UTERINE EVACUATION IN CRISIS SETTINGS USING MEDICATIONS AND MANUAL VACUUM ASPIRATION

FACILITATOR'S GUIDE

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*.

Ipas led on the development of the module and its revision. We especially acknowledge Emily Jackson and Bill Powell of Ipas for their clinical expertise and for overseeing the development of this publication.

We further thank the following people for their contributions, including those who served as the Master Trainers for the various pilots of the module:

Babatunde Adelekan
Talemoh Dah
Patrick Djemo
Jeannine Herrick
Myriam Kayumba
Jill Moffett
Diane Morof
Monica Oguttu
Sarah Neusy
Bill Powell
Jennifer Kiefer Soliman

Additionally, we are grateful to the IAWG Training Partnership Initiative Steering Committee and Safe Abortion Care Sub-Working Group Members, including Sandra Krause and Nguyen Toan Tran, as well as to the agencies which offered pilot sites: CARE, Family Planning Association of Nepal, Institut Africain de Santé Publique and the Ministry of Health in Burkina Faso, Juba College of Nursing and Midwifery, Médecins du Monde, and Save the Children (training adapted for PLGHA compliance). Alison Greer provided a review and edits. The training materials were originally designed by Mikhail Hardy and Chelsea Ricker. REC Design designed this combined training module.

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

TABLE OF CONTENTS

THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

This guide provides what we hope is a simple and user-friendly set of instructions to plan, conduct, and evaluate a clinical refresher training. Throughout this document, additional notes to help you as a facilitator are marked using the symbol to the left. You will also find more details about the design and use of this guide below in the section marked "Description of Facilitator's Guide."

INTRODUCTION

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

Nurses, midwives, and 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 Medications and Manual Vacuum Aspiration* is one of these modules. It combines content from the two previously published uterine evacuation training materials, *Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration and Uterine Evacuation in Crisis Settings Using Medications,* which were designed to be stand-alone trainings. Please visit www.iawg.net/scorts to access all training materials in the series and more information on their use.

Additional resources for implementing sexual and reproductive health services in crisis settings are available on the IAWG site at iawg.net/resources. In particular, facilitators and participants in this training may also want to explore:

- *The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
- *IAWG Programmatic Guidance for Sexual and Reproductive Health in Humanitarian and Fragile Settings During COVID-19 Pandemic*
- *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: 2020 Edition*
- *Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings Manual: 6th Edition*

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 discriminating, stigmatizing, and 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 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 participants in these trainings and persons living with disabilities in the communities they serve.
- **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 facilitators should keep these inclusive considerations of gender, age, disability, and diversity in mind when rolling out 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 in the end should not define who they are and how health staff should treat 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.

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.

FACILITATOR'S GUIDE AND TRAINING PLAN OVERVIEW

The *Uterine Evacuation in Crisis Settings with Medications and Manual Vacuum Aspiration Facilitator's Guide* intended to be used by facilitators leading a refresher training. The course is 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.

OBJECTIVE

This training includes a slide presentation, learning activities, and other participant materials and resources designed to help health care workers learn the knowledge and skills they need to provide uterine evacuation with medications and first-trimester uterine evacuation using Ipas MVA Plus® Aspirator and EasyGrip Cannulae®. 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 abortion 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

Please note that this course focuses on use of medications and manual vacuum aspiration, 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 Facilitator's Manual (2nd ed.)* and other Ipas curricula, available at www.ipas.org.

TARGET AUDIENCE

The training program is designed for health care workers, including midwives, nurses, general practice physicians, obstetrician/gynecologists, and others who will provide first-trimester uterine evacuation in crisis settings and have previous experience with intrauterine procedures including manual vacuum aspiration. The program provides the basic information necessary for provision of care, and includes resources for further study. Ipas recommends a maximum of twenty participants per workshop. Four facilitators are recommended (1 per 5 participants) to lead this training. This is ideal for adequate support during the hands-on manual vacuum aspiration skills sessions.

FACILITATOR CONSIDERATIONS AND PREPARATION

REQUIREMENTS

All facilitators should meet the following criteria:

- Be clinicians skilled in uterine evacuation with medications and MVA, capable of training on all elements of the course
- Follow current clinical guidelines
- Ideally, have prior experience with Ipas clinical training curricula
- Employ effective teaching methodologies based on adult learning principles
- Be effective presenters and facilitators
- Have facilitated numerous trainings on uterine evacuation, including postabortion care (PAC) using medications and MVA
- Have a strong working knowledge of the 2018 MISP and *Inter-Agency Field Manual on Reproductive Health in Crises*

RECOMMENDED PREPARATION

Before teaching the course, facilitators are advised to review the following resources:

- Ipas *Effective Training in Reproductive Health & Course Design and Delivery Reference Manual*.

- Ipas *Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences*.
- IAWG 2018 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*.
- Ipas *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training*, 2009.

These and other publications can be downloaded at www.ipas.org/resources or www.iawg.net or by contacting training@ipas.org.

PARTICIPANT PREREQUISITES

At a minimum, participants should have previous exposure to uterine evacuation with MVA and be able to:

- Demonstrate knowledge of the female reproductive system
- Take a medical history and conduct a physical exam
- Accurately assess the gestational age of an early pregnancy using bimanual examination
- Accurately diagnose incomplete abortion
- Recognize and manage or refer women for treatment of complications due to incomplete abortion
- Recognize signs and symptoms of an ectopic pregnancy

Facilitators should assess both knowledge and skills to determine the competency of each participant. The pre- and post-tests serve as knowledge assessments. Facilitators can use the skills checklists to assess participants' performance during role-plays or in a clinical practicum. Ipas recommends that at the end of the course, participants should complete the final evaluation to provide feedback for future trainings. If you find that there is a need for basic training for clinicians with limited or no experience in uterine evacuation, or need for values clarification on the provision of abortion and post-abortion care services in crisis settings:

- Advise the participants' organization to plan for an extended values clarification training, available online at www.ipas.org/resource/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences.
- Contact the IAWG Training Partnership Initiative Coordinator by emailing info.iawg@wrcommission.org.

Note: In crisis settings, refresher courses typically take place on-site. Be sure to bring all supplies to the training, including paper certificates, copies of the participant workbook or handouts, and additional resources in paper format or on a USB key. The IAWG S-CORTs site (www.iawg.net/scorts) provides recommendations for additional resources to download for participants. Bring paper copies of slides with notes for your use and extra flip chart paper as a backup in case a projector or electricity is not available. A flexible approach to facilitation will be needed to help you adapt to the context and participants' needs.

ACCOMPANYING PARTICIPANT WORKBOOK

One of the lessons learned from piloting S-CORT series is that participants preferred to have the materials shared with them in advance of the training to review and help them prepare.

The accompanying *Participant Workbook* includes copies of the relevant materials that pertain to each section of the training and provides additional background. These materials should be shared with participants as soon as possible, but at least 2-3 weeks before the training, in hard or soft copy. **In addition, participants should become certified in the *MISP for Sexual and Reproductive Health Distance Learning Module* (available at www.iawg.net/misp-dlm). This will help to provide a foundation prior to the training.**

DESCRIPTION OF THE FACILITATOR'S GUIDE

This guide is divided into seven units:

- One introductory unit
- Seven workshop units
- One course evaluation/closing unit

Each unit focuses on one component of uterine evacuation with medications or MVA service delivery, and includes five elements:

1. **Timing and methodology:** An estimate of how long it will take to complete the unit, its components, and the training methodology used
2. **Objectives:** Specific learning objectives to be met by participants by the end of each unit
3. **Materials:** Copies of all participant materials for distribution and answer keys for facilitators, color-coded and highlighted to identify materials you will need to print, download, or gather

4. **Preparation:** Instructions regarding information, activities, and materials to be prepared ahead of time
5. **Detailed session guide:** Step-by-step guidance on how to facilitate interactive participatory learning

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

DOCUMENTATION AND CERTIFICATE

Facilitators should document attendance as well as pre- and post-test results, and present certificates of completion as appropriate. A sample certificate template is included in the training package.

PARTICIPANT EVALUATION

Facilitators should conduct an informal process evaluation at the end of each workshop day to assess progress and participant satisfaction with the topics and activities. At the end of the course, participants should complete the final evaluation to provide feedback for further trainings.

PREPARATION FOR THE TRAINING

Facilitators should go through the sample agenda (Annex 1), facilitation plan, and tables below that outline the preparatory work that must be undertaken to successfully implement this course.

COURSE MATERIALS

The written or digital materials and complementary resources for this training are freely available for download at www.iawg.net/scorts. In advance of the course, it is recommended to download all the materials and resources to be used during the training, including all handouts and slide presentations. The materials also include text and picture-based pocket cards to help women recognize normal side effects and complications, and sample certificates of completion that facilitators can personalize in Microsoft Word. These materials can be stored on a USB key for use during the training and while offline. Copies of the materials can be shared with participants and other colleagues who are interested.

MATERIALS LIST

The following is a complete list of supplies needed for the successful implementation of the training. Each unit specifies from these lists which materials to print, download, or gather for that topic. Verify which supplies are already available at the training venue and make arrangements to bring any missing supplies with you.

