recognize and emphasize that:
  - Not only cis-gendered women (women who identify as women and were assigned the female sex at birth) can get pregnant and have rights to quality health care, to be treated with dignity and respect, and to be protected from stigma, discrimination, and violence in all settings. Persons who are trans men/transmasculine, intersex, non-binary, and gender non-conforming can experience pregnancy and face unique barriers to accessing sexual and reproductive health information and services. The S-CORT language strives to reflect this diversity whenever possible but for ease of reference and use, "women" or "women and girls" may be often applied.
  - Sexual violence "survivors" can be women, men, trans, intersex, non-binary, gender non-conforming individuals, and individuals of all ages.
- **On age**.[1] Adolescents—girls, boys, trans, intersex, non-binary, and gender non-conforming—have unique sexual and reproductive health needs and should not be discriminated against in terms of access to sexual and reproductive health information, services, care, and support. Equally important are the sexual and reproductive health needs of older persons. The S-CORT language strives to reflect this age diversity whenever possible, but for ease of reference and use, it often does not use age-specific terminology.
- **On disability**. The sexual and reproductive health needs of persons living with disabilities have been widely neglected. They should not be discriminated against regarding access to sexual and reproductive health information, services, care, and support. While for ease of reference and use disability-specific terminology is not

1. For updated resources and support for organizations supporting adolescents, see the updated IAWG Adolescent *Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings*: 2020 Edition, available at: iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition.

always applied, the S-CORTS were developed using universal design principles to ensure accessibility of these materials. Facilitators and organizations are encouraged to take into consideration the accessibility needs of persons living with disabilities in the communities they serve and in particular the interpretation, mobility, and other accessibility needs of participants in these trainings.

- **On diversity**. All individuals, no matter how diverse their personal, social, cultural, and economic background, have a right to access sexual and reproductive health information, services, care, and support free from stigma, discrimination, and violence. Images and language in this guide have been designed with diversity in mind, however, the S-CORT language is not always able to reflect the rich diversity of individuals who access sexual and reproductive health information, services, care, and support.

S-CORT participants should keep these inclusive considerations of gender, age, disability, and diversity in mind when attending these trainings to further universal access to sexual and reproductive health information, services, care, and support.

WHAT CAN HEALTH STAFF DO?

The use of inclusive, appropriate, and respectful language is a cornerstone of reducing harm and suffering. All terminology requires contextualization to the local language and socio-cultural environment as well as a pragmatic approach, but one that should not sacrifice the promotion and use of stigma-free and all-gender-age-disability-diversity inclusive language. To help mainstream such language, health staff should consider the following principles to guide the way they speak, write, and communicate among themselves and with and about the persons accessing sexual and reproductive health information and services. These principles can help health staff prioritize the use of terminology that adheres to their professional mandate: caring for all people.

- **Engage and ask people and respect their preferences**. As terminology requires adaptation in local languages and cultures, each linguistic and professional community should be engaged in discussing and contextualizing diversity-inclusive terms so that they are acceptable in the circumstances they are to be used. For example, avoid assuming the person's gender ("Miss" or "Mister") and ask instead: "Hello and welcome. My name is B and I am your provider today. Could you please tell me how I should address you?".
- **Use stigma-free, respectful, and accurate language**. Avoid using judgmental terms that are not person-centered. Favor the use of humane and constructive language that promotes respect, dignity, understanding, and positive outlooks (for example, prefer "survivor of sexual violence" to "victim").
- **Prioritize the individual**. It is recommended to place individuals at the center, and their characteristics or medical conditions second in the description (for example, persons living with disability or persons living with HIV). Therefore, the use of person-centered language should be preferred to describe what people have, their characteristics, or the circumstances in which they live, which should not define who they are and how health staff treats them.
- **Cultivate self-awareness**. Professionals working with persons from diverse backgrounds should be conscious of the language they use as it can convey powerful images and meanings. They should develop cultural humility and self-reflection, be mindful, and refrain from repeating negative terms that discriminate, devalue, and perpetuate harmful stereotypes and power imbalances. They should also encourage colleagues, friends, and their community to do so. Values clarification workshops for health (and non-health) staff working with people with diverse backgrounds and characteristics could be transformative in clarifying values and changing attitudes to improve interactions.

OBJECTIVE

This training includes a presentation and activities designed to help health care workers learn the knowledge and skills they need to provide first-trimester uterine evacuation using Ipas MVA Plus® and EasyGrip Cannulae® and uterine evacuation with medications. The pre- and post- tests serve as knowledge assessments. The skills checklists are used to assess participants' performance during role-plays or in a clinical practicum.

Please note that this course focuses on use of medications and manual vacuum aspiration (MVA), rather than comprehensive abortion or postabortion care. For broader training materials on comprehensive abortion care and comprehensive postabortion care, refer to the *Ipas Woman-Centered, Comprehensive Abortion Care Trainer's Manual (2nd ed.)* and other Ipas curricula, available at www.ipas.org.

TRAINING OVERVIEW

Uterine Evacuation in Crisis Settings with Medications and Manual Vacuum Aspiration is a refresher course for clinicians already familiar with intrauterine procedures, including manual vacuum aspiration (MVA), and who meet established pre-requisites regarding reproductive health care knowledge and skills but may or may not be trained in use of mifepristone and/or misoprostol for uterine evacuation. Course components include discussion and activities to promote sustainability for onsite uterine evacuation services. The course also provides ways to address ongoing training needs in crisis settings that have high staff turnover. It is intended for in-person workshops in crisis settings with limited resources.

HOW TO USE THIS WORKBOOK

This workbook is designed to serve as a learning tool during the training session and as a reference guide and job aid for your clinical work post-training. In addition to offering, you a centralized location to keep your notes and plans for providing uterine evacuation services in crisis settings, it also provides contextual information, skills checklists, and recommendations for additional resources. You can access this participant workbook in addition to the presentations, facilitator's guidance, and links to supplemental resources on the IAWG website at www.iawg.net/scorts.

SUPPLEMENTARY MATERIALS FOR THIS TRAINING

In addition to the materials included in this workbook, you may receive the following job-aids and materials from your workshop facilitator, or you can download them at any time from the IAWG website at www.iawg.net/scorts.

- 2018 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*
- *WHO Clinical Practice Handbook for Safe Abortion* "Pregnancy Dating and Labs Resource" (p.17)
- *Ipas Medical Abortion IEC Materials:*
  - *Abortion Pills in First 12 Weeks since Last Period: Mifepristone and Misoprostol in the Cheek*
  - *Abortion Pills in First 12 Weeks since Last Period: Mifepristone and Misoprostol under the Tongue*
  - *Abortion Pills in the First 12 Weeks since Last Period: Misoprostol in the Cheek*
  - *Abortion Pills in the First 12 Weeks since Last Period: Misoprostol under the Tongue*
- *COPE® for Comprehensive Abortion Care Handbook*
- Video: *Processing the Ipas instruments* (Ipas, 2019), 17 minutes

Additionally, in 2022 Ipas released a series of abortion care videos that are helpful for this training. The videos are available here: https://www.ipas.org/resource/abortion-care-videos/#abortion-care-videos-for-health-worker

FEEDBACK ON THE TRAINING MATERIALS

The IAWG Training Partnership Initiative is interested in hearing from you. Please share any questions or feedback to info.iawg@wrcommission.org regarding the training materials and their use in your context.

NOTES:

UNIT 1 COURSE OVERVIEW

At the end of this unit, participants will:

- Become familiar with one another, the course overview, and the course objectives.

COURSE OBJECTIVES

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

1. Explain why uterine evacuation is an essential part of reproductive health services in crisis settings
2. Counsel women seeking abortions in crisis settings
3. Provide uterine evacuation for women in crisis settings using medications and/or manual vacuum aspiration
4. Recognize and manage women who develop complications from uterine evacuation with medications or manual vacuum aspiration
5. Integrate uterine evacuation with medications and manual vacuum aspiration into their present reproductive health services and organize and monitor the services

NOTES:

MY EXPECTATIONS FOR THIS TRAINING

TOPICS I WANT TO REVISIT

UNIT 2 UTERINE EVACUATION IN CRISIS SETTINGS

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

- Explain why uterine evacuation is an essential part of reproductive health services in crisis settings.
- Articulate their comfort levels discussing, advocating, and providing uterine evacuation services.
- Explain what the current abortion law is in their setting and how it relates to what and how services are provided.

ABORTION LAW

The current abortion law in my country is…

"Abortion is legal up to _____ weeks gestational age.

Abortion is allowed up to _____ weeks for ☐ physical health of mother ☐ mental health of mother ☐ health of child ☐ rape ☐ incest."

Additional notes:

NOTES:

MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

iawg.net/IAFM

OBJECTIVE 1: ENSURE THE HEALTH SECTOR/ CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP
- Reports back to the health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation
- In tandem with health/GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services
- Shares information about the availability of SRH services and commodities
- Ensures the community is aware of the availability and location of reproductive health services

OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

- Work with other clusters especially the protection or gender based violence sub-cluster to put in place preventative measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence
- Make clinical care and referral to other supportive services available for survivors of sexual violence
- Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

IARH Kit 3 IARH Kit 5 IARH Kit 8 IARH Kit 9

OBJECTIVE 6: PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE AS SOON AS POSSIBLE. WORK WITH THE HEALTH SECTOR/CLUSTER PARTNERS TO ADDRESS THE SIX HEALTH SYSTEM BUILDING BLOCKS:

- Service Delivery
- Health Workforce
- Health Information System
- Medical Commodities
- Financing
- Governance and Leadership

GOAL

PREVENT MORTALITY, MORBIDITY, AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

OBJECTIVE 3: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

IARH Kit 1 IARH Kit 3 IARH Kit 5 IARH Kit 12 Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception] at primary health care facilities to meet demand
- Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

IARH Kit 1 IARH Kit 3 IARH Kit 4

OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
  - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage
  - At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)
  - At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure the availability of life-saving, post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

IARH Kit 2 IARH Kit 6 IARH Kit 8 IARH Kit 9 IARH Kit 10 IARH Kit 11 IARH Kit 12

IARH Kit 8 **Other Priority**: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

The MISP forms the starting point for SRH programming and respectful quality of care must be ensured from the start. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. These services should be sustained and built upon as soon as possible (ideally 3-6 months) with comprehensive SRH services and supplies throughout protracted crises and recovery.

Fundamental principles for SRH programming in humanitarian settings

- Work in respectful partnership with people receiving care, providers, and local and international partners
- Ensure equality by meeting people's varied sexual and reproductive health needs and ensuring that services and supplies are affordable or free, accessible to all, and of high quality
- Provide comprehensive, evidence-based, and accessible information and choice about the supplies and services available
- Ensure effective and meaningful participation of concerned persons and person-centered care that recognizes patients' autonomous decision-making power and choice for services and commodities
- Ensure privacy and confidentiality for everyone and treat people with dignity and respect
- Promote equity, with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g. rural/urban), disability, race, color, language, religion, political or other opinion, national, ethnic or social origin, property, birth, or other characteristics
- Recognize and address gender and power dynamics in healthcare facilities to ensure that people do not experience coercion, discrimination, or violence/mistreatment/disrespect/abuse in receiving or providing health services
- Engage and mobilize the community, including often marginalized populations such as adolescents, in community outreach to inform the community about the availability and location of MISP services and commodities
- Monitor services and supplies, and share information and results with the aim of improving quality of care

Community Level/Health Post: Community Level/Health Post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a 3-month period. The kits contain mainly medicines and disposable items.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 1A	Male Condoms	Red
Kit 2	Clean Delivery (A and B)	Dark blue
Kit 3	Post-Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	Treatment of Sexually Transmitted Infections	Turquoise

Primary Health Care Facility Level (BEmONC): Primary Health Care Facility Level (BEmONC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order theses kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance – Midwifery Supplies (A and B)	Brown
Kit 8	Management of Complications of Miscarriage or Abortion	Yellow
Kit 9	Repair of Cervical and Vaginal Tears	Purple
Kit 10	Assisted Delivery with Vacuum Extraction	Grey

Referral Hospital Level (CEmONC): Referral Hospital Level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 11	Obstetric Surgery and Severe Obstetric Complications Kit (A and B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels. The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

**** The new kit structure will only be available late 2019***

LEVEL	COMPLEMENTS	ITEM
Coordination	All Kits	Kit 0 - Administration and Training
Community and Primary Health Care - BEmONC	Kit 1	Kit 1B - Female Condoms
	Kit 2A	Chlorhexidine gel
	Kit 2B	Misoprostol (also complements Kits 6B and 8)
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)
Health Center or Hospital Level - CEmONC	Kit 4	Kit 7A - Intrauterine Device (IUD)
	Kit 4	Kit 7B - Contraceptive Implant
	Kit 6A	Non-Pneumatic Anti-Shock Garment
	Kit 6B	Oxytocin
	Kit 8	Mifepristone
	Kit 10	Hand-held Vacuum Assisted Delivery system

Complementary commodities are a set of disposable and consumable items and/or kits that can be ordered in specific circumstances to complement existing IARH Kits:

- where providers are trained to use the special supply;
- where the supplies were accepted and used prior to the emergency;
- after the rapid first order of SRH supplies in protracted crises or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels); and,
- where the use of the supplies is allowed to the fullest extent of the national law.

Information on the IARH kits and assistance with ordering can be provided by UNFPA country offices, or the UNFPA Humanitarian Office in Geneva. The IARH Kits can be ordered from UNFPA PSB in Copenhagen through either a UNFPA country office or the UNFPA Humanitarian Office; you can also reach out to the SRH working group/sub-sector coordinator to facilitate coordinated procurement of the IARH Kits.