COURSE MATERIALS CHECKLIST: ITEMS TO GATHER

Unit	Materials	Quantity	Acquired? (Yes/No)
All	Laptop	1	
All	Projector	1	
All	Copies of the Participant Workbook	1 per participant	
All	PowerPoint slides	1	
All	Pens or pencils	1 per participant, at least	
All	Flip chart paper	2-3	
All	Markers or crayons		
All	Tape	Several rolls	
All	Bell	1	
1	Long piece (3-4 yards) of brightly colored paper, with different years written along the top	3-4 yards	
1	Sheets of paper, at least 2 colors	Multiple per participant	
2	Colored tape or a piece of string or ribbon, 2-3 meters long		
3	Samples of contraceptive methods approved for use after uterine evacuation		
3	Samples of mifepristone and misoprostol		
6	Pelvic model(s)	2 at least (ideal is 1 per 5 participants)	
6	Fabric for draping		
6	Ipas MVA aspirators (and product insert)*	1 per participant, or at least one per site	
6	Ipas EasyGrip® Cannulae	2 at least per pelvic model; must be size 6 for use with pelvic model. Optional: one full set of cannulae available for demo	
6	Specula (various sizes including small)	1 per pelvic model	
6	Dilators	One set per pelvic model; can substitute the different sized cannulae if dilators are not available	
6	Tenaculae	1 per pelvic model	
6	Sponge holding forceps	1 per pelvic model	
6	Gloves	1-2 boxes of non-sterile exam gloves	
6	Samples of worn aspirators and cannulae that need to be replaced (if possible)	2 at least	
6	Syringes and needles	1 syringe and one needle per pelvic model; ideally 10-20 mL syringe and 21-23 gauge needle at least 3 cm (1 in)	

ADVANCE PREPARATION CHECKLIST: ITEMS TO DOWNLOAD, PRINT, AND PREPARE

Use the following checklist to ensure that all the necessary materials are prepared in the weeks before the training:

Unit	Description	Completed? (Yes/No)
All	Review all course materials and adapt to the context	
All	*Make copies of the Participant Workbook*	
All	Gather, pack, and/or ship all materials	
All	Ensure the training space and set-up meets training and learning needs	
1	Prepare a *Course Agenda* handout with detailed information on the course units, subtopics, and schedule	
1,9	Print copies of the knowledge *Pre-test* and *Post-test*	
1,2,5,8	Prepare flip charts	
2	Research current abortion laws and policies in your setting and prepare a short (15 minutes or less) presentation on the topic	
2	Put the current written law on a presentation slide, write it on a flip chart sheet, or prepare a handout	
2	Read through the following sections from the 2018 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*: • Chapter 8, "Comprehensive Abortion Care," Section 8.3.2 Needs Assessment (p. 147) • Chapter 8, "Comprehensive Abortion Care," Section 8.4 Human Rights & Legal Considerations (p. 160-2)	
2	Note anything applicable from the readings above to your training setting and share this information with participants	
3,6	Arrange to ship or carry samples of mifepristone, misoprostol, contraceptive methods, and all supplies for instrument facts and features, processing, and simulated uterine evacuation with you to ensure they make it through customs and other potential barriers in time for training	
3	Review included case studies and revise to ensure they are appropriate for training setting	
4	Download and print copies of the "Pregnancy Dating and Labs Resource" (see page 17) from *Clinical Practice Handbook for Safe Abortion*	
5	Download and print copies of the 4 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*	
6	Download/access videos using links below: Video: *Processing the Ipas instruments* (Ipas, 2019), 17 minutes Video*: *Manual Vacuum Aspiration Technique Using the Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae* ** You will need a password to access the second video. This video was adapted by Ipas with permission from Innovating Education in Reproductive Health. It is for classroom training use only. For access password, please contact info.iawg@wrcommission.org or training@ipas.org. Please do not distribute the video, video link, or password to participants.* 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	
6	Assess which method(s) of instrument processing is used and tailor Section 2 accordingly	
8	Be familiar with any monitoring practices in the participants' facilities	
8	Be prepared with examples of monitoring for abortion-related services	
8	Review the medical abortion and MVA calculators • Medical abortion calculator: www.ipas.org/supply-calculators/ma • MVA calculator: www.ipas.org/supply-calculators/mva	
8	Familiarize yourself with the Medical Abortion Commodities Database at www.medab.org before the training	
8	Download and print a copy of the COPE® for Comprehensive Abortion Care Handbook for participants to review	
9	Fill out participants' names on the certificates of completion	

ALERT: IMPORTANT RECOMMENDATIONS FOR BEFORE AND AFTER THE TRAINING

ABORTION LAW IN THE REGION

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

- Prepare some slides, a flip chart, or handout that explains the current laws and policies that can affect providing abortion care.
- Facilitate a short discussion where participants can think through various scenarios.
- Advocate for participants to provide abortion services to the fullest extent of the law.
- Review the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018 Revision, pp. 148, 160-2.

ADAPT TRAINING FOR PAC

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

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

Facilitators should not present different clinical recommendations without also stating current guidance from the World Health Organization (WHO) and Ipas as presented in this curriculum. Any deviation from clinical recommendations contained in this guide should be clarified as being at variance with WHO and Ipas standards.

CHARACTERISTICS OF EFFECTIVE TRAINING[2]

The following recommendations are necessary to ensure effective transfer of information during adult learning:

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

SITE ASSESSMENT

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

- Staffing protocols such as mentoring relationships, clinical supervision, turnover rate, and the available training resources.
- Availability of a projector and electricity for a laptop computer.
- Current and expected future caseload for uterine evacuation services.
- Type of facility, level of training, and staff experience providing uterine evacuation with medications and MVA.
- Availability of mifepristone and/or misoprostol.
- Availability of MVA kits and how instruments are processed and stored.
- Which staff offer uterine evacuation and related services such as patient assessment, counseling, family planning, and reproductive health linkages.
- How quality of patient care is monitored and what (if any) data systems are in place.

Work with site leaders to establish the following, for use during the training:

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

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

ASSESS PARTICIPANTS

It is important to assess the experience of participants prior to finalizing the contents of the training materials and beginning the training. Only providers who have already been trained in uterine evacuation using MVA are eligible for the refresher short course. If you find that there is a need for a basic MVA training for clinicians with no experience:

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

SENSITIVITY AND FLEXIBILITY IN A CRISIS SETTING

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

- Minimize the time providers spend away from their duty stations. This can be addressed by conducting the training at the facility, if possible.
- Be sensitive to long hours and double shifts health care providers may be working.
- Remember that some participants may have long travel times or have competing priorities at home that may prevent them from completing advanced reading or other assignments.
- Be prepared for participants with a range of abilities and experiences – some participants may be very new to the setting.
- Attendees will most likely be a range of nurses, midwives, physicians, and clinical officers.
- Be sensitive to the emotional needs of health care providers/participants in a crisis setting.
- Some providers may be experienced in using mifepristone and/or misoprostol or MVA for uterine evacuation, but inexperienced doing so in a crisis setting with limited resources and within a different structure.

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.

Lessons learned from uterine evacuation with medications and MVA trainings in Democratic Republic of Congo, Niger, and Uganda

Summary of recommendations to improve the capacity development continuum

During the initial roll outs of this training module, the following lesson and recommendations were learned from facilitators, participants, and organizers:

Pre-workshop preparation by the program coordinator

- The training should take place as early as possible, such as in the immediate period after the acute phase of a crisis;
- Having the right participants is key to a successful training. Participants for this training should be service providers who already had previous exposure to uterine evacuation and need a refresher course;
- Health facilities where participants work should ensure the sustainable availability of medication, manual vacuum aspiration syringes, and required materials and supplies to offer services to clients after the training;
- Organizers should share printed pre-reading materials to all participants at least a week in advance;
- Prepare training binders containing the trainee's manual, evaluation tools, and checklists, to streamline the way handouts and supportive materials are shared;
- Coordinate with the clinic(s) where hands-on practice will take place to ensure the availability of clients on the day planned for the practice session.

During the workshop, facilitators should ensure adequate time to cover the following sessions:

- Practical discussion on how to (better) integrate uterine evacuation into the health facility services and monitor its implementation;
- Medication regimen;
- Review of post-intervention contraception;
- How to use and complete the competency checklists, including a plan for a regular rehearsal of skills among providers using the checklists.

After the workshop, program managers should:

- Organize supportive supervision visits of service providers to accelerate the adequate skills transfer from training to clinic settings;
- When needed, facilitate the remote technical support by facilitators using mobile phone or videoconference.[3]

3. Tran, Nguyen Toan, Alison Greer, Talemoh Dah, Bibiche Malilo, Bergson Kakule, Thérèse Faila Morisho, Douglass Kambale Asifiwe, et al. "Strengthening Healthcare Providers' Capacity for Safe Abortion and Post-Abortion Care Services in Humanitarian Settings: Lessons Learned from the Clinical Outreach Refresher Training Model (S-CORT) in Uganda, Nigeria, and the Democratic Republic of Congo." *Conflict and Health* 15, no. 1 (April 6, 2021): 20. doi.org/10.1186/s13031-021-00344-x.

UNIT 1 COURSE OVERVIEW

Time:
60 minutes

Unit Objectives:

By the end of this unit, participants will:

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

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 15 minutes: Icebreakers/Introductions
- 15 minutes: Group Discussion: Housekeeping, Ground Rules, Expectations, and Agenda
- 30 minutes: Knowledge Assessment*

*Note: Participants can begin the knowledge assessment during registration and finish during this session to save time.

PREPARATION

- Print, download, and gather materials as listed below
- Prepare flip chart paper with the *Course Agenda* and schedule, and blank flip chart paper
- Prepare a *Course Agenda* handout with detailed information on the course units, subtopics, and schedule
- Prepare small pieces of paper with written numbers, one for each participant

PRINT:
Handouts, one per participant:
- ☐ Course Agenda
- ☐ Pre-Test

Participant Workbook:
- ☐ *Course Objectives*

DOWNLOAD:
Presentation:
- ☐ Slides 1 through 5

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart papers
- ☐ Long piece (3-4 meters) of brightly colored paper, with different years written along the top
- ☐ Half sheets of colored paper, at least one per participant
- ☐ Markers, pens, or crayons
- ☐ Tape

DETAILED SESSION GUIDE

INTRODUCTION/ICEBREAKER

Greet participants warmly. "Welcome to this course on providing uterine evacuation for women in crisis settings using medications and manual vacuum aspiration (MVA). This is a refresher course for health care providers already familiar with MVA and who may or may not have experience with uterine evacuation with mifepristone and/or misoprostol."

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

Introduce the activity as an opportunity to get to know one another better and learn where everyone in the group fits into the larger picture of work in crisis-affected settings. If not already done, **hang** the timeline on the wall where all participants can see it.

Ask everyone to think about when they first joined their organization or started doing work related to humanitarian crises, as appropriate. **Ask** each person to take a half sheet of colored paper and **draw** a symbol or picture or **write** a word that captures something about how they got involved in this work or with their organization. **Give** an example: "I might draw a picture of a nurse's hat because I was working as a nurse in a women's health clinic when I was asked to join this project" or "I might draw a picture of a newspaper because when I read about a certain situation in the paper it made me want to help." **Emphasize** that this is not about great artwork. People can use stick figures or write words if they prefer. **Ask** each learner to **sign** the paper with their first name and the first letter of their last name. **Allow** three minutes for this individual work, then **bring** the attention back to the larger group.

Ask that people who joined their organization or began working in crises in the last year come up to the timeline. **Ask** people to **say** their name, what their role is in the organization/field, and a brief sentence or two about how they became involved or what they wrote on their paper. **Ask** that they **tape** their paper on the timeline under the appropriate year.

Repeat this process for those who began in the last five years, ten years, and so on. Especially if it is a large group, **encourage** participants to be brief.

Summarize the activity by observing how much collective experience appears to be in the room. Those who have been with their organization or involved in crisis work for a long time have much institutional memory and experience. Others who are newer bring a fresh perspective and energy. All organizations and fields need both the experience of those who have been around a while and those with a new perspective.