UNFPA Humanitarian Office

UNFPA
Attn: Humanitarian Office
Palais des Nations
Avenue de la paix 8-14
1211, Geneva 10, Switzerland
Email: Humanitarian-SRHsupplies@unfpa.org

UNFPA Procurement Services Branch

UNFPA Procurement Service Branch
Marmovej 51
2100 Copenhagen, Denmark
Email: procurement@unfpa.org
Website: unfpaprocurement.org

Before placing an order, discuss with the SRH coordination group and/or the UNFPA country office to determine what is already being ordered and if orders can be combined.

Source: Inter-Agency Working Group on Reproductive Health in Crises. "Quick Reference for the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)," 2018. iawg.net/resources/misp-reference.

UTERINE EVACUATION AND THE MISP

The MISP for Sexual and Reproductive Health is part of the *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings*, which was revised in 2018.

The 2018 MISP includes the following uterine evacuation-related services:

- **Other Priority**: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.
- **Objective 2**: Prevent Sexual Violence and Respond to the Needs of Survivors
  - Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care, to the full extent of the law is included in the clinical care for survivors of sexual violence.
- **Objective 4**: Prevent Excess Maternal and Newborn Morbidity and Mortality
  - Ensure the availability of post-abortion care in health centers and hospitals.

CASE STUDIES

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

NOTES:

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. A bimanual examination confirms this gestational age. She has her four malnourished children with her. Her husband had been taken by enemy forces and has been missing for over a month. She has no means to support herself or her children. She claims that if the clinic cannot help her, she will have to do something herself as she knows she cannot support another child. Her last delivery was very difficult and she suffered complications. She fears that she will not survive childbirth in these conditions. She is the only person on whom her children can depend.

NOTES:

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

NOTES:

5 ELEMENTS OF PAC

1.

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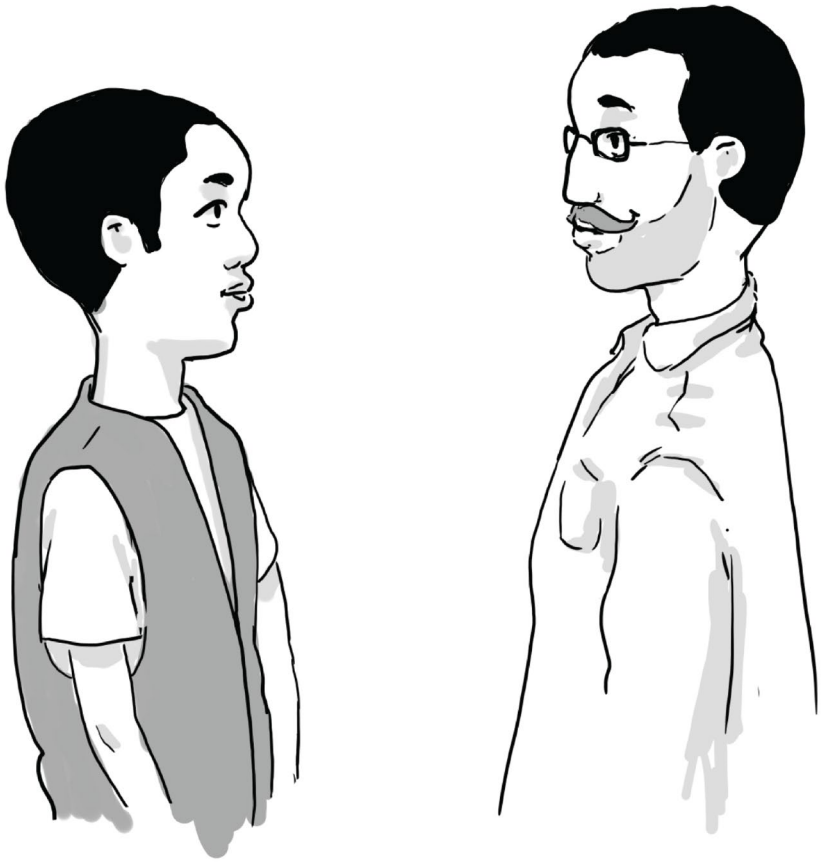
CAC IS



UNIT 3 UTERINE EVACUATION METHODS

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

- Describe the various uterine evacuation options and explain why MVA and mifepristone and misoprostol are especially useful in crisis settings.
- Describe the safety, effectiveness, and possible complications of vacuum aspiration and mifepristone and misoprostol.
- Explain the importance of uterine evacuation with vacuum aspiration as a backup to uterine evacuation with medications.
- Discuss medical eligibility for select methods of postabortion contraception, including emergency contraception.
- Provide uterine evacuation method options counseling and contraceptive counseling for women seeking uterine evacuation.
- Obtain informed consent prior to uterine evacuation.

NOTES:

UTERINE EVACUATION TREATMENT OPTIONS[2]

1. Induced Abortion			
	Vacuum Aspiration	**Mifepristone and Misoprostol Medical Abortion**	**Misoprostol-Only Medical Abortion**
What is it?	A procedure that uses electric or manual suction instruments to evacuate the uterus.	Two medications, taken together, that cause the uterus to expel the pregnancy.	One medication that causes the uterus to expel the pregnancy.
How does it work?	The pregnancy is removed through a tube (cannula) with suction created by an electric pump or handheld aspirator. The procedure takes two to ten minutes. Completion of the procedure is immediately confirmed, requiring only one facility visit.	Mifepristone makes the pregnancy detach from the wall of the uterus, softens the cervix, and makes the uterus more sensitive to misoprostol. Misoprostol causes uterine contractions that expel the pregnancy. Mifepristone is taken by mouth. Misoprostol is put either under the tongue, inside the cheek, or in the vagina one or two days later. The abortion usually occurs within four to six hours, but can take several days.	Misoprostol causes uterine contractions that expel the pregnancy. Misoprostol is put either under the tongue or in the vagina, and can be repeated several times until the pregnancy expels.
When can it be used?	Can be performed routinely from detection of pregnancy up to 13 weeks last menstrual period (LMP), or up to 15 weeks LMP if providers have been specially trained and have appropriately sized cannulae.	Can be used both before and after 13 weeks of pregnancy. Dose and timing of misoprostol must be adjusted depending on gestational age.	Can be used both before and after 13 weeks of pregnancy. Dose and timing of misoprostol must be adjusted depending on gestational age.
Where can it be used?	In a health care facility.	Mifepristone may be taken at home or in a health facility. Women with pregnancies up to 10 weeks may use misoprostol at home or in a health facility. Women with pregnancies after 10 weeks must use misoprostol in a health facility.	Women with pregnancies up to 10 weeks may use misoprostol at home or in a health facility. Women with pregnancies after 10 weeks must use misoprostol in a health facility.

2. Used with permission from Ipas.

How effective is it?	98-100% effective	95-98% effective	85% effective
Safe and effective for young women and adults?	Yes	Yes	Yes
What are the side effects?	Bleeding and cramping	Bleeding and cramping are expected effects. Possible side effects include nausea/vomiting, diarrhea, fever/chills, or dizziness.	Bleeding and cramping are expected effects. Possible side effects include nausea/vomiting, diarrhea, fever/chills, or dizziness.
What are the possible complications?	Rare complications include injury to the cervix or uterus, infection, hemorrhage, painful accumulation of blood in the uterus (hematometra), or incomplete abortion. Failed abortion occurs in less than 1% of cases, especially when performed by a skilled provider.	Rare complications include medication allergy, excessive or prolonged bleeding, infection, or incomplete abortion. Failed abortion (ongoing pregnancy) occurs in less than 2% of women. About 5% of women require vacuum aspiration for any reason.	Rare complications include medication allergy, excessive or prolonged bleeding, infection, or incomplete abortion. Failed abortion (ongoing pregnancy) occurs in 3-10% of women. About 15% of women require vacuum aspiration for any reason.
What if the abortion fails?	The procedure is repeated.	Vacuum aspiration is performed. If aspiration is not available, a second dose of misoprostol can be offered with close follow-up.	Vacuum aspiration is performed.
When can contraception be started?	Following an uncomplicated vacuum aspiration, all modern contraceptive methods can be used immediately; intrauterine devices (IUDs) can be inserted immediately after the procedure. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.	IUDs can be inserted when it is reasonably certain the woman is no longer pregnant. All other modern methods (such as pills, injectables, and implants) can be started with the first pill of the abortion regimen. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.	IUDs can be inserted when it is reasonably certain the woman is no longer pregnant. All other modern methods (such as pills, injectables, and implants) can be started with the first pill of the abortion regimen. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.
2. Postabortion Care			
	Vacuum Aspiration	**Misoprostol**	**Expectant Management**
How does it work?	The products of conception are removed through a tube (cannula) with suction created by an electric pump or handheld aspirator. The procedure takes two to ten minutes. Completion of the procedure is immediately confirmed.	Misoprostol causes uterine contractions that expel the products of conception. Misoprostol is either swallowed, placed under the tongue, or in the vagina, and can be repeated.	The products of conception are expelled through spontaneous uterine contraction without provider intervention.
How effective is it?	98-100% effective	91-99% effective	Up to 85% effective
How safe is it?	Rare complications include injury to the cervix or uterus, infection, hemorrhage, painful accumulation of blood in the uterus (hematometra), or incomplete abortion.	Rare complications include medication allergy, excessive or prolonged bleeding, infection, or incomplete abortion.	Rare complications include excessive or prolonged bleeding, infection, or incomplete abortion.
Where can it be used?	In a health care facility.	At home or in a health care facility.	At home. Access to emergency care is important in case of complication, such as infection or excessive or prolonged bleeding.

Why do some women choose this method?	Quick resolution of abortion, less bleeding, desire for immediate IUD placement.	Avoids procedure, is more active than expectant management, is private.	Avoids procedure and medications, is private, is more natural.
When can contraception be started?	Following an uncomplicated vacuum aspiration, all modern contraceptive methods can be used immediately; IUDs can be inserted immediately after the procedure. In cases of septic abortion, insertion must be delayed. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.	IUDs can be inserted when it is reasonably certain the woman is no longer pregnant. All other modern methods (such as pills, injectables, and implants) can be started with the first pill of the abortion regimen. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.	IUDs can be inserted when it is reasonably certain the woman is no longer pregnant. All other modern methods (such as pills, injectables, and implants) can be started with the first pill of the abortion regimen. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.

ADVANTAGES AND DISADVANTAGES OF MEDICAL INTERVENTION COMPARED TO VACUUM ASPIRATION CHART[3]

	Medical Intervention	Vacuum Aspiration
Advantages	• Avoids instrumentation, anesthesia • More natural, like menses • Less painful to some women • Easier emotionally for some women • Can be provided by mid-level staff • Woman can be more in control, involved	• Quicker • More certain • Less painful to some women • Easier emotionally for some women • Can be provided by mid-level staff • Provider controlled • Woman can be less involved
Disadvantages	• Bleeding, cramping, nausea (actual or feared) • Waiting, uncertainty • Depending on protocol, more or longer clinic visits • Cost	• Invasive • Small risk of uterine or cervical injury • Small risk of infection • Loss of privacy, autonomy

POSSIBLE COMPLICATIONS OF UTERINE EVACUATION WITH MVA AND MEDICAL METHODS:

3. Used with permission from Ipas.

UTERINE EVACUATION METHOD OPTIONS COUNSELING CASE STUDIES

For each case study below, think about why each woman might choose a specific method of uterine evacuation. Be prepared to explain your reasoning.

NOTES:

Case Study 1: A 28-year-old mother of three young children presents with an incomplete abortion. It has been ten weeks since her last menstrual period (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 health center.

NOTES:

Case Study 2: A 17-year-old student presents with an incomplete abortion. It is eight weeks since her LMP. She knew she was pregnant for about a week and does not want to talk about why she is having vaginal bleeding and some cramping. She lives with her parents but is alone at the health center. She was uncomfortable during the speculum and bimanual examinations she had during her evaluation. It was the first time she had these examinations. She seems nervous about a uterine evacuation procedure.

NOTES:

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

NOTES:

POSTABORTION CONTRACEPTION MEDICAL ELIGIBILITY[4]

WORLD HEALTH ORGANIZATION MEDICAL ELIGIBILITY CRITERIA FOR POSTABORTION CONTRACEPTION

	Sterilization	Intrauterine Device (IUD)	Implant	Injectables*	Combined Hormonal Pills, Patch, and Ring	Progestin Only Pills	Barrier	Fertility Awareness Based
Uncomplicated Uterine Evacuation (Aspiration or Medications)	1	1	1	1	1	1	1	Delay use of method*
Complicated Uterine Evacuation	Delay use of method*	4*	1	1	1	1	1	Delay use of method*

*See clarifications below.
World Health Organization categories for contraceptive eligibility:
(1) A condition for which there is no restriction for the use of the method;
(2) A condition where the advantages of using the method generally outweigh the theoretical or proven risks;
(3) A condition where the theoretical or proven risks usually outweigh the advantages of using the method;
(4) A condition which represents an unacceptable health risk if method is used.

ADDITIONAL INFORMATION RELATED TO SPECIFIC CONTRACEPTIVE METHODS

Sterilization: May be performed immediately after an uncomplicated uterine evacuation. In cases of septic abortion or pelvic infection, women should be treated with appropriate antibiotics and sterilization should be delayed until infection resolves. In cases of excessive blood loss, sterilization may need to be delayed if the woman is too anemic. Although sterilization is an appropriate method for women regardless of their age, special precautions may need to be taken with young women due to an increased risk of regret.