GROUP DISCUSSION: HOUSEKEEPING, GROUND RULES, EXPECTATIONS, AND AGENDA

Ask participants what they hope to learn in the course and **write** down their expectations on a flip chart titled "Course Expectations." **Post** the prepared flip chart titled "Course Agenda" on the wall and review the training schedule. **Refer** to the agenda throughout the course to stay on topic and on time. **Refer** to the handout: *Course Agenda*. **Refer** back to the participant expectations posted on the wall and **circle** what will be covered in this course and what may be beyond the scope of the training. **Keep** the list to **review** with participants at the end of the course to **ensure** that realistic expectations were met. **Show** slide 4: *Course objectives*.

Note: These are the overall course objectives. More detailed learning objectives for each unit will be reviewed at the start of each unit. Ask participants to take turns reading the objectives out loud.

Tell participants where the restrooms are and encourage them to leave the training room quietly, if needed. **Mention** that there will be morning and afternoon breaks with lunch in between and where these will take place. **Note** any relevant safety and security information, such as safe areas and available phones.

Note: Consider setting up a WhatsApp group or similar group platform for communication for all participants. This will help with sharing key training and security information.

Post a blank flip chart sheet and **draw** a flower at the top. **Explain** that during the course, any questions that cannot be addressed at that time will be put in the "garden" where it can grow. Throughout the course, the facilitator will refer to these questions and address them when most relevant. **Post** a blank flip chart sheet entitled "Ground Rules." **Explain** that ground rules are mutually agreed-upon guidelines to help the group work together, create a safe and respectful learning environment, and accomplish tasks efficiently. **Ask** participants to suggest ground rules. Possible ground rules may include participating, listening respectfully, speaking one at a time, turning off cell phones and pagers, and maintaining confidentiality. **Write** their suggestions on the flip chart.

KNOWLEDGE ASSESSMENT

Note: To save time, you can distribute the *Pre-test* during registration. Participants can begin answering the questions and finish once the activities above have been completed.

Distribute the *Pre-test* handout. **Say** participants have about 15 minutes to respond to the questions. **Prepare** small pieces of paper with numbers on them. **Ask** each participant to pick a number. **Explain** that this number will be used for tests and other assessments throughout the training. **Note for yourself** the participants' names and numbers, then **ask** participants to write their numbers on their tests. **Allow** 15 minutes to complete tests and collect them all the end of the allotted time. This allows for results to be shared anonymously.

UNIT 2 UTERINE EVACUATION IN CRISIS SETTINGS

Time:
75 minutes (1 hour 15 minutes)

Unit Objectives:

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 in 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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 15 minutes: Facilitator Presentation and Group Discussion
- 30 minutes: Values Clarification Activity: Crossing the Line
- 30 minutes: Facilitator Presentation and Case Studies

PRINT:
Participant Workbook:
- ☐ *Abortion Law*
- ☐ *MISP Reference*

DOWNLOAD:
References:
- ☐ *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018 revision

Presentation:
- ☐ Slides 6 through 17

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip charts and markers
- ☐ Colored tape or a piece of string or ribbon, 2-3 meters long
- ☐ Markers, pens, or crayons
- ☐ Tape

PREPARATION

- Print, download, and gather materials as listed below
- Research current abortion laws and policies in your setting and prepare a short (15-minutes or less) presentation on the topic
- Put the current written law on a slide, write it on a flip chart sheet, or prepare a handout
- Read through the following sections from the 2018 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*:
  - Chapter 8 Comprehensive Abortion Care, Section 8.3.2 Needs Assessment (p147)
  - Chapter 8 Comprehensive Abortion Care, Section 8.4 Human Rights & Legal Considerations (p160-2)

  Note anything applicable to your training setting and share this information with participants
- Using a long piece of tape or string, draw a line on the floor in the middle of an area large enough to accommodate all participants and allow them room to move around
- Review and adapt *Crossing the Line Statements*, if needed

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Discuss slides 8-11: *Uterine Evacuation is an Important Element of Reproductive Health in Crisis Settings*. Showing slide 8, **write** the following numbers on a blank sheet of flip chart paper:

- 5
- 25,100,000
- 8%
- 99%
- 55,700,000
- 193,000

Lead a discussion. **Ask** participants the following questions:

Ask: How many pregnancies around the world end in abortion?

→ **Circle** 55,700,000 on the flip chart. The World Health Organization estimates that 55.7 million abortions have occurred every year from 2010 to 2014.

Ask: How many abortions are performed each year that are considered unsafe by the World Health Organization definition?

→ **Circle** 25,100,000 on the flip chart. Worldwide, there are an estimated 25.1 million unsafe abortions performed every year; 45% of all abortions are unsafe. This means abortions performed by people who lack the necessary skills or in an environment lacking the minimum medical standards, or both.[4]

Draw a circle. **Ask**: What percentage of maternal deaths are caused by unsafe abortions?

→ **Circle** 8%. **Draw**, but do not fill in, 8% in the circle on the flip chart. Globally, unsafe abortion accounts for 8% of maternal deaths; it is the 5th leading cause of maternal mortality.[5]

Ask: How much (what percentage) within that 8% do you think takes place in low- and middle-income countries?

→ **Fill in** the wedge of 8%, leaving only a narrow sliver unfilled. **Draw** an arrow out from the 8% of the circle to the 99% written on the flip chart. **Say** 99% of maternal deaths due to unsafe abortion occur in low- and middle-income countries.

Show slide 9: *Making Pregnancy Safer*. **Explain** that making pregnancy safer includes the provision of, or referral for, safe abortion services to the full extent allowed by the law. It also includes timely and appropriate management of unsafe and spontaneous abortion for all women.

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

- Women may have lost or run out of their contraceptive method during displacement.
- Families may want to delay childbearing until their security and livelihoods are assured, but do not have access to contraceptives due to a disruption in health services.
- Rape and other forms of sexual violence are often documented in conflict settings.

Explain to participants that in 2003, the World Health Organization issued technical and policy guidance to strengthen the capacity of health systems to provide safe abortion care and postabortion care (PAC). This guidance was updated and reissued in 2012.[6] In 2014, the World Health Organization issued guidance for the clinical provision of abortion,[7] and in 2018 they issued new guidance on the medical management of abortion.[8] In 2022, WHO issued new Abortion Care Guidelines, which updated and replaced the guidance in all the above.[41]

On the flip chart sheet **write** "PAC" and the number "5." **Ask** participants to raise their hands if they are familiar with the term PAC. **Ask** a volunteer to explain it. **Explain** that PAC is a global strategy to reduce death and suffering from the complications of unsafe and spontaneous abortion. **Ask** participants if they know how the number five (5) relates to PAC. **Tell** them that PAC has five components.[9]

Show slides 10-11: *Elements of PAC.* **Ask** participants to raise their hands if they are familiar with the term "CAC." **Ask** a volunteer to provide an explanation. **Explain** that CAC means comprehensive abortion care. It includes all the elements of PAC with the important addition of safe induced abortion for all legal indications.

Circle 193,000 on the flip chart. **Explain** to participants that adding safe abortion to sexual and reproductive health care has the potential to improve the physical and mental health of as many as 25.1 million women every year and save the lives of 193,000 women every year. Now, **write**: PAC + CAC = ↓ maternal death. **Explain** that together, PAC and CAC contribute to reductions in maternal mortality.

4. Ganatra, B., Gerdts, C., Rossier, C., Johnson Jr., B.R., Tuncalp, O., Assifi, A., … Alkema, L. (2017). Global, regional, and subregional classification of abortion safety, 2010-14: Estimates from a Bayesian hierarchy. *Lancet*, 390, 2372-81.
5. Say, L., Chou, D., Gemmill, A., Tuncalp, O., Moller, A., Daniels, J., … Alkema, L. (2014). Global causes of maternal death: A WHO systematic analysis. *Lancet Global Health*, 2, e323-33.
6. World Health Organization. (2012). Safe abortion: Technical and policy guidance for health systems. Geneva: WHO Press.
7. World Health Organization. (2014). Clinical practice handbook for safe abortion. Geneva: WHO Press.
8. World Health Organization. (2018). Medical management of abortion. Geneva: WHO Press.
9. Corbett, M., & Turner, K. (2003). Essential elements of postabortion care: Origins, evolution and future directions. International Family Planning Perspectives, 29(3), 106-11.

VALUES CLARIFICATION ACTIVITY: CROSSING THE LINE

Introduce the Crossing the Line Activity. **Explain** that this activity asks participants to reflect their views on abortion and how stigma affects individual and societal views about abortion.

Ask all participants to stand on the same side of the line. **Explain** that you will read a series of statements. If the statement applies to their experiences or beliefs, they should **step** entirely on one side of the line. Participants must stand on one side of the line or the other; there is no 'in between.' There are no right or wrong answers.

Read an easy practice statement, such as "Cross the line if you had fruit for breakfast this morning." Once some people have crossed the line, **give** participants an opportunity to observe who crossed the line and who did not. **Thank them** and ask them to all return to one side.

Read the first *Crossing the Line Statement*. Once some people have crossed the line, **give** participants an opportunity to observe who crossed the line and who did not. **Invite** participants to notice how it feels to be wherever they are. **Ask** someone who crossed the line and someone who did not to volunteer to briefly **explain** their response to the statement. If someone is the only person who did or did not cross the line, **ask** them what that feels like. **Invite** them to move back to one side of the line.

Repeat for remaining statements. After finishing all the statements, **ask** participants to return to their seats. **Discuss** the experience. Discussion questions might include:

- How did you feel about the activity?
- What did you learn about your own and others' views about abortion?
- Were there times you felt tempted to move with the majority of the group? Did you move or not? How did that feel?
- What did you learn from this activity?
- What does this activity teach us about stigma surrounding abortion?
- How might stigma affect women's emotional experience with abortion? How would it affect family members?
- How might stigma impact the experience of health workers and providers working in abortion care?

Debrief, especially on the last statement. If everyone in the group crossed the line, discuss this commonality. If everyone did not cross the line, discuss how these different views affect people's work on abortion care and the broader social climate for abortion in that setting.

CROSSING THE LINE STATEMENTS FOR FACILITATORS

Say: Cross the line if:

- You were raised to believe abortion should not be openly discussed.
- At some point in your life, you believed abortion is wrong.
- You have ever avoided the topic of abortion to avoid conflict with others.
- You were raised to believe that abortion is a woman's right.
- You have been asked to keep someone's abortion a secret.
- You have felt uncomfortable talking about abortion.
- You have ever heard a politician talking in a derogatory manner about women who have had abortions.
- You have ever heard a friend or family member talk in a derogatory manner about women who have abortions.
- You or someone you are close to has had an abortion.
- You are comfortable having uterine evacuation services provided in your facility.
- You are comfortable discussing uterine evacuation with colleagues at work.
- You are comfortable discussing uterine evacuation outside of your work setting.
- You are comfortable performing (or assisting with performing, if you are not authorized to perform) uterine evacuation.
- You are comfortable with uterine evacuation being used to treat a spontaneous incomplete abortion.
- You are comfortable with uterine evacuation being used to treat an incomplete abortion for a woman who induced her own abortion.
- You are comfortable with adolescent and young women seeking uterine evacuation services.
- You believe unmarried women should receive a contraceptive after uterine evacuation, if they want one.
- You are comfortable advocating for women's access to safe abortion.
- You believe all women deserve access to safe, high quality abortion services.

FACILITATOR PRESENTATION AND CASE STUDIES

Present slides 13-16: *Review of Abortion Law* using discussion notes in slide presentation.

Show slide 17: *Case Studies*. **Read** the following three scenarios aloud. **Facilitate** a discussion about how each woman can be treated within the fullest extent of the law. If time allows, **divide** participants into small groups to **discuss**. **Appoint** someone in each group to report back key

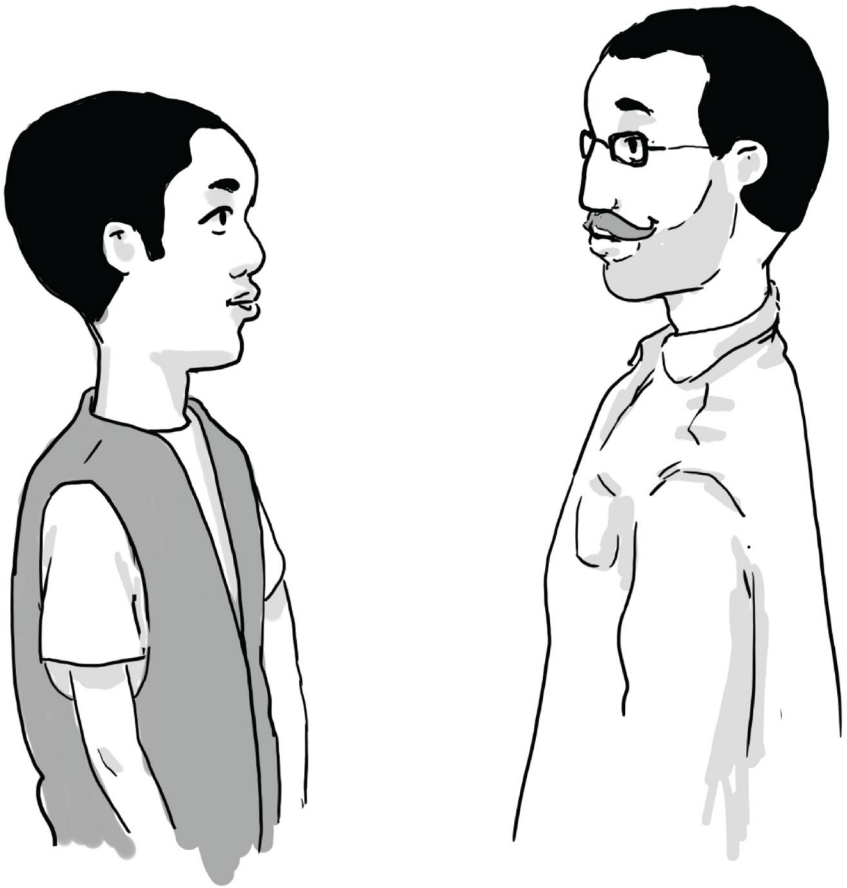
points to the larger group, then **facilitate** a large group discussion. Recommendations and strategies will vary based on each setting. Be sure to **address** situations where safe abortion may be legal but there are additional requirements regarding consent, counseling, and the period of time when it is permissible. Carefully go over any requirements. Feel free to **create** scenarios that best address the legal complexities and represent the physical, social, and emotional challenges of your specific setting.

CASE STUDY SCENARIOS

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.

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.

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.



UNIT 3 UTERINE EVACUATION METHODS

Time:
90 minutes (1 hour 30 minutes)

Unit Objectives:

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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 25 minutes: Facilitator Presentation and Group Discussion
- 20 minutes: Small Group Work: Case Studies
- 25 minutes: Facilitator Presentation and Group Discussion
- 20 minutes: Case Studies: Other Special Considerations

PREPARATION

- Print, download, and gather materials as listed below
- Arrange to ship or carry samples of mifepristone, misoprostol, and contraceptive methods with you to ensure they make it through customs and other potential barriers in time for training
- Review included case studies and ensure they are appropriate for training setting

PRINT:
Participant Workbook:
- ☐ *Uterine Evacuation Treatment Options Chart*
- ☐ *Advantages and Disadvantages of Medical Intervention Compared to Vacuum Aspiration Chart*
- ☐ *Uterine Evacuation Method Options Counseling Case Studies*
- ☐ *Postabortion Contraception Medical Eligibility*
- ☐ *Contraceptive Counseling Skills Checklist*
- ☐ *Special Contraceptive Counseling Considerations*

DOWNLOAD:
Presentation:
- ☐ Slides 18 through 69

GATHER:
- ☐ Projector and computer with sound
- ☐ Samples of mifepristone and misoprostol
- ☐ Samples of contraceptive methods approved for use after uterine evacuation
- ☐ Flip chart paper
- ☐ Markers, pens, or crayons
- ☐ Tape

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Show slides 18-43 and **emphasize** the notes and activities listed below the slides on *Method Options for Uterine Evacuation*.

Pause on slide 32: *Possible complications of MVA*, and **read** the following paragraphs aloud:

1. As with any uterine evacuation, one or more of the following may occur during or after the procedure: vagal reaction, incomplete evacuation, uterine or cervical injury or perforation, pelvic infection, hemorrhage or acute hematometra. Serious complications, such as bleeding, necessitating transfusion, or a uterine injury requiring surgical repair, are very rare and occur much less than 1% of the time. However, when they do occur, some complications can lead to secondary infertility, serious injury, or death.
2. Before performing uterine evacuation, any life-threatening conditions should be addressed immediately. These include: shock, hemorrhage, severe pelvic infection, sepsis, perforation, or abdominal injury, as may occur with incomplete or clandestine abortion.
3. However, uterine evacuation is often an important component of definitive management in these cases. Once the patient is stabilized, the procedure should not be delayed.
   A history of blood dyscrasia may be a factor in the woman's care. Uterine evacuation should not be performed until the size and position of the uterus and cervix have been determined. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and to perform intrauterine procedures, including MVA.

Showing slide 35: *Clinical Applications for Mifepristone (Combined with Misoprostol)*, **post** a blank sheet of flip chart paper. **Ask**: in some cases, patients may prefer medical methods for uterine evacuation if the option is available. Why do you think some patients may prefer medical methods to vacuum aspiration? **Record** responses on the flip chart.

Show slides 36-39 and discuss using instructions included in the presentation. Showing slide 40: *Possible Complications of Medical Methods*, **post** a blank sheet of flip chart paper. **Ask**: What are possible complications of uterine evacuation with medical methods?

Record answers on flip chart. Answers should include:

- failure of medications to evacuate uterus, including the small risk of fetal malformations in the event of a continuing pregnancy after misoprostol use
- prolonged or very heavy bleeding/hemorrhage
- infection
- allergy
- possible need for vacuum aspiration

Participants may respond by naming expected effects or side effects of misoprostol, such as pain/cramping, nausea/vomiting, fever/chills, or diarrhea. **Acknowledge** that these are expected effects of treatment with misoprostol, and something to discuss with women before use. **Advise** participants that treatment of complications and counseling to provide to women to manage expected effects and side effects, will be covered in the next section. Move through slides 42-43 on *Uterine Evacuation Methods Options Counseling*. **Refer** participants to *Uterine Evacuation Treatment Options Chart* and *Advantages/Disadvantages of Medical Intervention Versus Vacuum Aspiration Chart* in the *Participant Workbook*.

SMALL GROUP WORK: CASE STUDIES

Show slide 44: *Uterine Evacuation Method Options Counseling: Case Studies*. **Ask** a participant to read each of the *Uterine Evacuation Method Options Counseling Case Studies* to the group. **Ask** the group to explain why they think each woman might choose a specific method of uterine evacuation. Depending on the size of the group, you may want to **divide** into small groups, triads, or pairs to facilitate more discussion. You may want to make copies of the cases to distribute to the groups. Participants may want to refer to the handouts *Uterine Evacuation Treatment Options Chart* and *Advantages and Disadvantages of Medical Intervention Compared to Vacuum Aspiration Chart* in their *Participant Workbook*.

Ask: What other questions would you ask the women in the following situations to help them decide which uterine evacuation method would be best?

Group Process: In each of these scenarios, the woman might choose one method over another. It is important to not make assumptions about what would be more convenient, less painful, or more appropriate for a woman. Instead, ask clarifying questions to help her make her own decision.

UTERINE EVACUATION METHOD OPTIONS COUNSELING CASE STUDIES

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.

CASE STUDY 2: A 17-year-old student presents with an incomplete abortion. It is eight weeks since 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.

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.

UTERINE EVACUATION METHOD COUNSELING CASE STUDIES: ANSWERS

CASE STUDY 1: This woman may prefer to take misoprostol because staying at the clinic to wait for vacuum aspiration might take longer. She might also be concerned that she has no one to watch her children during a procedure, especially if she had a complication. Alternatively, she may be concerned about pain and bleeding with misoprostol, especially if she does not have anyone to help her at home when she uses the medicine. She may be concerned about having to return to the health center and would prefer MVA to treat her condition quickly and effectively. She may be interested in starting a contraceptive method, or she may want to try to become pregnant again. With two small children, returning on another day for contraception may be difficult.

CASE STUDY 2: This woman may be nervous about a uterine procedure and does not have anyone with her to support her during a procedure. Misoprostol might cause her less anxiety. However, she may be concerned about having more severe cramping and bleeding at home, especially if she wants to keep the pregnancy and abortion a secret from the people she lives with. She may have used medicines to cause her vaginal bleeding and would prefer a procedure so that she knows the abortion process is complete before she goes home. She may be anxious about her family discovering a contraceptive method, such as pills, and prefer something that is more easily hidden. She could be interested in an IUD, especially if she would like to delay childbearing until after she finishes school, while also being anxious about undergoing an additional uterine procedure to have the method placed.

CASE STUDY 3: Having a medical abortion might allow this woman to get home more quickly, which she seems anxious to do. However, she may not have trust in pills if she tried to take a medicine to cause an abortion that had no effect. Vacuum aspiration may be appealing as she has a support person with her, and she would feel confident that her abortion was complete at the end of the procedure. Additionally, as she does not want another child at this time, she may prefer to have an IUD inserted immediately after a vacuum aspiration, instead of returning to the health center at a later time for IUD insertion.