Intrauterine Device (IUD): When compared to short-acting methods, long-acting reversible methods of contraception (LARC), such as IUDs and implants, have higher continuation rates and lower pregnancy and abortion rates. IUD insertion immediately following an uncomplicated vacuum aspiration is safe and practical. There is no increase in the rate of serious adverse events, such as infection or uterine perforation, when IUDs are inserted immediately after vacuum aspiration. There is a very small increased risk that an IUD inserted immediately following a vacuum aspiration procedure will expel. When women desiring an IUD are unable to have it placed immediately after vacuum aspiration, and instead must return to the health facility at another time for their IUD, or they are sent to a different health facility for IUD insertion, they are much less likely to receive the IUD. Following uterine evacuation with medical methods, women may have an IUD placed as soon as it is reasonably certain the woman is no longer pregnant. Women using medical methods who expel the pregnancy in a health facility may have the IUD inserted after expulsion. Women who expel the pregnancy at home or in another location may have the IUD inserted at a follow up visit.

In cases of septic abortion or in women who have purulent cervicitis at the time of uterine evacuation, women should be treated with appropriate antibiotics and the IUD insertion should be delayed until the infection resolves. Women should be provided an interim contraceptive method. If a woman contracts a sexually transmitted infection after the IUD is placed or develops a uterine or pelvic infection with an IUD in place in the uterus, she should be treated with appropriate antibiotics to resolve the infection. It is not necessary to remove the IUD.

Implants: Women may have their implant placed at the time of vacuum aspiration or, for those using medications for uterine evacuation, at the time medications are prescribed, dispensed, or administered. When placement of an implant is delayed until a subsequent visit or when women are referred to a different health facility for placement, they are less likely to receive the implant.

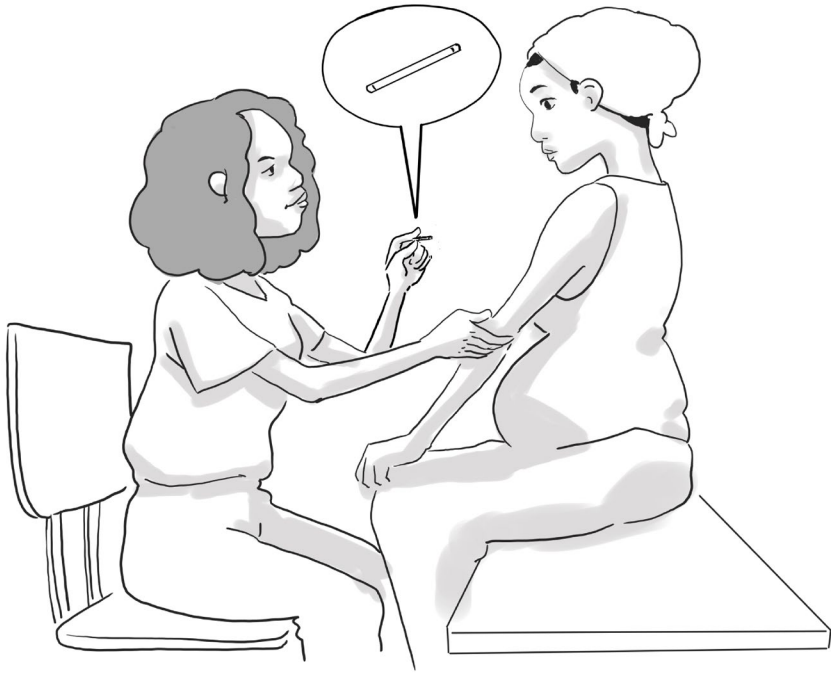
4. World Health Organization. (2015). Medical Eligibility Criteria for Contraceptive Use, 5th ed. WHO Press: Geneva.

Progestin-only injection: Depot medroxyprogesterone acetate (DMPA) is classified by the World Health Organization as category 2 (a condition where the advantages of using the method generally outweigh the theoretical or proven risks) for women under 18 years of age due to theoretical concerns about bone mineral density.

Combined hormonal pills, patch, or ring: Women may begin combined hormonal pills or patch at the time of vacuum aspiration or, if using medications for uterine evacuation, at the time when medications were started. Women may begin a combined hormonal contraceptive ring one week after vacuum aspiration or medical uterine evacuation, if desired, due to abortion-related vaginal bleeding.

Barrier: In women who have suffered genital injury, a provider may need to determine if female barrier methods can be used.

Fertility awareness-based methods: Use of method should be delayed until the woman has had at least one postabortion menses.



POSTABORTION MEDICAL ELIGIBILITY QUESTIONS AND ANSWERS

Question:
When can a woman safely begin using a fertility awareness-based method, such as the counting days or calendar method?

Answer:

_____
_____
_____

Question: What are two reasons that a sterilization procedure may need to be delayed following an abortion?

Answer:

_____
_____
_____

Question:
When can an IUD be placed after an abortion?

Answer:

_____
_____
_____

WHY OFFER EMERGENCY CONTRACEPTION (EC)?

_____
_____
_____
_____
_____
_____
_____

CONTRACEPTIVE COUNSELING SKILLS CHECKLIST[5]

Instructions for observer: Silently observe and evaluate the counseling session. Do not interact with the woman or provider. Check "yes" or "no," depending on whether the provider demonstrated the skill during the counseling session, and write comments. Offer your evaluation and comments to the provider at the end of the session.

Skill	Yes	No	Comment
Establishes Rapport			
Greets clients in a friendly way, demonstrating interest and concern			
Assures privacy and confidentiality			
Asks for permission prior to including others in session			
Assesses Woman's Needs			
Asks open-ended questions about woman's circumstances and needs			
Without judgment, explores factors that led to the need for an abortion			
If she was using contraception, assesses reasons for failure of method			
Explains Human Reproduction (if necessary)			
Determines Desire to Delay or Prevent Pregnancy			
Explores woman's current desire to delay or prevent pregnancy			
Provides information on the health benefits of child spacing			
Assesses Woman's Individual Situation			
Assesses woman's clinical and personal situation			
Discusses potential barriers to successful use of contraception and ways to resolve them			
Explains Characteristics of Available and Effective Methods			
Discusses any contraindications and methods for which she is medically eligible			
Offers a full range of methods available at the facility and where the woman will seek re-supply			
Discusses when contraceptives can be provided in relation to her uterine evacuation method and process			

5. Ipas. "Contraceptive Counseling Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 143–45. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

Skill	Yes	No	Comment
Explains, in order from most to least effective, her eligible methods' effectiveness, characteristics, use and side effects			
If she will need re-supplies, explains where she can access them			
Shows actual methods and uses educational tools, pamphlets, pictures or anatomical models			
Helps the Woman Choose Her Method			
Supports the woman in selecting the most effective method for her situation			
Ensures informed choice of method			
Ensures Understanding of Chosen Methods			
Ensures woman fully understands the method she has chosen			
Helps her plan for continued use, ensuring she knows where and when to resupply or change her method if necessary			
Provides chosen method or interim method if chosen method is not available			
Provides EC and instructions for use as a back-up method, if available			
Refers to Other Resources As Needed			
Manages special needs			
Has resource lists available to make referrals			
If unable to offer specialized counseling or services or meet woman's needs, makes referrals to appropriate services			

SPECIAL CONTRACEPTIVE COUNSELING CONSIDERATIONS[6]

YOUNG WOMEN (AGES 10-24)

Young women's contraceptive needs vary greatly. A young married woman with one child who wants to avoid having a second may have different considerations than a young woman who may be at higher risk for sexually transmitted infections (STIs), including HIV. Some young women may want to become pregnant immediately and do not require contraception. When providing contraceptive counseling and services, it is important to ask what the young woman's immediate and longer-term reproductive plans are and then provide appropriate counseling.

Contraceptive counseling should also include information on fertility awareness, by asking what the client knows about her menstrual cycle and fertility and building on that to educate her about the fertile and infertile points in her cycle. Fertility awareness-based methods are not recommended for young women with erratic or irregular menstrual cycles. As with abortion, young women may have concerns about the safety or efficacy of contraceptive methods, which may be based on misinformation. They may not know how pregnancy occurs or is prevented. For example, they may have heard that pregnancy will not occur if they have intercourse in certain positions, in water, or during menstruation, or believe that contraception will cause future permanent infertility. Because of misinformation like this, it is important that providers explain how a contraceptive works, including efficacy, potential side effects such as weight gain or breast tenderness and their incidence, and the long-term clinical implications of any such side effects. Providers can ask indirect questions, such as "What are some things your friends say about how you can and cannot get pregnant?" and "What are some things you heard about this method?" to find out whether a young woman is misinformed. Contraceptive counseling should be reality-based. That is, it should begin by uncovering and addressing what clients believe, whether or not it is accurate, in order to avoid the method's discontinuation. Providers should also learn from the young woman what barriers she may face in using different contraceptive methods and help the young woman identify the most appropriate option for her. A young woman's privacy needs can also influence her selection of a contraceptive method. For example, injectables, implants, or an intrauterine device may suit a young woman with high privacy needs, even if her preferred method might otherwise be something else.

Making a larger range of contraceptive methods available is correlated with increased acceptance of a method among young and adult women. In addition to her method of choice, the young woman should be offered to leave the facility with at least one dose of emergency contraceptive pills (ECPs), in case of an accident or contraceptive failure.

The following information should also be presented when discussing contraception with young women:

Medical eligibility for young women

Clinical eligibility guidelines for postabortion contraceptives for young women are the same as for adult women. Several methods have implications for young women that bear additional discussion. These include sterilization, long-acting contraception methods, intrauterine devices, and injectables.

Sterilization

There is no clinical contraindication for sterilization in young women. However, women under the age of 30 are significantly more likely to experience regret after sterilization. During counseling, providers should emphasize that it is a permanent method, and make it clear that there is no extra benefit to doing the procedure at the time of the abortion versus using a non-permanent method for some time to be sure it is the method she wants. There may be laws and policies in place that affect a minor's ability to consent to permanent surgical modification and whether sterilization is an option for minors. Providers should offer information in a factual manner and support the young woman's informed decision.

Long-acting contraceptive methods

Long-acting reversible contraception, such as intrauterine devices (IUDs) or implants, are safe and effective and benefit young women. For all women, these methods are more effective at preventing pregnancy than other modern methods, including pills, injections, and condoms. In addition, because women who use IUDs or implants do not have to remember pills every day, buy more supplies, or get an injection every three months, there is no chance of method failure because of problems with use. Young women have more difficulty using short-acting methods than older women which results in pregnancy rates that are double that of older women who use short-acting methods. Therefore, the ease of use of IUDs and implants may be particularly beneficial for young women. Finally, women who use IUDs and implants are satisfied with them, leading to longer continuation of use than pills or injectables. Because unintended pregnancy occurs when women stop or switch methods, satisfaction and continuation are keys to the effectiveness of IUDs and implants.

Intrauterine devices (IUDs)

Young women are medically eligible to use IUDs. There are no clinical contraindications based on age alone. IUDs are less likely to be selected by young women than by older women in some countries. It is unclear whether this is in part due to providers' reluctance to offer IUDs to young

6. Used with permission from Ipas.

women, or young women's reluctance after being given accurate, unbiased information on the method. In studies that have examined IUD use among young women, where young women were provided non-directive counseling and IUDs at no cost, rates of IUD acceptance and continuation were comparable to those of older women. Use of IUDs by young women decreases the rates of pregnancy, birth, and induced abortion in this group.

Injectables

Injectables include progestin-only and estrogen and progestin ("combined") formulas, including Depo-Provera (DMPA), and Mesigyna and Norigynon (NET-EN). There has been some concern that DMPA may permanently decrease bone mineral density (BMD) in young women, as it does temporarily decrease BMD and adolescents have not yet attained their peak bone mass. A study specifically on adolescent women found that all of them had complete recovery of BMD within 12 months of discontinuation, and the length of use of DMPA did not affect this recovery. However, the World Health Organization's latest recommendations on medical eligibility for contraceptives state that most studies have found that women regain BMD after discontinuing DMPA, but that it is unclear whether use in young women will affect peak bone mass. For this reason, it is listed as a Category 2 method ("generally use the method") for women under 18. For comparison, Category 1 means "use method in any circumstances."

WOMEN WITH MULTIPLE ABORTIONS

If a woman does not want to become pregnant and has experienced multiple unwanted pregnancies and abortions, the provider should help the woman identify any difficulties she may have using or accessing contraception and work with her to resolve those difficulties.

When discussing contraception with a woman who has had multiple abortions:

- Explore with the woman her history of contraceptive use. If she has not been using contraception, ask her about this, using non-judgmental language.
- If she has been using contraception, identify and resolve any difficulties she has experienced with her chosen method or help her select a method that may be more appropriate for her.
- If resupply of her chosen method has been problematic, help her identify a method that she can obtain more consistently.
- Advise the woman about how to access and use emergency contraception (EC) if she has unprotected intercourse or if contraceptive failure occurs. If possible, provide her with a supply of emergency contraceptive pills (ECPs).

WOMEN WHO HAVE EXPERIENCED VIOLENCE

When helping a woman who has experienced violence select an appropriate contraceptive method, ask her to consider whether there is a connection between the violence and her contraceptive use. If the violence is a result of her contraceptive use, help her consider a method that cannot be detected by others. If the woman cannot control the circumstances of her sexual activity, advise her on using methods that do not require partner participation, such as injectables, IUDs, and implants and also how to access and use EC. It may be beneficial to provide ECPs in advance.

WOMEN LIVING WITH HIV

The following information should be presented when discussing contraception with an HIV-positive woman:

- Male and female condoms help protect against HIV transmission and need to be used correctly each time intercourse occurs.
- If the woman engages in unprotected sexual intercourse with an HIV-positive partner, she may be exposed to a different strain of HIV or other sexually transmitted infections (STIs).
- Dual protection is recommended. This practice consists of the simultaneous correct and consistent use of male or female condoms for STI/HIV protection with another, more effective contraceptive method for pregnancy prevention, or with ECPs as a back-up method for pregnancy prevention. Women being treated for HIV need information on contraceptive options in relation to their treatment regimens.

WOMEN WHO ENGAGE IN SEX WORK

The following information should be presented when discussing contraception with women who engage in sex work:

- Providers should recommend the use of dual protection through the simultaneous use of condoms and another method. This will protection against both STIs and unwanted pregnancy. If male condom use is not feasible for the woman, she may want to consider the use of female condoms, if available.
- The woman should be informed on how to access and use ECPs. It may be beneficial to provide the woman with ECPs in advance.

WOMEN WITH COGNITIVE AND DEVELOPMENTAL DISABILITIES AND/OR MENTAL ILLNESS

The provider should begin by assessing what knowledge and experience the woman already has regarding contraception. The provider can then assist her in determining which method is most suitable for her by asking who she has sex with and under what circumstances. The following information should be considered when discussing contraception with women who have cognitive disabilities and/or mental illness:

- The woman may have difficulty remembering how or when to use certain methods, such as taking a pill every day. However, these methods may still be a good option if instructions are given clearly and the woman has a caregiver who can help remind her and establish the method as part of her daily or monthly routine.
- Some women with developmental disabilities may have trouble with fine motor skills. In such cases, certain methods, such as diaphragms, may not be advisable.
- Women in this population should be instructed on how to use and negotiate barrier methods. Providers should emphasize that they must be used every time she engages in intercourse if she wants to prevent pregnancy and STIs.
- The provider should demonstrate the method—using actual condoms, diaphragms, or cervical caps—and/or use illustrative instructions.
- Providers should also give the woman written and/or illustrative instructions to take home and other helpful tools, such as a calendar.
- For women who do not know in advance when they will engage in sexual intercourse, advance provision of EC pills, with specific instructions, may be advisable.
- Under no circumstances should any method be performed or provided without the woman's explicit consent. Women with cognitive disabilities and/or mental illness have the same right as other women to make choices regarding childbearing.
- Regarding informed consent, providers should be aware that the woman may or may not be her own guardian. If the woman is indeed able to make decisions about her own care, the provider should make an extra effort to ensure that she clearly understands what she is consenting to and what her choices are.

WOMEN WHO HAVE EXPERIENCED GENITAL CUTTING

A woman's type of genital cutting and her preferences around deinfibulation and reinfibulation need to be considered when supporting her in selecting her preferred contraceptive method. A recent review of the evidence shows no known increased incidence of HIV infection among women who have undergone female genital cutting. As for all women, encourage the use of barrier methods, such as male and female condoms, to decrease the risk of HIV infection.

WOMEN WHO PARTNER WITH WOMEN

Providers should not make contraceptive-related assumptions about women who state that they have female sexual partners. Women who partner with women may also engage in sexual relationships with men, be at risk for STI/HIV and unwanted pregnancy, desire a future pregnancy, and/or need contraceptive information and methods. Providers should engage in an open discussion with all women to determine their risks and needs.

CONTRACEPTION PROVISION IN CRISIS SETTINGS:

CASE STUDIES

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 when she was pregnant. She has come to the facility with a lot of vaginal bleeding and cramping. She is afraid to discuss contraception with her husband.

NOTES:

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.

NOTES:

Case Study 3:
Young Women: A 16-year-old woman is sexually active with her boyfriend. They use withdrawal because she does not 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 facility because she is not married.

NOTES:

NOTES:

UNIT 4 CLINICAL ASSESSMENT AND ELIGIBILITY

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

- Describe how to conduct a clinical assessment before uterine evacuation with medicines and/or MVA, including for postabortion care.
- Discuss medical eligibility, contraindications, and precautions for uterine evacuation with medicines and/or MVA.

WHAT DO YOU LEARN FROM A BIMANUAL EXAM AND WHY IS IT IMPORTANT?

WHAT ARE SOME REASONS THAT THE UTERINE SIZE MAY BE LARGER THAN EXPECTED BASED ON THE WOMAN'S LAST MENSTRUAL PERIOD?

WHAT ARE SOME REASONS THAT THE UTERINE SIZE MAY BE SMALLER THAN EXPECTED BASED ON THE WOMAN'S LAST MENSTRUAL PERIOD?

WHAT CAN YOU DO IF THERE IS UNCERTAINTY ABOUT UTERINE SIZE?

POSTABORTION CARE CASE STUDIES

Case study 1:
An 18-year-old woman walks into the clinic holding onto her partner's arm to steady herself and complains of feeling sick. She is having moderate vaginal bleeding and lots of cramping. Her partner asks for immediate help.

Case study 2:
A 28-year-old woman comes to the hospital in no visible pain and no distress. She reports that she has had vaginal bleeding and cramping for more than 10 days and does not know why it has not stopped. In the last two days, the bleeding has become very heavy and her cramping has become very strong.

Case study 3:
A 34-year-old woman comes to the health care facility and at first glance looks like she might have the flu. She is having fever and chills, and appears pale. Upon questioning, she says that she has been bleeding heavily for the last 4 hours and is having abdominal pain that comes in waves. She has difficulty talking when the cramping occurs.

UTERINE EVACUATION WITH MEDICATIONS ELIGIBILITY CASES

Case study #1 (PAC)

- → 38-year-old woman with painful cramping and vaginal bleeding for 5 days
- → Appears well
- → 8 weeks since her last period
- → 5 previous deliveries
- → Previous tubal ligation

NOTES:

Case study #2 (PAC)

- → 25-year-old woman with chills, abdominal pain, and vaginal bleeding for 2 days
- → Anxious, pale, and clammy; becomes dizzy when getting up from the chair to the exam table
- → 14 weeks since last menstrual period (LMP)
- → 5 previous deliveries
- → HR 116, BP 80/50, Temp 39°C
- → Uterine size 11 weeks, fundal and cervical tenderness, os open
- → Blood visible in vagina and bright red blood at os

NOTES:

Case study #3 (PAC)

- → 32-year-old woman with moderate bleeding for 10 days and pelvic pain similar to contractions
- → Appears well
- → 12 weeks since LMP
- → 2 previous deliveries
- → HR 88, BP 120/90, afebrile
- → Uterine size 8 weeks, no uterine tenderness, and cervical motion tenderness
- → Open cervical os, foul smelling discharge

NOTES:

Case study #4 (CAC)

- → A 20-year-old woman comes to the clinic six weeks since her LMP.
- → She was not using any contraceptive method and usually has regular periods every 28-30 days.
- → She has been having mild nausea and breast tenderness.
- → You perform a bimanual exam and find her uterus to be consistent with six weeks LMP. You find no masses or tenderness.
- → She has heard about medical abortion and asks if she can take the pills today or if she needs an ultrasound.

NOTES:

Case study #5 (CAC)

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

NOTES:

Case study #6 (CAC)

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

NOTES:

NOTES:

UNIT 5 UTERINE EVACUATION WITH MEDICAL METHODS

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

- Explain recommended mifepristone and/or misoprostol regimens.
- Explain the essential information to be given to women having uterine evacuation with mifepristone and/or misoprostol.
- Explain the expected effects, side effects, and warning signs of uterine evacuation with mifepristone and/or misoprostol.
- Describe potential complications of uterine evacuation with mifepristone and/or misoprostol, and complications management.
- Describe post-procedure care and follow-up for uterine evacuation with mifepristone and/or misoprostol.

NOTES:

MEDICATION REGIMENS FOR UTERINE EVACUATION POCKET REFERENCE[7]

Medical abortion with mifepristone and misoprostol	Medical abortion with misoprostol only	Medical treatment for incomplete abortion, missed abortion or intrauterine fetal demise (postabortion care)
Before 13 weeks gestation: • Mifepristone 200mg orally • Misoprostol 800mcg buccally, sublingually or vaginally 1-2 days after mifepristone. • The dose of misoprostol can be repeated to achieve abortion success. • After 9 weeks gestation, routinely using at least two doses of misoprostol, administered 3-4 hours apart, improves abortion success rates. **At or after 13 weeks gestation (13-24 weeks):** • Mifepristone 200mg orally • Misoprostol 400mcg buccally, sublingually or vaginally 1-2 days after mifepristone, then every three hours until fetal and placental expulsion • The median time to abortion is 6-10 hours after beginning misoprostol, although some individuals will require more time to successfully abort.	**Before 13 weeks gestation:** • Misoprostol 800mcg buccally, sublingually or vaginally every three hours until expulsion • Individuals undergoing misoprostol-only medical abortion outside of a health facility should be provided with 3 to 4 doses of misoprostol depending on the scenario. **At or after 13 weeks gestation (13-24 weeks):** • Misoprostol 400mcg buccally, sublingually or vaginally every three hours until fetal and placental expulsion. Vaginal dosing is more effective than other routes. • The average time to abortion is 10-15 hours after beginning misoprostol, although some individuals will require multiple days to successfully abort.	**Less than 13 weeks uterine size:** • Incomplete abortion: · Misoprostol 600mcg orally in a single dose or 400mcg in a single dose buccally, sublingually or, in the absence of vaginal bleeding, vaginally • Missed abortion: · Misoprostol 800mcg buccally, sublingually or, in the absence of vaginal bleeding, vaginally every 3 hours until expulsion (generally 1-3 doses) · Where available, add pretreatment with mifepristone 200mg orally 1-2 days before misoprostol **13 weeks or larger uterine size:** • Incomplete abortion: · Misoprostol 400mcg buccally, sublingually or, in the absence of vaginal bleeding, vaginally every three hours until expulsion • Intrauterine fetal demise (up to 24 weeks): · Misoprostol 400mcg buccally, sublingually or, in the absence of vaginal bleeding, vaginally every 4-6 hours until expulsion. · Where available, add pretreatment with mifepristone 200mg orally 1-2 days before misoprostol.

7. Ipas. "Protocols for Medical Abortion [Dosage Card]," 2023. https://www.ipas.org/resource/protocols-for-medical-abortion-dosage-card/.

UTERINE EVACUATION WITH MEDICATIONS SKILLS CHECKLIST[8]

Instructions: Check whether the skill was performed well (YES/NO) and add comments.

First Clinic Visit	Yes	No	Comments
Ensures privacy during visit			
Greets the woman in a friendly, respectful manner			
Uses age-appropriate, simple language understood by the woman			
Provides basic information about conception, pregnancy, and pregnancy options, if needed			
Confirms with the woman that she wants to terminate her pregnancy, and that her decision is voluntary			
Explores what kind of support she has for her decision			
Asks if she came with someone, and if she would like that person to join her during the information/counseling session			
Determines whether someone can be with her and offer support during the medical abortion process			
Explains what to expect during the clinic visit			
Asks about her general health and any medical conditions			
Asks about her reproductive health history			
Asks her if she has any allergies to medications			
Determines medical eligibility for medical abortion			
If routine in local protocols, determines Rhesus (Rh) status and administers Rh-immunoglobulin to Rh-negative women			
If routine in local protocols, performs hemoglobin or hematocrit assessment, if indicated and available. *Note: this may be part of local protocols but may not be feasible or routine in many settings*			
Performs bimanual examination to confirm gestational age			
Explains which abortion methods are available, including their characteristics, effectiveness, and what she is likely to experience			
Explores views on abortion method options and what method is best for her			

8. Used with permission from Ipas.

First Clinic Visit	Yes	No	Comments
If she chooses medical abortion, provides additional information in simple language that is understood by the woman			
Clarifies her feelings on having heavy bleeding and cramping at home			
Explains how and when to take mifepristone and/or misoprostol			
Explains what to expect after taking mifepristone and/or misoprostol			
Explains common side effects of mifepristone and/or misoprostol			
Explains how to take pain medications and suggests other methods to reduce pain (such as a hot water bottle applied to abdomen)			
Explains warning signs indicating need to seek additional care			
Ensures she understands the expected effects, side effects, and warning signs of using mifepristone and/or misoprostol			
Explains what to do in case of questions or problems at home			
Provides contact information if a problem or emergency arises			
Explains the likelihood that medical abortion could fail, and the further steps that will be necessary to terminate the pregnancy			
Explains the very small risk of birth defects associated with misoprostol if abortion fails			
Solicits and answers questions			
Obtains informed consent			
Discusses information about return to fertility and sexual activity			
Enquires about future pregnancy intentions and the need/desire for contraception			
Discusses contraceptive methods, if desired			
Provides contraceptive counseling, if desired. *See* Contraceptive Counseling Skills Checklist *for further information*			
Provides mifepristone and/or misoprostol in clinic or to take home (per protocol)			
Provides information and makes referrals for other services, if needed, including those related to HIV, cancer screening, and violence prevention and care			
Schedules the woman for a follow-up appointment if she desires one. *However, follow-up is not necessary after medication abortion with mifepristone and misoprostol or with misoprostol alone unless desired by the woman or complications develop.*			

Follow-Up Visit *(if necessary)*	Yes	No	Comments
Ensures privacy during visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow up visit			
Asks the woman how she is feeling			
Asks the woman about her experience with the abortion process			
Asks the woman if she thinks the abortion was successful			
Assesses the status of the abortion by: • Taking a history of the abortion process (amount and duration of bleeding, cramping) • Asks about current cramping and bleeding • Asks about current pregnancy-related symptoms • Performs bimanual examination			
If it is unclear whether the woman is still pregnant, discusses options: • Have another or more experienced clinician evaluate the woman • Perform an ultrasound, if available • If appropriate, ask the woman to return in 1 week to reassess • Perform vacuum aspiration			
If the abortion was successful, provides: • Information about how to contact the health center if she has questions or concerns • Information about return to fertility, return of menses, and contraception • Contraceptive counseling and a method, if desired and not done at an earlier visit			
If the bleeding is prolonged or heavier than usual, discusses options: • Expectant management, if appropriate • An additional dose of misoprostol • Vacuum aspiration			
If the woman is still pregnant, discusses and provides or refers for vacuum aspiration			
Provides information and makes referrals if needed for other services, including those related to HIV, cancer screening, and violence prevention and care			
Asks the woman if she has any additional questions, concerns, or needs			

MISOPROSTOL FOR INCOMPLETE ABORTION SKILLS CHECKLIST[9]

Instructions: Check whether the skill was performed well (Yes/No) and add comments.