FACILITATOR PRESENTATION: METHOD OPTIONS FOR POSTABORTION CONTRACEPTION

Refer participants to these handouts in their workbook: *Postabortion Contraception Medical Eligibility, Contraceptive Counseling Skills Checklist*, and *Special Contraceptive Counseling Considerations*.

Show slides 45-49 and **discuss** using notes and activities included in the presentation on *Postabortion Contraception*.

Pause on slide 49 and **instruct** participants to read through the *Postabortion Contraception Medical Eligibility* handout in their workbooks. **Explain** that you are going to ask some questions regarding postabortion contraception medical eligibility. After reading each question, **ask** participants to respond with the correct answer. You may want to have small prizes available for the first person to correctly answer each question. If participants are unable to answer questions, **remind** them that all the necessary information is included in the handout.

Resume the presentation and move through slides 50-56. Pause on slide 56: *Supply EC Pills*. **Ask**: Why is it particularly important to offer emergency contraception (EC) in addition to their contraceptive method of choice?

Response should include:

- It can be used as a back-up method in case of contraceptive failure, such as when a condom breaks.
- It can be used if women forget to use their regular contraceptive method or run out.
- It can be used after unprotected sex.
- It can be used when sex is non-consensual.

Direct participants to the *Contraceptive Counseling Skills Checklist*. **Explain** that this checklist can be used as a reference to guide high-quality contraception counseling, which helps to ensure that women are given the opportunity to make an informed choice of contraceptive.

Show slides 57-59 on *Privacy, Confidentiality and Informed Choice* and **discuss** using the notes included in the presentation.

POSTABORTION CONTRACEPTION 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: After her first normal menstrual period. Remind participants that an interim contraceptive method should be provided if she requires effective contraception before her menses returns, as most women will ovulate prior to their first menstruation after an abortion. Additionally, for some women, their first menses may not return for six to eight weeks.

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

Answer: In cases of septic abortion or pelvic infection, women should be treated with appropriate antibiotics and sterilization delayed until the infection resolves. In cases of excessive bleeding, sterilization may need to be delayed if the woman is too anemic to safely have her sterilization procedure. It is important to provide women with an interim contraceptive method until sterilization can be performed.

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

Answer: An IUD can be placed immediately following an uncomplicated vacuum aspiration. For women who have uterine evacuation with medical methods where pregnancy expulsion occurs in a health care facility, an IUD can be placed immediately afterwards. For women who have pregnancy expulsion at home, an IUD can be placed when it is reasonably certain the woman is no longer pregnant, often at a follow up visit. In cases of septic abortion or frank purulent cervicitis, women should be treated with appropriate antibiotics and the IUD insertion delayed until after the infection resolves. Women should be provided an interim method to use until they can have their IUD placed.

CASE STUDIES: OTHER SPECIAL CONSIDERATIONS

Show slide 60: *Special Considerations: Women in Refugee and Displaced Settings*. **Explain**: Refugee and displaced women may be dealing with many different emotional stresses related to safety and personal security issues: institutional, societal, and personal violence; displacement from family, culture, and home; lack of food and other necessities; lack of access to comprehensive medical care; and insecurity about the future. Many women may have survived violence during the initial period of displacement, while many others continue to experience violence in their present location. It is important when counseling refugee and displaced women to let them guide the counseling process. The provider must be sensitive to language differences between the provider and the woman and have a native speaker of the woman's language present to translate, if possible. **Ask** participants to brainstorm some of the complexities that might be encountered while providing contraceptive counseling to women in crisis settings.

On slide 61: *Contraceptive Methods: Special Considerations*, pause and **facilitate** a discussion about available contraceptive methods, and supply and access issues in the crisis setting. Contraceptive counseling should begin with what will continue to be available and should consider the likelihood of the woman remaining in the setting or moving elsewhere within a given time. Women may have been using one method before displacement and will need to re-evaluate what method(s) will work best given their new life circumstances. Consider lack of personal storage and privacy, and discuss the risk of rape and violence, especially for adolescents.

Be sure to discuss the following general points:

- High levels of sexual violence, including sexual coercion for food, protection, and shelter; disruption in medical and contraceptive services; and the general uncertainty of refugee life, place refugee women at an increased risk for unprotected sex and unwanted pregnancy.
- Medical settings for refugees or displaced persons may not have the full range of contraceptive supplies; providing counseling based on the methods available is most beneficial.
- In situations where flight from war, migratory population movement, repatriation, or relocation is imminent, counselors are advised to develop a protocol that addresses the long-term needs of contraceptive clients. The provider and patient can discuss the benefits and drawbacks of each method according to the woman's individual preferences and situation.
- Poverty, high population density, and limited medical provision can all contribute to the increased risk of exposure to sexually transmitted infections (STIs) and HIV. Population migration, increased violence, and military troop movements combine with these factors to create a high risk of exposure to STIs and HIV for refugee and displaced women. Counseling around patients' needs for barrier methods is important.
- Adolescent girls are among the most vulnerable in refugee or displaced settings. Every effort should be made to provide adolescents with contraceptive information and methods.
- Counselors should be aware of EC provision in the refugee or displaced setting and counsel women on the availability of EC pills, directions for use, and provision of supplies. A protocol should be developed to provide these pills in advance, where possible.

Explain: There are certain specialized considerations providers should keep in mind when providing contraceptive counseling. **Ask** participants to **review** the information provided in their workbook under *Special Contraceptive Counseling Considerations* for information on how providers can meet the specific contraceptive needs of patients in these circumstances.

Ask a participant to read the following short case studies on slides 62-66 aloud. **Discuss** each one at a time.

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

Conclude the presentation with a discussion about Informed Consent using slides 63-65.

Conclude the presentation with a review and discussion of informed consent using slides 67-69.

CASE STUDIES AND ANSWERS

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.

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

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.

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

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.

- Learn what her privacy needs are and identify the barriers she may face in using different contraceptive methods, to help her choose the most appropriate option for her.
- Some young women may want to become pregnant immediately and do not require contraception. As with all women, ask what her immediate and longer-term reproductive plan is.
- Include basic information on her menstrual cycle, fertility, and how pregnancy occurs and is prevented, if needed.
- Fully explain how any contraceptive she is interested in works, including efficacy, potential side effects, and long-term clinical implications of any side effects, to allay fears about contraceptives causing illness or future permanent infertility.
- Offer to have her leave the facility with at least one dose of EC, in addition to her contraceptive method of choice.
- Clinical eligibility guidelines are the same for young women as for adult women.
- Young women are more likely to experience regret after sterilization.
- Methods that do not require a daily regimen may be more effective for some young women. LARC – such as IUDs and implants – have been found to be more effective and have higher satisfaction for young women than pills in preventing future pregnancies.
- An IUD would have particular benefits for **her** because it would not be obvious to her family.

For all LARC there are no resupply concerns and there is no chance of improper use on her part.

UNIT 4 CLINICAL ASSESSMENT AND ELIGIBILITY

Time:
45 minutes

Unit Objectives:

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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 25 minutes: Facilitator Presentation and Postabortion Care Presentation Case Studies
- 20 minutes: Case Studies (Method Choice) and Group Discussion

PREPARATION

- Print, download, and gather materials as listed below

PRINT:
- ☐ *Pregnancy Dating and Labs Resource from WHO Clinical Practice Handbook*

Participant workbook:
- ☐ *Postabortion Care Presentation Case Studies*

DOWNLOAD:
Presentation:
- ☐ Slides 70 through 99

GATHER:
- ☐ Projector and computer with sound

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND CASE STUDIES

Show slides 70-84 and **discuss** using notes and activities included in the presentation. **Show** slide 85: *Clinical assessment: Considerations for Postabortion Care*. **Post** a blank sheet of flip chart paper and **write** "Postabortion Care Services" at the top. **Ask**: What are the reasons that women need postabortion care services? **Write** responses on flip chart, grouping them into the following three categories:

- Unsafe abortion, possibly self-induced
- Complications from safe abortion
- Spontaneous abortion

Have a different participant read each of the *Postabortion Care Case Studies* aloud. **Ask**: What do these descriptions have in common?

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.

Explain: These are all typical ways that women can present for postabortion care services. In most cases, women who need postabortion care are not in an emergent situation. **Move** through slides 86-92. **Stop** on slide 93.

UTERINE EVACUATION WITH MEDICATIONS ELIGIBILITY CASES

Explain to participants that in the next activity, you will **present** a clinical case and give them a couple of minutes to consider it. Then, ask them to **vote** if they think the woman is eligible to use medications or not. You may also **distribute** a small piece of red, yellow, and green paper to each participant. **Ask** them to **hold up** the green paper if they believe the woman is eligible, red if she is not eligible, and yellow if they are unsure or would like additional information. After they **vote**, **ask** participants to **share** what their clinical recommendations are. **Ask** individuals who both thought that the woman was eligible and those who thought she was ineligible to share the reasons for their recommendations. Use a flip chart to **record** their responses. Use the key points to **summarize** each case study on slides 94-99.

UNIT 5 UTERINE EVACUATION WITH MEDICAL METHODS

Time:
105 minutes (1 hour 45 minutes)

Unit Objectives:

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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 30 minutes: Facilitator Presentation and Group Discussion
- 60 minutes: Demonstration and Role Plays
- 15 minutes: Facilitator Presentation and Group Discussion

PREPARATION

- Print, download, and gather materials as listed below
- Prepare flip chart pages for the *Identifying and Managing Complications of Uterine Evacuation with Medications* activity

PRINT:
- ☐ *Medical Abortion IEC materials*

Participant Workbook:
- ☐ *Medication Regimens for Uterine Evacuation Pocket Reference*
- ☐ *Uterine Evacuation with Medications Skills Checklist*
- ☐ *Misoprostol for Treatment of Incomplete Abortion Skills Checklist*
- ☐ *Uterine Evacuation with Mifepristone and/or Misoprostol Role-Play Scenarios*

DOWNLOAD:
Presentation:
- ☐ Slides 100 through 131

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart paper
- ☐ Markers, pens, or crayons
- ☐ Tape

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND CASE STUDIES

Move through slides 100-123 about *How to Use Mifepristone and/or Misoprostol, Expected Effects, Side Effects, and Warning Signs*.

DEMONSTRATION AND ROLE PLAYS: UTERINE EVACUATION WITH MIFEPRISTONE AND/OR MISOPROSTOL

Explain to participants that they are now going to practice providing uterine evacuation with medical methods (slide 124). **Refer** participants to the handouts *Uterine Evacuation with Medications Skills Checklist* and *Misoprostol for Treatment of Incomplete Abortion Skills Checklist* and the *Medical Abortion IEC Materials*. Participants can also refer to the *Contraceptive Counseling Skills Checklist* they used in Unit 3.