First Clinic Visit	Yes	No	Comments
Ensures privacy during visit			
Greets the woman in a friendly, respectful manner			
Uses age-appropriate, simple language understood by the woman			
Asks the woman the reason for her visit			
Asks the woman if she believes she was or is pregnant			
Takes an appropriate medical history, including: • Last menstrual period • History of any bleeding, and bleeding pattern. Asks if she has passed clots, tissue, or had bleeding like a heavy period. • Asks if she has had pain or cramping • (If appropriate) Asks if she had an abortion procedure, has used medicines, or taken action to end the pregnancy			
Asks about her general health and any medical conditions			
Asks about her reproductive health history			
Asks her if she has any allergies to medications			
Explains what to expect during the clinic visit			
Performs bimanual examination to assess uterine size			
If routine in local protocols, determines Rhesus (Rh) status and administers Rh-immunoglobulin to Rh-negative women			
If routine in local protocols, performs hemoglobin or hematocrit assessment if indicated and available. *Note: this may be part of local protocols but may not be feasible or routine in many settings*.			
Asks if she came with someone, and if she would like that person to join her during the information/counseling session			
Determines whether someone can be with her and offer support during the uterine evacuation process			

9. Ipas. "Contraceptive Counseling Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual, Second Edition*, 143–45. Chapel Hill, NC, 2014. https://www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition/.

First Clinic Visit	Yes	No	Comments
Explains which uterine evacuation methods are available, including their characteristics, effectiveness, and what she is likely to experience			
Explores views on abortion method options and what method is best for her			
If she chooses medical abortion, provides additional information in simple language that is understood by the woman			
Determines medical eligibility for uterine evacuation with misoprostol			
Clarifies her feelings on having the uterine evacuation happen at home, and what support or challenges she might have there			
Explains how and when to take misoprostol			
Explains what to expect after taking misoprostol			
Explains common side effects of misoprostol			
Explains how to take pain medications and suggests other methods to reduce pain (such as a hot water bottle applied to abdomen)			
Explains warning signs indicating a need to seek additional care			
Ensures she understands the expected effects, side effects, and warning signs of using misoprostol			
Explains what to do in case of questions or problems at home			
Provides contact information if a problem or emergency arises			
Explains that if uterine evacuation with misoprostol fails, she will need vacuum aspiration			
Solicits and answers questions			
Obtains informed consent			
Discusses information about return to fertility and sexual activity			
Enquires about future pregnancy intentions and the need/desire for contraception			
Discusses contraceptive methods, if desired			
Provides contraceptive counseling, if desired. *See* Contraceptive Counseling Skills Checklist *for further information*.			
Provides misoprostol in clinic or to take home (per protocol)			
Provides information and makes referrals if needed for other services, including those related to HIV, cancer screening, and violence prevention and care			
Advises the woman that follow-up care is available if needed or desired			

Follow Up Visit *(if necessary)*	Yes	No	Comments
Ensures privacy during visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up visit			
Asks the woman how she is feeling			
Asks the woman about her experience with the uterine evacuation process			
Asks the woman if she thinks the evacuation process was successful			
Assesses the status of uterine evacuation by:			
• Taking a history of the process (amount and duration of bleeding, cramping)			
• Asking about current cramping and bleeding			
• Asking about current pregnancy-related symptoms			
• Performing a bimanual examination			
If it is unclear whether the process was successful, discusses options:			
• Have another or more experienced clinician evaluate the woman			
• Perform an ultrasound, if available			
• Perform vacuum aspiration			
If the abortion was successful, provides:			
• Information about how to contact the health center if she has questions or concerns			
• Information about return to fertility, return of menses and contraception			
• Contraceptive counseling and a method, if desired and not done at earlier visit			
If the treatment is not successful, discusses treatment options: expectant management, additional misoprostol administration, or vacuum aspiration			
Provides information and makes referrals if needed for other services, including those related to HIV, cancer screening, and violence prevention and care			
Asks the woman if she has any additional questions, concerns, or needs			

UTERINE EVACUATION WITH MEDICATIONS ROLE PLAY SCENARIOS

ABORTION

Client #1: You are a 30-year-old married woman with two children under the age of six. Your period is three weeks late. You cannot manage having another child right now, but you and your husband belong to a religion that prohibits abortion. You are determined to have an abortion but feel more comfortable using medications than a procedure. However, you are afraid about your husband or other family members finding out. After the abortion you want to begin using a contraceptive method that your husband will not detect, because you think he will not approve.

Client #2: You are a 35-year-old married woman with three children. Together with your husband, you have been living in temporary housing for several months. You recently ran out of your regular birth control method. A pregnancy test you took 2 weeks ago when you missed your period was positive. You want an abortion. Your husband does not know about the pregnancy. You think he would not approve of an abortion, so you have never discussed it with him. You have childcare responsibilities as well as household chores and some farming responsibilities. You husband is unemployed. After hearing your options, you have chosen medications.

Client #3: You are a 25-year-old woman living with your boyfriend. You are pregnant and your last period was 7 weeks ago. You fought with your boyfriend because you wanted to have an abortion. He beat you, and for 3 days you had vaginal bleeding, which stopped several days ago. You were hoping you might have a miscarriage, but you are still having pregnancy-related symptoms like nausea and vomiting. You are afraid of your boyfriend. You have chosen to use medications.

Client #4: You are an 18-year-old woman living with your parents and your two sisters live nearby. Your last period was 10 weeks ago. You are in school and unable to have a child at this time. You and your boyfriend broke up over this pregnancy, so you do not expect to be having sex again for a while. You do not want you parents to know about the pregnancy. After hearing your options, you choose medications.

Client #5: You are a 20-year-old woman who has had one previous induced abortion. At that time, you had a procedure and it was very painful for you. Your last period was 12 weeks ago. Your boyfriend is supportive of your decision. You came to this health center because you heard they have pills to cause an abortion. You prefer this as you do not want to have another abortion procedure.

POSTABORTION CARE

Client #1: You are a 35-year-old woman with an unwanted pregnancy. Your last period was about 10 weeks ago. You began bleeding a few days ago, and your bleeding recently became heavier with some occasional strong cramping. Your cervix is open, and your uterine size is consistent with an 8-week pregnancy. You are sharing living quarters with a several other families, all of whom share access to a single bathroom. After hearing the treatment options, you would prefer to use misoprostol.

Client #2: You are a 15-year-old who comes to the health facility with an unwanted pregnancy. You went to the village midwife 2 days ago, who helped you to terminate the pregnancy using a surgical instrument. You have had light bleeding and some moderate cramping since then. You are not sure when you had your last period. On examination, the cervix is slightly dilated with minimal bleeding. There are no signs of injury or infection, and your uterus is around 9 weeks size. You and your boyfriend, who is with you at the visit today, are very scared, particularly of another vaginal procedure. You have not told your family about the pregnancy, but they are generally loving and supportive.

Client #3: You are a 17-year-old woman who sometimes engages in transactional sex. Your last period was 12 weeks ago. You tried to terminate this pregnancy yourself 4 weeks ago when you first realized your period was late. You used some pills that a friend gave you, and had a couple of days of light bleeding, which stopped. Two days ago, you began having heavy bleeding with clots. Your examination reveals an open cervical os, cervical bleeding, and a uterine size of 11 weeks. You decide to take misoprostol.

Client #4: You are a 26-year-old woman. You have had three prior miscarriages. You are happily married and want to start a family. You were happy to find out that you were pregnant and upset that you began having cramping and bleeding today. Your exam reveals that you have had a spontaneous abortion and that you likely have retained tissue in your uterus, which is consistent with an 8-week size. After listening to your options, you prefer to use misoprostol as you have had a manual vacuum aspiration procedure with an earlier miscarriage, and it was very painful.

Client #5: You are a 20-year-old female who legally terminated a pregnancy 3 weeks ago using misoprostol. You are still bleeding and your breasts are still tender. Your examination is consistent with a 9-week uterine size. After having your options explained, you decide to take misoprostol again.

UNIT 6 UTERINE EVACUATION WITH MVA

By the end of this unit, participants will 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 available 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.
- Create a pain management plan with the woman that is sensitive to her situation.
- Discuss elements of post-procedure care.
- Provide referrals to other reproductive health services.

NOTES:

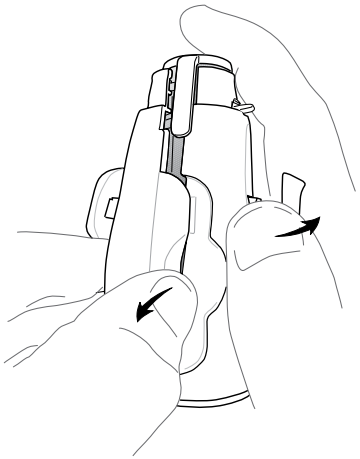
Tips for using the Ipas MVA Plus®

Cap removal

With one hand, press down on the cap release tabs; with the other hand, pull the cap off.

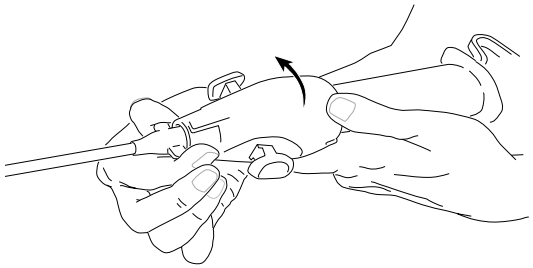
Opening the valve body

Remove valve body from the cylinder. Place right thumb along side the right valve button and left thumb on the valve latch. With the left thumb, pull up and to the left on the valve latch while pushing down and out on the valve body with the right thumb.



Removal and insertion of Ipas EasyGrip® cannula

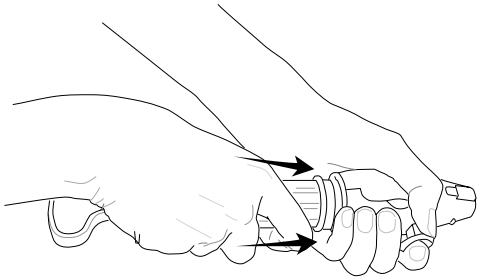
If cannula removal is necessary during the procedure: **Stabilize the cannula** by grasping it at the base with one hand and holding it steady; with the other hand, hold the aspirator by the valve body, **rotate the aspirator** and gently separate it from the cannula. To insert the cannula, hold the aspirator by the valve body (not the cylinder), push cannula base in firmly, twisting slightly if necessary.

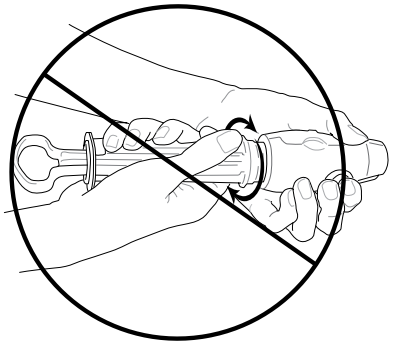


10. Ipas. "Tips for Using the Ipas MVA Plus," n.d. www.ipas.org.

Aspirator assembly

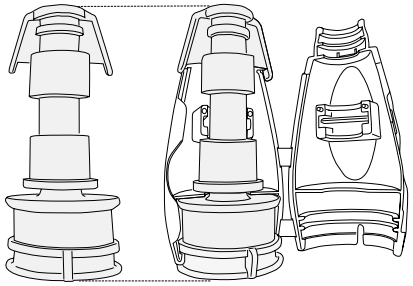
When assembling the aspirator, push the cylinder straight into the valve. Do not twist the barrel or valve when assembling as this will cause the liner to dislodge and may lead to device failure.





Reassembly of Ipas aspirators

Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place. Snap the cap into place on the end of the valve.



Processing tips

- When processing the aspirator with liquid agents, make sure the parts are rinsed thoroughly in boiled/sterile water. When processing agents are allowed to dry on the devices, the plunger does not move easily in the cylinder. When chlorine is not rinsed sufficiently, it may also cause the valve hinges to wear prematurely.
- When the cylinder becomes cloudy or pitted due to processing, soak the cylinder for a few minutes in vinegar, then clean the inside with a soft brush. Rinse in clean water.
- Devices must be completely disassembled prior to cleaning. It is important to remove the O-ring from the plunger prior to cleaning and make sure lubricants are removed during cleaning.

INSTRUMENT PROCESSING SKILLS CHECKLIST: IPAS MVA PLUS® AND IPAS EASYGRIP® CANNULAE[11]

Skill	Yes	No	Comments
1. Point-of-Use Preparation			
Fills a container with water			
Wears gloves and face protection			
Draws solution into the aspirator and cannulae			
Submerges MVA instruments			
Uses gloves or forceps to remove			
2. Cleaning			
Wears barriers—gloves, gown, apron, face protection			
Cleans all instruments, removes tissue or blood, washes all surfaces in warm water and detergent if possible			
Flushes soapy water through the cannula; uses a cotton-tipped probe, soft brush or soft cloth to gently remove material			
Disassembles aspirator			
Uses a small brush to clean crevices and inside			
Cleans until no material is visible upon careful inspection			
Dries with a clean cloth if desired			
Discards the cannula if not possible to remove all matter			
3. HLD or Sterilize			
Method: Steam Autoclave (Sterilization)			
Places cannula and disassembled aspirator in paper or linen			
Places to allow steam contact to all surfaces, not obstructing openings			
Sterilizes at 121°C (250°F) for 30 minutes at 106 kPa (15 lbs/in2)			
Cools before use			

11. Ipas. "Instrument Processing Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 222–23. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

Skill	Yes	No	Comments
Method: Glutaraldehyde (Sterilization)			
Immerses cannula and aspirator so solution fills them			
Soaks according to manufacturer's instructions (10 hours for Cidex)			
Removes with sterile forceps or gloves			
Rinses with sterile water			
Changes the solution every two weeks or per manufacturer's instructions			
Method: Glutaraldehyde (HDL)			
Immerses instruments so that solution fills them			
Soaks according to manufacturer's instructions (20 minutes for Cidex)			
Removes using HLD or sterile gloves or forceps			
Rinses with sterile or boiled water			
Method: 0.5 percent Chlorine (HLD)			
Immerses so that solution fills instrument			
Soaks in 0.5 percent chlorine solution for 20 minutes			
Removes using HLD or sterile gloves or forceps			
Rinses with boiled or sterile water			
Changes chlorine solution at least daily			
Method: Boiling (HLD)			
Ensures water is at a rolling boil			
Boils cannula and aspirator for 20 minutes			
Cools before removing			
Removes using HLD or sterile gloves or forceps			
Handles cannula by non-aperture end			

Skill	Yes	No	Comments
4. Handling, Storage, Reassembly			
Keeps in covered containers, protected from contaminants			
Processes instruments every day if processed using chemicals or boiling			
Keeps only a few instruments in each container			
Uses forceps to remove cannula by the non-aperture end; avoids touching the rest of the cannula			
Reassembles and tests vacuum of aspirator			

FOUR STEPS FOR PROCESSING INSTRUMENTS:

1. Point-of-use preparation:

2. Cleaning:

3. Sterilization or high-level disinfection:

4. Storage:

UTERINE EVACUATION PROCEDURE WITH IPAS MVA PLUS® SKILLS CHECKLIST[12]

Skill	Yes	No	Comments
Creates pain management plan			
Tailors pain management to the woman's needs			
Discusses sources of pain, options, potential side effects			
Includes combination of support and pharmacological measures			
Takes into account her medical and psychological status, staff skills, nature of the procedure and availability of supplies			
Prepares the instruments			
Checks vacuum retention of aspirator			
Has more than one instrument available			
Prepares the woman			
Administers pain medication in timely fashion			
Administers prophylactic antibiotics to all women, and therapeutic antibiotics if indicated			
Asks woman to empty her bladder			
Asks what supportive measures she would like and provides them			
Asks for permission to start			
Puts on barriers and washes hands			
Performs pelvic exam to confirm assessment findings			
Warms and inserts speculum gently			
Performs cervical antiseptic prep			
Follows No Touch Technique			
Uses antiseptic sponges to clean os and, if desired, vagina			
Administers paracervical block			
Uses 20mL of 1% lidocaine (less than 200mg lidocaine)			
Aspirates before injecting 2mL at tenaculum site			

12. Ipas. "Uterine Evacuation Procedure with Ipas MVA Plus® Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 222–23. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

Skill	Yes	No	Comments
Places tenaculum			
Applies slight traction to expose tissue transition			
Aspirates before slowly injecting the remaining 18mL in equal amounts at the cervicovaginal junction to 3cm depth at 2, 4, 8 and 10 o'clock			
Dilates cervix if needed			
Gently dilates cervix until cannula fits snugly			
Inserts cannula			
Applies gentle traction to cervix			
Rotates cannula while gently applying pressure			
Inserts cannula just past internal os into uterus or to fundus and pulls back			
Suctions uterine contents			
Holds tenaculum and end of cannula in one hand			
Attaches charged aspirator			
Releases buttons to start vacuum			
Rotates cannula 180 degrees in each direction			
Uses an "in and out" motion			
Does not withdraw aperture beyond os			
Uses gentle operative technique			
Uses positive, respectful, supportive reassurance			
Stops when pink foam without tissue passes through cannula, gritty sensation is felt, uterus contracts around cannula and uterine cramping increases			
Removes the instrument			
Is ready to evacuate again after inspecting tissue if needed			
Inspects tissue			
Empties aspirator into container			
Looks for POC			
Evaluates amount based on estimated length of pregnancy			

Skill	Yes	No	Comments
Determines all POC have been removed			
Completes remaining steps			
Wipes cervix to assess bleeding			
Considers if pelvic exam is advisable			
Reassures the woman that the uterine evacuation procedure is finished			
Performs any concurrent procedures (such as inserting an IUD or implant, performing female sterilization or repairing a cervical tear)			
If inserting an IUD or implant, follows steps in skills checklists			
Performs post-procedure care			
Removes barriers and washes hands			
Ensures woman is escorted to recovery area			
Processes instruments			
Resolves technical problems that arise			

Post-MVA IUD Insertion Skills Checklist	Yes	No	Comments
Maintains rapport with the woman, ensures continued privacy and comfort			
Confirms that the woman received counseling and gave informed consent for IUD insertion			
If speculum was removed, reinserts speculum and swabs cervix with antiseptic solution			
Sounds uterus			
Opens IUD package sterilely			
Prepares IUD according to uterine size			
Inserts IUD using appropriate no-touch technique			
Trims strings			
Ensures that woman knows aftercare information			

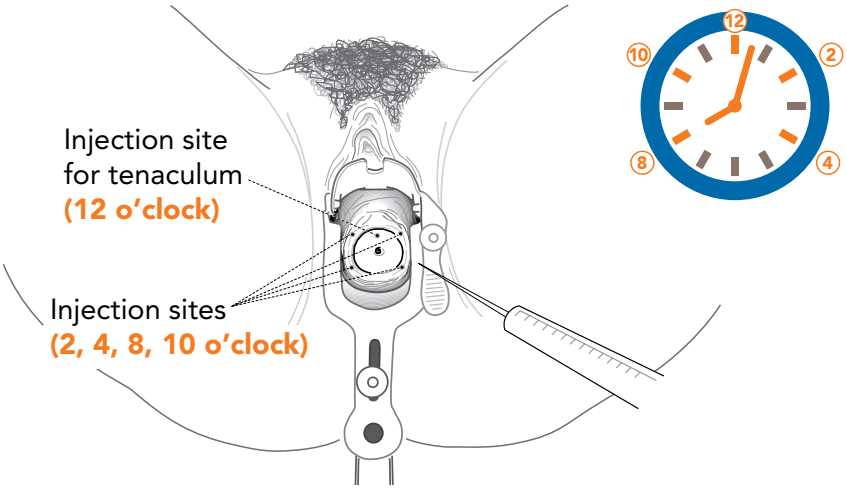
Implant Insertion Skills Checklist	Yes	No	Comments
Maintains rapport with the woman; ensures continued privacy and comfort			
Confirms that woman received counseling and gave informed consent for implant insertion			
Positions woman comfortably with forearm exposed			
Marks insertion point, swabs arm with antiseptic solution			
Injects local anesthesia into insertion point			
Places implant appropriately using sterile technique			
Confirms appropriate implant placement with the woman			
Places dressing on arm			
Gives woman instructions on wound and dressing care			

UTERINE EVACUATION WITH THE IPAS MVA PLUS® PROCEDURE STEPS:

1. Prepare instruments
2. Assist the woman
3. Perform cervical antiseptic prep
4. Perform paracervical block
5. Dilate cervix
6. Insert cannula
7. Suction uterine contents
8. Inspect tissue
9. Perform any concurrent procedure
10. Take immediate post-procedure steps, including instrument processing

NOTES:

PARACERVICAL BLOCK JOB AID[13]



1. **Prepare lidocaine syringe using 20mL of 1% lidocaine and a 3cm (1in) needle.**
2. **Place the speculum and perform cervical antiseptic prep.**
3. **Inject 2mL of lidocaine superficially into the anterior lip of the cervix where the tenaculum will be placed (12 o'clock).**
4. **Grasp cervix with the tenaculum at 12 o'clock.**
5. **Inject remaining lidocaine in equal amounts at the cervicovaginal junction, at 2, 4, 8 and 10 o'clock.**
6. **Begin procedure without delay.**

PRACTICE TIPS

- Do not exceed the lidocaine maximum dose of 4.5mg/kg or 200mg total.
- If 1% lidocaine is unavailable, 10mL of 2% may be substituted. A two-point paracervical block technique (injecting at 4 and 8 o'clock) may be used.
- Where available, and where staff have been trained to do so, sodium bicarbonate may be added to the paracervical block (1mL of sodium bicarbonate for every 10mL of anesthetic solution).
- Deep injection of lidocaine (3cm or 1in) provides more effective pain relief than superficial injection.
- Aspirate before injecting to prevent intravascular injection.
- Possible side effects seen with intravascular injection include peri-oral tingling, tinnitus, metallic taste, dizziness or irregular/slow pulse.
- Midlevel providers trained to provide paracervical block demonstrate similar safety and efficacy as physicians.
- Serious adverse events related to paracervical block are rare.

13. Ipas. "Paracervical Block Technique," 2018. www.ipas.org/clinicalupdates.

PSYCHOSOCIAL FACTORS ASSOCIATED WITH INCREASED PAIN: CRISIS SETTINGS

Please be aware of the following:

- anxiolytics that are locally available

- the drugs that are locally available for paracervical block

- oral non-steroidal anti-inflammatory drugs or narcotic analgesics that are locally available

PHARMACOLOGIC APPROACHES TO PAIN MANAGEMENT DURING MVA[14]

Though the medications shown below are commonly used for pain management during uterine evacuation, many other options exist.

This table does not cover general anesthetic agents. Both anxiolytics and narcotics may cause respiratory depression, especially when they are used together. Accordingly, lower doses should be used when they are together than when they are separate. When medications are given intravenously immediately before a procedure they should be given slowly and intermittently by a specially trained provider. Problematic side effects can be avoided by repeated small intravenous doses that are titrated to a woman's level of pain and sedation. The peak analgesic effect should occur during the procedure to avoid excessive post-procedure sedation.

Even clinicians using lighter sedation analgesia must be able to manage respiratory arrest, in the unlikely event that an unintentional overdose should occur. Providers should be trained in airway management and cardiopulmonary resuscitation, and resuscitative equipment and appropriate antagonist drugs (naloxone and flumazenil) should be available.

Drug Type	Generic Drug Name	Dose and Timing	Half-life	Side Effects	Comments
Local anesthetic	Xylocaine	15-20ml of 0.5%-1% solution in a paracervical block not to exceed 4.5mg/kg	60-90 minutes	Buzzing in ears, dizziness, numbness in lips, mouth and tongue, metallic taste, seizures (rare)	• Pull back plunger before injecting to avoid intravascular injection. Wait three minutes for medication to take effect. • Mild reaction (itching, rash, hives) can be treated with 25-50mg diphenhydramine IM or IV. • For intense reaction or respiratory distress obtain IV access immediately. Give epinephrine 0.4mg subcutaneously and diazepam 5mg slow IV push. Support respiration. If wheezing is present, inhaler may be helpful. • Allergic reaction is very rare. Reactions that do occur may be due to preservatives in multi- dose vials. Preservative- free lidocaine allergy is extremely rare.
NSAID	Ibuprofen	Oral: 400 to 800mg one hour before the procedure	4-6 hours	Possible gastrointestinal upset	• Do not use in women with active peptic ulcer disease or renal failure
	Naproxen	Oral: 550mg one hour before the procedure	4-6 hours	Possible gastrointestinal upset	• Do not use in women with active peptic ulcer disease or renal failure
	Ketorolac	Oral: 20mg one hour before procedure IV: 30 mg over at least 15 seconds 30 to 60 minutes before procedure IM: 60 mg 30 to 60 minutes before procedure ** For women less than 50kg, all doses should be halved*	4-6 hours		• Single dose IM ketorolac prior to surgery may reduce opiod use and post-operative pain (de Oliveira 2012, Roche 2012) • Do not use in women with active peptic ulcer disease, renal failure, breastfeeding or sensitivity to other NSAIDs. • Breakthrough pain should be managed with narcotics rather than increasing ketorolac beyond the recommended doses.

14. Ipas. "Appendix A: Pharmacologic Approaches to Pain Management during MVA." In *Woman-Centered, Comprehensive Abortion Care Reference Manual, Second Edition*, 191–95. Chapel Hill, NC, 2015. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-reference-manual-second-edition.