Explain that these checklists can be used as a guide while learning the steps of talking to women about uterine evacuation with medications. These checklists can also be used to monitor the quality of services and to guide facilitative supervision of providers. The medical abortion information, education, and communication (IEC) materials provide simple instructions for safely using abortion with pills and are intended as resources for health providers to share with their patients.

Explain that the next activity demonstrates information sharing about uterine evacuation with medical methods. **Ask** a volunteer to come to the front of the room to **act** as a woman who has come to the health facility for uterine evacuation. You will **act** as a health care provider and **demonstrate** good information sharing skills. **Remind** participants that because women often use mifepristone and/or misoprostol on their own and outside of a health facility, providing clear information about what to expect, including warning signs for when to seek additional care, can help her feel prepared for what she will experience and ease any anxiety she may be feeling.

Share a role-play from *Uterine Evacuation with Medications Role-Play Scenarios* with the volunteer/woman. Ask the participants to observe the demonstration using their checklists, and to be prepared to give feedback on what went well and what may have been missed or inadequately discussed.

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.

Conduct the demonstration for about 10 minutes. **Try** to make the demonstration as realistic as possible. **Speak** to the volunteer as you would a patient seeking care in your health facility. Although you will not be demonstrating uterine evacuation options counseling in this demonstration, be sure to **ask** the volunteer about any medical problems that could prevent her from safely taking the medications, such as an allergy. Together with the volunteer, **make** a plan for when and how she will use her medication based on her personal situation. **Ask** her about future pregnancy intentions and contraceptive method choice, if desired. **Be sure** that she receives her method of choice or a plan is created for her to receive her method of choice.

After concluding the demonstration, **ask** participants for feedback, using the checklists. **Ask** the volunteer to provide feedback regarding how they felt during the interaction, and if they understood what was explained to them. **Ask** for questions about the demonstration or uterine evacuation with medications more generally. **Answer questions and lead a discussion** about any issues raised.

Following the demonstration, **inform** participants that they will now have an opportunity to **practice** using role-play. **Divide** participants into groups of three. One person will **play** the provider, one will **play** the patient, and the other will be the observer using the checklists. Each group will do three role-plays, so that each participant gets the chance to play each role during the exercise. **Assign** three role-play scenarios from the *Uterine Evacuation with Medications Role-Play Scenarios* to each group.

Tell participants that they will conduct three role-plays. They will have about 10 minutes for each role-play, and about five minutes for the observer to **give** feedback. **Tell** the observer to use the checklists to **make** observations and provide feedback. **Remind** participants that this is their opportunity to **practice** uterine evacuation with medications counseling and encourage them to note any questions that they have.

During the role-plays, **move** around the room to **observe** the groups and **provide** input, if necessary. After 10 minutes, **signal** to the group that it is time for feedback on the first role-play. After five additional minutes, **signal** to the group that is time for them to **switch** roles and **begin** the next role-play. Do this two more times, until all groups have completed all three role-plays.

Bring the group back together for a summary and discussion of the exercise. **Ask** participants what went well and what was difficult about the exercise. Additional questions to include could be:

- What did you find most challenging about playing the provider?
- What was the most difficult to explain?
- What questions did the woman ask that were most difficult to answer?

Be sure to **ask** the participants for their questions before **closing** the session.

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Show slides 125-131 on *Follow-up of Uterine Evacuation with Mifepristone and/or Misoprostol* and **discuss** using notes and activities included in the presentation.

UNIT 6 UTERINE EVACUATION WITH MVA

Time:
315 minutes (5 hours 15 minutes)

Unit Objectives:

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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 30 minutes: Facilitator Presentation and Demonstration: MVA Facts and Features
- 45 minutes: Video and Presentation: Instrument Processing
- 60 minutes: Video and Presentation: MVA Procedure
- 60 minutes: Demonstration and Simulated Practice
- 15 minutes: Small Group Practice and Review: Solving Technical Problems Using MVA
- 15 minutes: Facilitator Presentation and Group Discussion: Pain Management
- 60 minutes: Simulated Practice with Pelvic Models
- 30 minutes: Facilitator Presentation and Group Discussion: After Uterine Evacuation

PREPARATION

- Print, download, and gather materials as listed below
- Arrange to ship or carry with you the supplies listed below, ensuring they make it through customs and other potential barriers in time for the training
- Assess which method(s) of instrument processing is used and tailor content accordingly
- Bring all supplies for instrument facts and features, processing, and simulated uterine evacuation. Bring at least two of everything, more if possible. *If possible, bring one aspirator per participant, or at least one per site

Note: Refer to *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training*[10] for lists of equipment and supplies for pelvic model sessions.

PRINT:

Participant workbook:

- ☐ *Tips for Using the Ipas MVA Plus®*
- ☐ *Instrument Processing Skills Checklist*
- ☐ *Uterine Evacuation Procedure with Ipas MVA Skills Checklist*
- ☐ *Paracervical Block Job Aid*
- ☐ *Pharmacologic Approaches to Pain Management During MVA*
- ☐ *Post Procedure Care Skills Checklist*
- ☐ *Discharge Information Sheet*

DOWNLOAD:

Presentation:

- ☐ Slides 132 through 259

Videos:

- ☐ *Processing the Ipas instruments*,[11] 17 minutes
- ☐ *Manual Vacuum Aspiration Technique Using the Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae*,[12] 8 minutes
- ☐ Optional: *Ipas Abortion Care Videos* (2022)

GATHER:

- ☐ Projector and computer with sound
- ☐ Flip chart paper
- ☐ Markers, pens, or crayons
- ☐ Tape

Minimum 2 of each, more if possible:

- ☐ Pelvic model(s)
- ☐ Fabric for draping
- ☐ Ipas MVA aspirators (and product insert)*
- ☐ Ipas EasyGrip Cannulae® (6 mm)
- ☐ Specula (various sizes including small)
- ☐ Dilators
- ☐ Tenaculae
- ☐ Sponge holding forceps
- ☐ Gloves
- ☐ Samples of worn aspirators and cannulae that need to be replaced (if possible)

10. Ipas. *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training*, 2009.
11. Ipas, 2019
12. Ipas, adapted from *Innovating Education in Reproductive Health.* You will need a password to access the second video. This video was adapted by Ipas with permission from *Innovating Education in Reproductive Health*. It is for classroom training use only. For access password, please contact info.iawg@wrcommission.org or training@ipas.org.

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND DEMONSTRATION: MVA FACTS AND FEATURES

- **Distribute** an aspirator set to each participant. If you are providing sets to each site rather than each participant, have participants **share** the sets. **Allow** them a few minutes to **inspect** and handle the aspirator and cannulae. **Tell** participants to **follow** along with the presentation using the aspirator in their sets. **Refer** participants to *Tips for Using the Ipas MVA Plus®* in their *Participant Workbook*.
- **Show** slides 132-139, **discuss** and **demonstrate** using notes included in the presentation on *Facts and Features of Ipas MVA and Ipas EasyGrip Cannulae®*.
- On slide 140: *Disassembling the aspirator*, **demonstrate** using your fully assembled aspirator with cannula attached. **Instruct** participants to follow along with the aspirator in their sets. **Ask** a volunteer to **disassemble** the aspirator. **Point** to the steps on the slide as you **describe** how to disassemble the instrument while the volunteer follows your directions.
- **Continue** with slides 141-142. At slide 142: *MVA parts disassembled*, **ask** for another participant to **demonstrate** the steps of instrument assembly using the disassembled instrument. **Ask** the participant to **follow** the steps described on the next slides 143-149.
- **Pause** at slide 149 and **demonstrate** instrument assembly and preparation again, this time asking participants to **follow** along with their instruments. **Ensure** that all participants have properly assembled and prepared their aspirators. **Determine** if anyone is having any difficulty with assembly, especially with inserting the plunger O-ring.
- **Show** the participants in detail the correct position of the plunger arms over the edge of the cylinder. **Ensure** that all participants have now properly charged their aspirators. If necessary, **coach** individual participants. **Tell** them to leave their instruments charged and not release vacuum until they are instructed.
- **Demonstrate** how to release the valve buttons. **Ask** one participant at a time to **release** the vacuum in their aspirators. **Ensure** that all participants have properly **tested** their aspirators. If they did not hear the rush of air indicating vacuum release, **check** to determine why they failed to create a vacuum.
- **Describe** what you are doing to each part as you **disassemble** your aspirator, following the steps outlined previously. **Ask** participants to **disassemble** their devices while you walk around the room coaching them. **Ensure** that all participants have properly disassembled their aspirators. Finally, have them **practice** assembling, charging, and disassembling their instruments while you walk around coaching them.
- **Continue** through slides 150-155 using the notes and directions in the presentation on *Maintaining Ipas Instruments*. Pause on slide 155: *Discard and Replace Cannula If* and **pass** around the worn aspirators and cannulae that you brought as samples of devices that should be replaced. **Ask** learners to explain why each should be replaced.

VIDEO, PRESENTATION, AND PRACTICE: INSTRUMENT PROCESSING

Note: You may want to create Instrument Processing Practice Stations for participants to work in pairs practicing the method that is used in the crisis setting.

Show the 17-minute Ipas video *Processing the Ipas Instruments* and quickly review and answer questions with the following content.

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

Show slides 156-159 and discuss using notes in the presentation on *Instrument Processing*. **Refer** participants to *Instrument Processing Skills Checklist* in their *Participant Workbook*. **Allow** participants a minute to look at it. Then, ask them to **follow** along as you present the information on slides 160-182 reviewing the four steps for processing instruments:

1. Point-of-use preparation
2. Cleaning
3. Sterilization or high-level disinfection
4. Storage

Explain that although participants may not process instruments themselves, they should **use** this checklist to **ensure** the quality of instrument processing.

VIDEO, PRESENTATION, AND PRACTICE: MVA PROCEDURE

Show the instructional video *Manual Vacuum Aspiration Technique Using the Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae* (8 minutes) and then **discuss** each step of the procedure using slides 183-214 on *Uterine Evacuation with the Ipas MVA Plus®*, including:

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

DEMONSTRATION AND SIMULATED PRACTICE

Refer to the *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training* for guidance on how to set up and conduct effective pelvic model demonstration and practice.

Pelvic model practice should simulate clinical practice as closely as possible, including infection prevention and client interaction. It is important to simulate the procedure exactly as participants should perform it in actual clinical settings (including glove use, modesty draping, etc). All participants should achieve simulated competence on a pelvic model before they perform on the procedure on women.