Drug Type	Generic Drug Name	Dose and Timing	Half-life	Side Effects	Comments
Analgesic	Acetaminophen	Oral: 500 to 1000mg 30 to 60 minutes before procedure	3-6 hours		• Not a first-line pain medication for vacuum aspiration or medical abortion. May be used as an antipyretic. • Liver toxicity from overdose (maximum dose = 4000mg/day) is a risk.
Narcotic/ analgesic combination	Acetaminophen 300mg + codeine 30mg	Oral: 1-2 tablets one hour before procedure	3-6 hours	Drowsiness, light-headedness, nausea and vomiting, CNS and respiratory depression	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). • Be aware of combining with other acetaminophen containing products. Liver toxicity from overdose of acetaminophen (maximum dose = 4000mg/day)
	Acetaminophen 500mg + hydrocodone 5mg	Oral: 1-2 tablets one hour before procedure	4-6 hours	Drowsiness, light-headedness, nausea and vomiting, CNS and respiratory depression	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). • Be aware of combining with other acetaminophen containing products. Liver toxicity from overdose of acetaminophen (maximum dose = 4000mg/day)
Narcotic	Meperidine	Oral: 100-150mg 30 to 60 minutes before procedure IV: 25-50mg 5-15 minutes prior to procedure IM/SC: 50-100mg 30 to 90 minutes prior to procedure	4-6 hours	Drowsiness, light-headedness, nausea and vomiting, CNS and respiratory depression, hypotension, seizures	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). • More rapid onset and shorter duration of action than morphine. • Meperidine 60-80mg = morphine 10mg
	Fentanyl	IV: 50-100mcg immediately before procedure (may repeat every 10-15 minutes, not to exceed 250mcg) IM: 50-100mcg 30 to 60 minutes before procedure	30-60 minutes	Drowsiness, light-headedness, weakness, bradycardia, CNS and respiratory depression, hypotension, seizures	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). • More rapid onset and shorter duration of action than meperidine • Fentanyl 100mcg = meperidine 75mg = morphine 10mg • Onset of action is 2-7 minutes when given IV
	Tramadol	IV/IM: 50-100mg 15-30 minutes prior to procedure. Oral/suppository: 50-100mg 60-90 minutes prior to procedure.	4-6 hours	Drowsiness, light-headedness, weakness, sweating, fatigue, seizures	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). • Less respiratory depression than morphine or meperidine • Tramadol 100mg = morphine 10mg

Drug Type	Generic Drug Name	Dose and Timing	Half-life	Side Effects	Comments
Anxiolytic (Benzodiazepine)	Diazepam	Oral: 10mg one hour before procedure IV: 2-5mg IV 20 minutes before procedure	21-37 hours	Blurred vision, dizziness, diorientation, pain and redness on injection, CNS and respiratory depression	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with flumazenil (see below). • Has a mild amnestic effect. • Onset of action is 2-10 minutes when given IV.
	Midazolam	IV: 1-2mg immediately before the procedure then 0.5-1mg IV every five minutes as needed, not to exceed 5 mg IM: 0.07-0.08mg/kg or about 5mg up to one hour before procedure	1-4 hours	Blurred vision, dizziness, disorientation, CNS and respiratory depression	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with flumazenil (see below). • Midazolam 2.5mg = diazepam 10mg • Stronger amnestic effect than diazepam. • Onset of action is 1-5 minutes when given IV and 15-30 minutes when given IM.
	Lorazepam	Oral: 1-2mg 30-60 minutes before procedure IV: 2mg given over one minute before the procedure IM: 0.05mg/kg up to a maximum of 4mg within 2 hours before the procedure	14 hours	Blurred vision, dizziness, disorientation, CNS and respiratory depression	• If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with flumazenil (see below). • Amnestic effect. • Occasionally may increase patient anxiety.
Reversal agent for narcotic	Naloxone	IV: 0.4mg vial mixed in 10mL saline. Give 1mL (40mcg/mL) every two minutes until reversal is seen			• Naloxone's duration of action is one hour and may wear off before the narcotic. Therefore, patients treated with naloxone must be monitored closely for several hours. • Maintain airway and respirations while giving naloxone.
Reversal agent for benzodiazepine	Flumazenil	IV: 0.2mg every minute until respirations return. Do not exceed 1mg			• Flumazenil's duration of action is one hour and may wear off before the benzodiazepine. • Therefore, patients treated with flumazenil must be monitored closely for several hours. In the event of overdose with narcotic and benzodiazepine, reverse the narcotic first with naloxone and use flumazenil subsequently if needed. • Maintain airway and respirations while giving Flumazenil.

References:
De Oliveira, G. S., Agarwal, D., &Benzon, H. T. (2012). Perioperative single dose ketorolac to prevent postoperative pain: a meta-analysis of randomized trials. *Anesthesia & Analgesia*, 114(2), 424-433.
Roche, N. E., Li, D., James, D., Fechner, A., &Tilak, V. (2011). The effect of perioperative ketorolac on pain control in pregnancy termination. Contraception.

POST PROCEDURE CARE SKILLS CHECKLIST[15]

Skill	Yes	No	Comments
Monitors the woman's physical status			
Ensures the woman is resting comfortably			
Takes vital signs immediately			
Reviews chart for condition and history			
Monitors physiological status, including vital signs			
Evaluates bleeding and cramping at least twice			
Continues therapy for any existing problems			
Assesses and manages complications			
Manages pain			
Evaluates pain levels			
Administers and monitors desired options for pain relief			
Addresses other physical-health issues			
Addresses other physical-health needs and provides referrals if needed for: anemia, RTIs/ HIV, cervical cancer, violence, infertility			
Administers Rh-immunoglobulin, if protocol			
Provides emotional monitoring and support			
Responds sensitively to emotions			
Monitors emotional status			
Provides counseling and referrals for emotional-health needs			
Provides contraceptive counseling (if not done before the procedure)			
Determines desire for future pregnancy and reproductive needs			

15. Ipas. "Post-Procedure Care Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 268. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

Skill	Yes	No	Comments
Provides contraceptive counseling, methods and resupply information			
Makes sure that the woman knows how to use the method of contraception she has chosen and answer any of her questions			
Arranges for follow-up care as desired or needed			
Schedules follow-up appointment according to her condition and/or request			
Secures her consent before releasing records to other providers			
Discharges the woman			
Ensures recovery before discharging according to protocols			
Provides instructions on: self-monitoring normal recovery; pain relief/medications; behaviors that increase problems; when and how to seek treatment for complications; follow-up care			

DEVELOPING A PAIN MANAGEMENT PLAN

DISCHARGE INFORMATION SHEET[16]

How to Take Care of Yourself

- Resume normal activities only when you feel comfortable doing so.
- Eat according to your normal customs and diet.
- Showering, tub bathing and swimming are permitted.
- Correctly and completely take the medications that you have been given:
- _____ is for pain and discomfort. Take _____ pill(s) every _____ hour(s), as needed.

Other medications:

- Call the clinic (telephone number: _____) or come in before then if you have concerns.
- If you have received a contraceptive method, start using it *right away*. It is possible to become pregnant almost immediately after an abortion. If you did not receive a contraceptive method but would like to use one, see your provider as soon as possible. In the meantime, abstain from sexual intercourse or use condoms to prevent pregnancy.

What to Avoid

- Do not have sex until your contraceptive method has had a chance to take effect, if you wish to avoid becoming pregnant. Avoid using a vaginal sponge, diaphragm or cervical cap until all bleeding has stopped.
- Do not douche for one week after the procedure. Routine douching is not recommended unless prescribed by your clinician.

What is Normal

- Bleeding and cramping similar to a normal period for up to one week; spotting may occur for up to several weeks.
- Mild fatigue for a few days.
- There is no “normal” emotional reaction to an abortion procedure. Some women feel a sense of relief, while other women feel sad. If you experience strong emotions, it may help to talk with a trusted friend, relative or provider about these feelings.

Seek care immediately if you experience any of these abnormal symptoms:

What is Abnormal

- Fever
- Abdominal pain
- Nausea / vomiting
- Vaginal discharge that smells bad
- Dizziness, lightheadedness or fainting
- Severe cramping
- Bleeding that is much heavier than a normal period

Adapted from EngenderHealth, 2002b and Policar et al., 1999

16. Ipas. “Appendix E: Discharge Information Sheet.” In *Woman-Centered, Comprehensive Abortion Care Reference Manual*, Second Edition, 199. Chapel Hill, NC, 2015. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-reference-manual-second-edition.

UNIT 7 MANAGING COMPLICATIONS AND ASSESSMENT OF SHOCK AND UNDERLYING CAUSES IN POSTABORTION CARE

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

- Identify signs and symptoms of severe abortion-related complications, including shock.
- Describe management for the complications.

MANAGEMENT OF COMPLICATIONS (CAC) SKILLS CHECKLIST[17]

Skill	Yes	No	Comments
Incomplete abortion or infection			
Administers antibiotics as indicated			
Performs uterine evacuation as indicated			
Continuing pregnancy			
Performs uterine evacuation with vacuum aspiration			
Hemorrhage			
Gives supportive therapy including oxygen, IV fluid and blood transfusion as indicated			
Evaluates for presence of incomplete abortion, uterine atony, laceration or perforation			
Provides appropriate therapy (see steps below)			
Transfuse if vital signs remain unstable			
Uterine atony			
Begins with bimanual massage			
Gives uterotonics			
Performs uterine aspiration			
Performs intrauterine tamponade			
Performs or refers for hysterectomy if bleeding cannot be stopped by other measures			
Ectopic pregnancy			
Recognizes and treats or refers suspected ectopic pregnancy			
Cervical or vaginal lacerations			
Applies silver nitrate or applies pressure by clamping ring forceps for minor lacerations			
Applies sutures as needed			

17. Ipas. "Management of Complications (CAC) Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 358–60. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

Skill	Yes	No	Comments
Uterine perforation			
Admit and observe if perforation occurred during the UE, woman is stable and there are no other injuries			
Laparotomy or laparoscopy to diagnose and manage if the woman is unstable and/or there are signs of intra-abdominal injury			
Stabilize and transfer if facility cannot manage the complication			
Medication-related complication			
Treats as indicated for allergic reactions or overdose			
Hematometra			
Performs uterine aspiration			
Vasovagal reaction			
Treats with positioning			
Atropine injection if prolonged			
Failed medical abortion			
Performs uterine aspiration as indicated			
Persistent pain			
Performs evaluation for retained products, ectopic pregnancy or infection			
Removes tissue trapped at the cervical os			
Offers adequate pain management or refers for further evaluation			
Postabortion care			
Perform rapid initial assessment for shock			
Shock management			
Performs secondary assessment (bimanual and speculum exam) for underlying causes of shock, e.g., incomplete abortion, cervical or vaginal laceration, uterine perforation, uterine atony, infection or sepsis			
Treat underlying causes of shock			

Skill	Yes	No	Comments
Emergency response			
Has a 24-hour emergency response plan in place			
Has a referral plan for complicated patients			
Gives adequate post-procedure care			
Has a plan for monitoring and evaluating adverse events			

MANAGEMENT OF COMPLICATIONS (PAC) SKILLS CHECKLIST[18]

Skill	Yes	No	Comments
Performs rapid initial assessment for shock			
Calls for help, activates emergency procedures			
Performs initial management of shock			
Ensures open airway			
Turns head to the side			
Elevates legs			
Gives oxygen, five L/minute by mask or nasal cannula			
Inserts one or two large bore IVs, gives one liter crystalloid bolus			
Transfuse if vital signs remain unstable			
Keeps woman warm			
Places urinary catheter			
Monitors and records vital signs every 15 minutes			
Monitors intake and output			
Send laboratory evaluations			
Prepares for emergency transfer if adequate treatment is not available			

18. Ipas. "Management of Complications (PAC) Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 398–400. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

Skill	Yes	No	Comments
Performs secondary assessment for underlying causes of shock			
Performs bimanual and speculum exam for signs and symptoms of incomplete abortion, cervical or vaginal laceration, uterine perforation, uterine atony, infection or sepsis			
Incomplete abortion			
Administers antibiotics as indicated			
Performs uterine evacuation as indicated			
Cervical or vaginal lacerations			
Applies silver nitrate or applies pressure by clamping ring forceps for minor lacerations			
Applies sutures as needed			
Uterine perforation			
Admit and observe if perforation occurred during the UE, woman is stable, there are no other injuries			
Laparotomy or laparoscopy to diagnose and manage if the woman is unstable and/or there are signs of intra-abdominal injury			
Stabilize and transfer if facility cannot manage the complication			
Uterine atony			
Begins with bimanual massage			
Gives uterotonics			
Performs uterine aspiration			
Infection or sepsis			
Shock management as indicated			
Begin broad spectrum antibiotics			
Uterine evacuation or surgical management as indicated			
Manages other complications			
Hematometra			
Performs uterine aspiration			

Skill	Yes	No	Comments
Vasovagal reaction			
Treats with positioning			
Atropine injection if prolonged			
Persistent pain			
Performs evaluation for retained products, ectopic pregnancy or infection			
Removes tissue trapped at the cervical os			
Offers adequate pain management or refers for further evaluation			
Allergic reactions			
Treats as indicated for allergic reactions			
Ectopic pregnancy			
Recognizes and treats or refers suspected ectopic pregnancy			
Emergency response			
Has a 24-hour emergency response plan in place			
Has a referral plan for complicated patients			
Gives adequate post-procedure care			
Has a plan for monitoring and evaluating adverse events			

VASOVAGAL REACTION

_____
_____
_____
_____
_____
_____
_____
_____

ABC SIGNS

A _____
B _____
C _____
C _____
C _____

SIGNS OF SHOCK

HOW TO STABILIZE FOR SHOCK

HEMORRHAGE

UTERINE ATONY

CERVICAL OR VAGINAL LACERATIONS OR INJURY

INFECTIONS AND SEPSIS

IDENTIFYING AND MANAGING COMPLICATIONS OF UTERINE EVACUATION WITH MEDICATIONS: CASE STUDIES

Case Study #1

Postabortion Care: A 19-year-old woman, who was approximately 7 weeks pregnant, tried to terminate her pregnancy on her own. She comes to the health facility for help because she had mild but consistent bleeding for 2 weeks and she suspected that she never fully expelled the pregnancy. She was eligible for misoprostol to treat incomplete abortion, which she used at home. She contacts the health center 12 days after using the pills because she continues to have vaginal bleeding. She had heavy cramping and bleeding the day she took misoprostol and diminished bleeding with some spotting thereafter. She is worried because she is now using three pads a day for her bleeding. Her bleeding alternates between a light to moderate period, but the pads are not saturated. The bleeding overall is lighter than it has been during this process. She is not feeling lightheaded or dizzy, but is very worried because she has been bleeding almost a month since she first tried to terminate the pregnancy.

NOTES:

Case Study #2

Postabortion Care: A young woman calls you at midnight, two hours after taking misoprostol for a spontaneous abortion at 8 weeks last menstrual period. She is alarmed because she is bleeding heavier than her period. She is soaking 1 pad per hour and passing very large blood clots that she estimates to be the size of a lemon. She has intense cramps. She is worried she needs emergency care.