Demonstrate the uterine evacuation procedure on a pelvic model for the entire group.

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

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

TRAINING TIPS FOR USING PELVIC MODELS IN MANUAL VACUUM ASPIRTAION (MVA) CLINICAL TRAINING

Note: Ipas pelvic models can only accommodate size 6 mm cannulae and smallest dilators.

Each practice station needs:

- ☐ Pelvic model
- ☐ Fabric for draping
- ☐ Ipas MVA Aspirators (and product insert)*
- ☐ Ipas EasyGrip Cannulae® (6 mm)
- ☐ Specula (various sizes including small)
- ☐ Dilators
- ☐ Tenaculae
- ☐ Sponge holding forceps
- ☐ Gloves

*Always check pelvic models and other equipment to ensure that all parts and present and set-up is fully functional. Store pelvic models in a dry environment protected from direct sunlight and high temperatures which can cause melting and disfigurement.

Ask: What questions do you have about this demonstration of the procedure? **Answer** questions and incorporate into the discussion of possible adverse events as they might occur.

Say: You will now practice the procedure. **Divide** participants into groups of four. Each group is to **perform** simulated practice of the uterine evacuation procedure at the pelvic model stations.

Ask one participant to **play** each of the following roles:

- the provider who is performing the procedure
- the observer who is reading the checklist aloud
- the woman
- the support person

At the end of each demonstration, providers should first **give** feedback describing their experience. Then, the support persons, women, and observers should **give** the provider feedback about skills that were performed well and areas for improvement. Participants should

switch roles until all have had the opportunity to **practice** performing the procedure, using the checklist to observe, acting as the woman, and practicing the support role.

While participants are practicing, **rotate** to each pelvic model station to **observe**, **listen**, **address** issues that arise, **correct** technique as needed, and **ensure** that roles are being followed.

Evaluate each participant's performance using the checklist when they indicate that they are ready. Other participants can **continue** practicing while you conduct evaluations. All participants must be evaluated as competent with simulated practice on a pelvic model before they can perform the procedure on actual patients. **Make** arrangements for participants who fail to reach competency at this time to have additional practice and evaluation.

Ask: What final questions do you have about the procedure? **Answer** questions and incorporate into the discussion of possible adverse events as they might occur.

SMALL GROUP PRACTICE AND REVIEW: SOLVING TECHNICAL PROBLEMS USING MVA

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

Refer participants to *Tips for using the Ipas MVA Plus®*, which includes "Solving technical problems during the MVA procedure" on the back page. **Ask**: What technical problems have you experienced with MVA in the past? **Record** responses on a flip chart. **Reassure** participants that you will go through all the problems they have mentioned and some other possibilities as well so that they will feel prepared to troubleshoot when providing uterine evacuation.

Explain that the most common technical problem seen with MVA instruments is loss of vacuum. During most MVA procedures, the vacuum remains constant until the aspirator is approximately 80% or 50 mL full. However, a decrease in vacuum may occur before the aspiration is complete for several reasons. **Ask**: Why might vacuum decrease unexpectedly during the procedure?

Conclude this section of the presentation with slides 216-221 using the notes and prompts in the presentation.

FACILITATOR PRESENTATION AND DEMONSTRATION: PAIN MANAGEMENT

Show slides 222-233 and **discuss** using notes and activities included in the presentation on *Pain Management*.

Pause on slide 227: *Psychosocial Factors Associated with Increased Pain with Vacuum Aspiration*. **Explain** that addressing the woman's psychosocial state is part of providing high quality woman-centered care. In a crisis setting, the woman may be feeling high levels of anxiety and intense emotions for a range of reasons. **Ask** the participants to name few of these reasons. Be sure most on the list below are named.

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

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

Pause on slide 232 *Addressing Pain from Psychosocial Factors*. **Refer** participants to *Pharmacological Approaches to Pain Management During MVA* in the *Participant Workbook*. Give participants a minute to review the chart. **Say**: We will now create a list of locally available drugs and usual practices. **Ask** participants to name:

- anxiolytics that are locally available
- the drugs that are locally available for paracervical block
- oral non-steroidal anti-inflammatory drugs or narcotic analgesics that are locally available

Write their answers in the spaces on the flip chart. When the list is complete, **ask** participants to describe nonpharmacological support measures that could be locally provided to address pain. **Write** their answers in the spaces on the flip chart. This will result in a comprehensive list of locally available drugs and non-pharmacological support measures for MVA pain management to use in the case study activity.

Finish this section with slide 233 using notes in the presentation.

SIMULATED PRACTICE WITH PELVIC MODELS

Continue where you left off before lunch with simulated practice on the pelvic models.

FACILITATOR PRESENTATION AND GROUP DISCUSSION: AFTER UTERINE EVACUATION

Begin with slides 235-239, using notes and prompts in the presentation on *Post-Procedure Care*. Pause on slide 239 and **refer** participants to the *Post-Procedure Care Skills Checklist*. **Ask** participants to follow along with the checklist as you discuss the elements of post-procedure care.

Move through slides 240-253. On slide 253, *Signs To Monitor If They Worsen Over Time*, refer participants to *Discharge Information Sheet* in their Participant Workbook.

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

OPTIONAL:

Ask participants to practice giving discharge instructions in pairs.

Pause on slide 254: *Before Discharge*. **Say**: There may be other resources in the community to which links can be provided. **Ask** participants to brainstorm about services available in their communities to which they could provide referrals. **Write** all responses on a flip chart and group responses by topic (for example, cancer-screening services) or by location (for example, next town). On slide 255, explain the *Post-Procedure Skills Checklist* describes all the steps prior to discharge, and that it can be used to develop facility protocols and as a monitoring tool for quality assurance. **Present** slides 256-259 using notes and instructions in the presentation on *Follow-up Care*.

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

Time:
90 minutes (1 hour, 30 minutes)

Unit Objectives:

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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 45 minutes: Facilitator Presentation and Group Discussion
- 45 minutes: Case Studies

PREPARATION

- Print, download, and gather materials as listed below

PRINT:
Participant Workbook:
- ☐ *Management of Complications (CAC) Skills Checklist*
- ☐ *Management of Complications (PAC) Skills Checklist*
- ☐ *Identifying and Managing Complications of Uterine Evacuation with Medications Case Studies*

DOWNLOAD:
Presentation:
- ☐ Slides 260 through 309

GATHER:
- ☐ Projector and computer with sound

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Show slides 260-294 and **discuss** using notes and instructions in the presentation on *The Assessment and Management of Complications*. **Pause** on slide 290: *Cause of Vasovagal Reactions*.

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

Ask: How is a vasovagal reaction treated? Make sure the following points are made:

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

Show slides 295-308 and **discuss** using notes and instructions in the presentations on *Rapid Initial Assessment and Management of Shock* and *Secondary Assessment for Underlying Causes of Shock*.

Pause on slide 297: *Signs of Shock*. Explain that shock can develop at any time during postabortion care, especially if underlying injuries were not detected during the initial assessment. Once shock is stabilized, it is necessary to determine the underlying cause. Shock in postabortion care is usually either hemorrhagic or septic.

Ask: How do you stabilize for shock? **Answers should include**:

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

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

Stop the presentation on slide 308. **Refer** participants to the *Management of Complications (PAC) Skills Checklist*. **Ask** if participants have any questions about management of complications before moving on to the next activity.

SMALL GROUP WORK: COMPLICATION CASE STUDY

Explain that in the next activity, participants will **use** case studies to think through various clinical complications that can arise when using medications for uterine evacuation. **Remind** participants that these complications are very rare, and that it is important to work through cases because they may not see these complications very often.

Divide participants into small groups and **assign** one case study from the handout *Identifying and Managing Complications of Uterine Evacuation with Medications Case Studies* to each group. **Instruct** each group to **designate** a note-taker and someone who will **report back** to the larger group. **Provide** each group with a sheet of flip chart paper and some markers. **Ask** the group to **report** their diagnosis, which presenting symptoms they used to make their diagnosis, and their recommendations for subsequent treatment or action.

Allow the groups five minutes to discuss the case study. **Reconvene** the group. **Ask** each reporter to briefly **review** their case study and the conclusions their group reached. **Solicit** questions and comments from the full group. **Address** any missing points using the answer key.

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

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.

CASE STUDY 1:
Answer Key: Prolonged Bleeding: The diagnosis is prolonged bleeding. Many clinicians, and sometimes women themselves, are concerned about prolonged bleeding, especially if it was not anticipated. The duration of bleeding varies with misoprostol for treatment of incomplete abortion but can continue for as long as 14 days. For some women, light bleeding or spotting can continue even longer. This woman needs reassurance that she is having variable bleeding that is a normal part of her treatment. She has no signs of hypovolemia or infection of retained products of conception. As long as the general pattern of bleeding is diminishing over time, this is normal. Encourage iron-rich food and provide iron tablets, if available.

This woman should be informed that she has three options to manage the problematic prolonged bleeding:

1. Expectant management.
2. An additional dose of misoprostol to assist with uterine contractility and expel residual tissue (if any). Although a second dose of misoprostol is widely used for this purpose, its efficacy has not been specifically studied. If she is given an additional dose of misoprostol for prolonged bleeding, she should be contacted or assessed again about a week later to determine if bleeding has diminished.
3. Vacuum aspiration.

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.

CASE STUDY 2:
Answer Key: Normal Uterine Evacuation Process: Comprehensive information prior to the misoprostol administration could have helped this woman avoid unnecessary anxiety and an after-hours phone call. Her bleeding (heavier than a period, soaking 1 pad per hour) is normal after taking misoprostol, and it is common to see large blood clots. Reassure her that these signs are indications that the medication is working as it should be, and this is part of the process of her uterus becoming empty. Remind her of the warning signs that should prompt her to call you. If you can, arrange to speak to her again in two hours to assess her bleeding. In most cases, having a reassuring, experienced person available is all that is needed. Remind her that ibuprofen is often helpful for the cramping she is experiencing, and she can use as directed. A heating pad, hot water bottle, or warm cloths to the abdomen or low back may also help.

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.

CASE STUDY 3:
Answer Key: Successful Abortion: A positive pregnancy test does not provide useful information 2 weeks after using mifepristone and/or misoprostol. Her urine hCG pregnancy hormone level would have dropped sharply after a successful abortion, but is at its peak at around 8 to 9 weeks. Even with a successful abortion (as all clinical signs indicate) her pregnancy test will likely be positive. In other words, a negative test would be reassuring, but a positive test does not mean much. Pregnancy tests after medications for uterine evacuation often add confusion, not clarification, to follow-up.

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.