NOTES:

Case Study #3

Comprehensive Abortion Care: A 20-year-old woman with a 9-week gestation used mifepristone and misoprostol at home to induce an abortion. After using the medication, her bleeding was heavier than a period for a week, and she noticed blood clots, which she has never experienced with her menses. She had cramps that she described as severe, but did not use any pain medication. She is in the health center for follow-up 2 weeks after her first appointment. Her uterus is non-tender and a non-pregnant size. However, her urine pregnancy test is positive.

NOTES:

Case Study #4

Comprehensive Abortion Care: A 22-year-old woman returns to the health facility the day after seeking misoprostol to terminate an 8-week pregnancy. She took two doses of sublingual misoprostol at home yesterday evening, and has been bleeding heavily since, soaking more than 2 pads per hour for several hours. She says that she has felt dizzy at times today, but that may be because she was up much of the night tending to her bleeding. Her pulse is slightly elevated and her bleeding is noted on speculum exam.

NOTES:

Case Study #5

Comprehensive Abortion Care: A 28-year-old woman reports abdominal tenderness four days after taking misoprostol. She first noticed it when her small son was sitting on her lap. She is concerned now because the pain has become severe. She has a fever and is visibly uncomfortable. She had a mild fever and chills after taking the misoprostol, but was told this was a side effect.

NOTES:

Case Study #6

Postabortion Care: A 17-year-old woman was 11 weeks by last menstrual period, at the time she tried to induce an abortion with herbs and medicines. She received misoprostol for incomplete abortion in a health facility 1 week later. She is returning for her follow-up visit 2 weeks later. She had very heavy bleeding the day she used misoprostol, but the bleeding steadily declined after that. She resumed her normal activities the day after using misoprostol. She feels that she is no longer pregnant but complains of continued cramping. Her uterus is a non-pregnant size and non-tender. Her bleeding is like a light period. There is a visible piece of clot and tissue at her cervical os.

NOTES:

Case Study #7

Comprehensive Abortion Care: A 26-year-old woman who was 6 weeks pregnant when she received her medical abortion with misoprostol returns for a two-week follow-up. She had little bleeding after taking the misoprostol and reports taking all the medicines as directed. She is in no pain, but has breast tenderness. You do a pelvic exam and her uterus is larger than at her first visit.

NOTES:

Case Study #8

Comprehensive Abortion Care: A 35-year-old woman is approximately 8 weeks pregnant as indicated by last menstrual period. She wants a medical abortion. She is having some spotting and wonders if she is having a miscarriage. On pelvic examination, you feel a retroverted uterus of 6 to 8-week size. On speculum examination, you see a closed cervical os and no blood. She received the medicines for medical abortion. She returns to the health center three days later, reporting that she had very little bleeding after using them. While in the waiting room, she began to experience some pelvic pain and wonders if maybe her abortion is finally beginning.

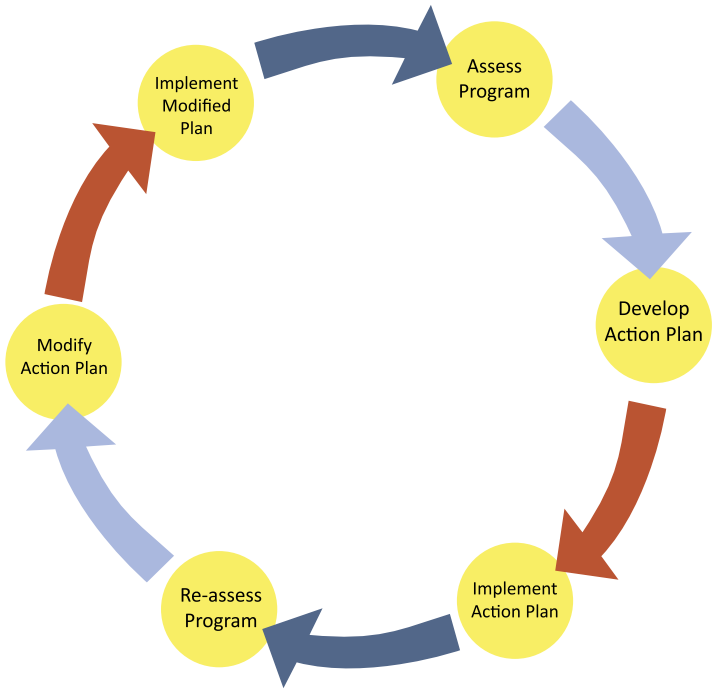
NOTES:

UNIT 8 SERVICE DELIVERY

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

- Describe monitoring and its importance in improving abortion-related services.
- Describe the general steps for integration of abortion-related services into existing sexual and reproductive health programs.
- Understand and contribute towards a work plan to ensure the supply and resupply of instruments, medications, and supplies, the sustainability of uterine evacuation services, and ongoing training/mentoring needs.

MONITORING IS A CONTINUOUS PROCESS



INDICATORS FOR MONITORING QUALITY OF UTERINE EVACUATION SERVICES

EXAMPLES OF ABORTION SERVICES MONITORING[19]

Types of Services **Which services should be monitored?**	**Indicators** **What will we use to measure our activities?**	**Information Sources** **Where can we get this information?**	**Checklists, Questionnaires and Exit Interviews** **What type of questions should we ask?**
Infection prevention	Percentage of cases in which infection-prevention practices were fully adhered to	Observe services using performance checklists	Was no-touch technique performed? Were MVA instruments properly processed?
Management and organization of services	Average amount of time clients spend in the facility Average amount of time from arrival to procedure Hours during which services are available	Review records of clinic finances, personnel and inventory Observe and evaluate clinic flow Review client records and conduct interviews with staff	During what times of the day does client waiting time increase?
Counseling	Number and percentage of women receiving high-quality counseling services	Observe contraceptive counseling services using performance checklists Review recent cases in logbooks	Were women with special needs given appropriate referrals when necessary?
Contraceptive counseling and services	Number and types of contraceptives dispensed on site Number and percentage of women who received contraceptive counseling Number and percentage of women desiring contraception who received a method	Observe counseling services using checklists Conduct exit interviews with women Review recent cases in logbooks	How well was the woman counseled about which contraceptive methods are available? Did the woman leave with the desired method or information? Did the woman have to go to another facility to receive a contraceptive method?
Client satisfaction	Percentage of women who indicate that they received respectful care Percentage of women who agree that clinic costs are reasonable	Conduct exit interviews with women Review financial records	Did you feel that you were treated respectfully? Do you think the amount you had to pay for services was reasonable?

19. Ipas. "Table 5-2: Examples of Abortion Services Monitoring." In *Woman-Centered, Comprehensive Abortion Care Reference Manual, Second Edition*, 66. Chapel Hill, NC, 2015. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-reference-manual-second-edition.

WORKSHEET: PRELIMINARY PREPAREDNESS FOR AND IMPLEMENTATION OF SAFE ABORTION CARE (SAC)[20]

HAS YOUR SITE...	PRELIMINARY PREPAREDNESS				IMPLEMENTATION		
	Yes	No	Not sure	Notes / Next steps?	Issues / challenges?	Possible solutions?	What do you need?
Discussed/clarified the legal context with local authorities and staff at all levels?							
Conducted values clarification activities with staff at all levels?							
Conducted whole-site orientation about SAC services with all facility staff?							
Disseminated and discussed the agency's internal policy toward SAC?							
Considered patient flow through the facility for efficiency and to ensure privacy?							
Decided on a system for monitoring the quality of programs and services?							
Built SAC clinical and management capacity?							
Established processes and systems for clinical mentoring and facilitative supervision?							
Planned how to integrate or link SAC with existing sexual and reproductive health services? (e.g., contraceptive care; gender-based violence; etc.)							
Planned for an adequate and sustainable supplies for manual vacuum aspiration and medical abortion services?							
Established a referral system to a higher-level of care, including understanding the capacity of the referral facility and emergency transport system?							
Identified local SAC champions and potential partners within local ministries?							
Established connections with existing local women's or other community groups that could help advocate for and inform the population of available services?							

20. Ipas. Chapel Hill, NC. 2018.

SUPPLY AND EQUIPMENT CHECKLIST FOR FIRST TRIMESTER (<13 WEEKS) COMPREHENSIVE ABORTION CARE[21]

This checklist should be used to help plan for service implementation of high quality comprehensive abortion care, both medical and manual vacuum aspiration, for gestations less than 13 weeks. Many of the items listed below are not unique to comprehensive abortion care and may already be available in the facility. Items essential to perform abortion and to ensure safety need to be available prior to service initiation whereas other items can continue to be obtained as service provision develops. Items marked with an asterisk (*) are required for infection prevention.

FACILITY

- ☐ Private area for counseling (ideally both visual and auditory privacy)
- ☐ Restrooms with toilets should be easily accessible to all women receiving abortion-related care
- ☐ Handwashing stations *
- ☐ Potable water for drinking/cups
- ☐ Emergency transport/referral capability
- ☐ Referral forms
- ☐ Service delivery logbook
- ☐ Consent forms for abortion care
- ☐ Procedure room (MVA only)
- ☐ Recovery area (MVA only)
- ☐ Safe box for sharps*
- ☐ Colored bins for waste segregation*
- ☐ Pamphlets, educational materials (for adult and younger women)
- ☐ Stool for exam/procedure room
- ☐ Lockable cupboards for medications
- ☐ Job aids: MA regimen card, instrument processing wallchart*, MA/MVA supply guidance, MA wheel, etc.

EQUIPMENT/SUPPLIES/DRUGS

- ☐ Available contraceptive methods, including IUD/IUS, implants and associated equipment
- ☐ Blood pressure cuff
- ☐ Thermometer
- ☐ Stethoscope
- ☐ Personal protective barriers (for instrument processing: heavy duty gloves, boots/shoe covers, face protection, gown/apron; for procedure/exam: clean and sterile gloves, gown/apron, boots/shoe covers, eye protection) *
- ☐ Sanitary pads
- ☐ Disinfectants*
- ☐ Instrument trolley, instrument tray, drums/containers for storage of autoclaved MVA packs*, kidney dishes (large and medium), gulli pot
- ☐ Pelvic Exam Table
- ☐ Lamp for pelvic exams
- ☐ Cover/drape to cover client's legs
- ☐ Laboratory supplies
    - (optional) Ultrasound and its accessories
    - (optional) Urine ß-hCG tests and urine cups
    - (country-dependent) Rh testing and Anti-D immunoglobulin
    - Not required for abortion care but optional if other preventative health testing is provided: cervical cancer screening, STI testing, HIV testing, anemia screening, immunizations.
- ☐ Medications
    - Mifepristone, depending on availability, or combipack
    - Misoprostol
    - Antibiotics (prophylaxis and treatment dosing)
    - Side-effect medications (e.g. anti-nausea medicine)
    - Pain medication
- ☐ NSAIDS
- ☐ Narcotic/Anxiolytics and reversal agents
- ☐ MVA supplies
    - Atraumatic tenaculum or vulsellum forceps
    - Sponge/ring forceps (Foerster)
    - Gauze
    - Betadine® (povidone-iodine) and cup *
    - Ipas MVA Plus® Aspirator
    - Ipas EasyGrip® Cannulae
    - Self-retaining speculums of varying sizes
    - Denniston or Pratt dilators
    - Container for POC, lamp, clear basin, sieve
    - Bucket with soaking fluid*
    - Paracervical block supplies and local anesthetic
- ☐ 10-20ml syringe, 21-23 gauge needle at least 3cm (1in)
- ☐ Lidocaine 1.0%
- ☐ Instrument processing*
    - Protective barriers listed above

21. Ipas. "Supply and Equipment Checklist for First Trimester (<13 Weeks) Comprehensive Abortion Care," 2019.

- ☐ (optional) sterile forceps
    - 3 buckets (soak, HLD/Sterilizer, Rinse)
    - Small brush
    - Tap water, sterile or boiled water, detergent, HLD (0.5% Chlorine) or Sterilizer (Glutaraldehyde)
    - If HLD with boiling, large metal pot and heat source
    - If sterilizing with autoclave- paper or linen, autoclave
    - Covered containers to store instruments

COMPLICATION MANAGEMENT

- ☐ Blanket
- ☐ Instruments for assessment/vital signs as listed under Clinical Assessment
- ☐ Oxygen tank
- ☐ Gloves*
- ☐ IV fluids/set
- ☐ Antibiotics (po or IV)
- ☐ Diphenhydramine
- ☐ Pain medication
- ☐ Uterotonics
- ☐ Emergency tamponade supplies (Foleycatheter, obstetric balloon, sterile gauze)
- ☐ Ability to transport/emergently refer

*Items with an asterisk (*) are required for infection prevention.

CALCULATIONS OF AVERAGE DAILY MVA CASELOAD

NUMBER OF MVA DEVICES NEEDED IN ACTIVE STOCK

NUMBER OF MVA DEVICES NEEDED IN RESERVE

MVA INITIAL SUPPLY AND RE-RESUPPLY CHART (BASED ON CASELOAD AND POISSON DISTRIBUTION)[22]

Active Stock in Procedure Room			Reserve Stock in Facility Store-Room		Planning Data	
A **Average caseload per day**	**B** **Cases to plan for (95% coverage)**	**C** **Active Devices Needed**	**D** **Reserve Maximum (3 months of supply)**	**E** **Reorder Point (1 month of supply)**	**F** **Total Initial Stock**	**G** **Devices to Replace Each Year**
0.5	2	3	2	0	5	7
1	3	4	4	1	8	15
2	4	6	7	2	13	29
3	6	8	11	3	19	44
4	7	9	15	4	24	58
5	9	11	18	5	29	73
10	16	11*	37	12	48	146
*Two processings per shift or day						

22. JSI, and Ipas. "MVA Initial Supply and Re-Supply," 2009.

UNIT 9 EVALUATION AND CLOSING

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

- Explain how the training met their expectations and course objectives.

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

1.

2.

3.

NOTES:

Suggested citation:
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