CASE STUDY 4:
Answer Key: Hemorrhage: This woman is experiencing excessive blood loss or hemorrhage. She requires medical attention immediately. She needs vacuum aspiration and rehydration, and possibly a transfusion if her current status worsens. If this is not possible, she should be transferred to another facility capable of managing her bleeding.

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.

CASE STUDY 5:
Answer Key: Infection: The symptoms are consistent with a uterine infection or endometritis. The abdominal tenderness and persistent fever are not typical misoprostol side effects. Transient fever associated with misoprostol use should not last past the day the woman takes misoprostol. She should be evaluated and receive appropriate antibiotics and vacuum aspiration.

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.

CASE STUDY 6:
Answer Key: Trapped Tissue: Occasionally, a large clot or piece of tissue can become trapped in the cervical os. This can be very painful and is often felt as persistent cramping. By their 2-week follow-up, women are generally no longer experiencing cramping. Using a ring forceps or similar grasping instrument, try to draw the tissue out of the cervix. If the tissue cannot be removed, uterine massage may help. Alternatively, the woman can be managed with a repeat dose of misoprostol, which can soften the cervix and cause contractions to expel the clot, or with vacuum aspiration. If you give a repeat dose of misoprostol, as long as the cramping subsides within a day and she feels fine, she does not need to return for another follow-up visit.

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.

CASE STUDY 7:
Answer Key: Medication Failure: These symptoms indicate a failed medical abortion; the pelvic exam suggests a growing pregnancy. Vacuum aspiration is recommended. It is important that she receives her procedure before exceeding any legal or functional limitations on abortion availability. Misoprostol carries a small risk of causing fetal malformations, which she should be counseled about if she were to decide to continue the pregnancy. Ectopic pregnancy is an important consideration as well, especially if there is doubt that the uterus enlarged the amount expected with a growing pregnancy. Misoprostol will not treat ectopic pregnancy. If pregnancy tissue is returned after vacuum aspiration, ectopic pregnancy can be excluded.

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.

CASE STUDY 8:
Answer Key: Possible Ectopic Pregnancy: These symptoms indicate a possible ectopic pregnancy. This woman needs immediate medical attention. The initial pelvic examination may have been difficult due to the position of the uterus and some uterine enlargement can occur with ectopic pregnancy. The pain and lack of history of expulsion of the pregnancy (little bleeding and cramping) suggest that this is not an intrauterine pregnancy. You may be able to feel an adnexal mass on examination, although this is a rare finding in women with an ectopic pregnancy.

A ruptured ectopic pregnancy is a gynecological emergency that can be life-threatening. It requires immediate surgical intervention. A woman with a suspected ectopic pregnancy should be treated or transferred as soon as possible to a facility that can confirm the diagnosis and begin treatment. Early diagnosis and treatment of ectopic pregnancy saves women's lives and helps preserve their fertility.

UNIT 8 SERVICE DELIVERY

Time:
60 minutes (1 hour)

Unit Objectives:

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.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 60 minutes: Facilitator Presentation and Group Discussion

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

PREPARATION

- Print, download, and gather materials as listed below
- Label flip chart: "Monitoring" and write down the *Elements of a Monitoring/Sustainability Plan for Uterine Evacuation Services in Crisis Settings* on slide 162
- Be familiar with any monitoring practices in the participants' facilities
- Be prepared with examples of monitoring for abortion-related services
- Review the medical abortion and MVA calculators
  - Medical abortion calculator: www.ipas.org/supply-calculators/ma
  - MVA calculator: www.ipas.org/supply-calculators/mva
- Review the Medical Abortion Commodities Database at https://medab.org/

PRINT:
COPE® for Comprehensive Abortion Care Handbook for participants to review

Participant Workbook:
- ☐ *Examples of Abortion Services Monitoring*
- ☐ *Worksheet for preliminary preparedness for implementation of SAC*
- ☐ *Supply and Equipment Checklist for First Trimester (<13 weeks) Comprehensive Abortion Care*
- ☐ *MVA Supply-Resupply Chart*

DOWNLOAD:
Presentation:
- ☐ Slides 310 through 331

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart paper
- ☐ Markers, pens, or crayons

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

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

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

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

OPTIONAL:
If time allows and the internet is available, after discussing:

- Slide 324, go to medab.org for a quick tour/demo and search for commodities available in the country in which you are training. Be sure you are familiar with the *Medical Abortion Commodities Database* before the training.
- Slide 327, click on the link to open the medical abortion calculator for a quick tour/demo.
- Slide 329, click on the link to open the MVA calculator for a quick tour/demo.

Be sure you are familiar with all of these resources before the training.

Show slides 310-331 and **discuss** using notes and activities included in the presentation. **Pause** on slide 328: *MVA Calculator* for participants. **Review** the *MVA Initial Supply and Re-Supply chart*. **Ask** participants to calculate their average daily MVA caseload and then use the chart to determine the number of MVA devices needed in active stock and the number needed in reserve.

Ask participants to return to the "Worksheet for Preliminary Preparedness for Implementation of Safe Abortion Care" in their workbooks. **Refer** to slide 320. **Review** and discuss the worksheet as a group. If time allows, ask participants to complete the worksheet and share their results.

UNIT 9 EVALUATION AND CLOSING

Time:
60 minutes

Unit Objectives:

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

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

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 10 minutes: Facilitator Presentation and Group Discussion
- 10 minutes: Course Evaluation
- 30 minutes: Knowledge Assessment
- 10 minutes: Closing Ceremony

PREPARATION

- Print, download, and gather materials as listed below
- Fill out participants' names on certificates of completion

PRINT:
Handouts (1 per participant):
- ☐ *Certificate of Completion*
- ☐ *Knowledge Post-Test*
- ☐ *Course Evaluation*

DOWNLOAD:
Presentation:
- ☐ Slides 332 through 337

GATHER:
- ☐ Projector and computer with sound
- ☐ "Course Expectations" flip chart from beginning of training

Note: Allow time for additional simulated practice and skills evaluation before concluding the training. See the sample agenda for further details.

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Review slides 333-334: *Course Objectives*. **Review** all objectives, **reminding** participants of activities and methods used to increase knowledge, build skills, and change or strengthen attitudes. **Revisit** the flip chart paper with participant expectations listed. **Ensure** that all expectations have been addressed.

COURSE EVALUATION

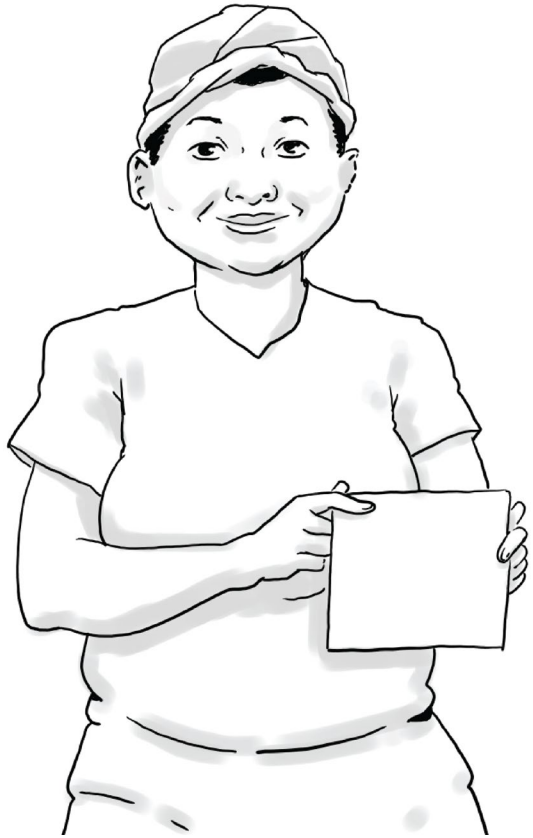
Thank participants for their attention and their participation in the short course. **Distribute** the *Course Evaluation Form*. **Ask** participants to take 10 minutes to complete the *Course Evaluation* and **provide** feedback on which areas of the training went well and which areas could be improved. **Remind** participants that their input is critical in improving the course.

KNOWLEDGE ASSESSMENT

Distribute and ask participants to complete the knowledge *Post-test*, which covers content from the entire course. **Ask** participants to take 30 minutes to complete the test. Participants should use the same number they selected at the beginning of the training instead of writing their names. The results, along with their participation and skills practice during the Case Study Role-Plays and pelvic model practice will help assess participants' readiness to provide uterine evacuation with medications and MVA to women. Ideally, the facilitator should review the correct answers for the knowledge assessment with the participants after all have completed and submitted them.

CLOSING CEREMONY

Present each participant with their prepared certificate of completion and congratulate them.



ANNEX 1: SAMPLE COURSE AGENDA FOR COMBINED TRAINING

The following is a sample course agenda for a uterine evacuation with medications and manual vacuum aspiration combined two-day training. This template assumes that participants have already been through a values clarification and attitude transformation (VCAT) workshop. Therefore, only one VCAT exercise as an early group activity is incorporated in the agenda. If participants have not been through a prior VCAT workshop, it is recommended to add, if possible, a one-day VCAT workshop prior to starting the uterine evacuation module(s).

UTERINE EVACUATION IN CRISIS SETTINGS USING MEDICATIONS AND MANUAL VACUUM ASPIRATION

Unit	Time	Content	Training Method
Day 1: 8 hours			
1	15 minutes	• Welcome • Facilitator introduction • Ice breaker	• Paired interview
1	15 minutes	• Course agenda • Participant expectations • Course objectives (optional) • Housekeeping/Parking lot	• Brainstorm
1	30 minutes	• Knowledge pre-test	
2	15 minutes	Uterine evacuation an important element of reproductive health in crisis settings because: • Maternal mortality linked to unsafe abortion • Lack of security • High risk of sexual violence • Disruption in contraceptive and other health services • May want to delay childbearing during a crisis	• Interactive presentation and group brainstorm (Why might a woman need a uterine evacuation in a crisis setting?)
2	30 minutes	• Values clarification	• Group activity: Comfort Continuum
2	30 minutes	• Review of abortion law	• Presentation • Read case studies aloud, large (or small) group process
	15 minutes	**BREAK**	
3	45 minutes	• Method options for uterine evacuation • Uterine evacuation method options counseling	• Interactive presentation • Case studies • Large or small group process
3	45 minutes	• Postabortion contraception • Special considerations for women in refugee and displaced settings • Informed consent	• Review and discussion • Case studies

Unit	Time	Content	Training Method
	60 minutes	**LUNCH**	
4	45 minutes	• Clinical assessment • Determining eligibility for uterine evacuation with medications	• Interactive presentation • Case studies and group discussion
	15 minutes	**ENERGIZER**	
5	30 minutes	• How to use mifepristone and/or misoprostol, expected effects, side effects and warning signs	• Presentation
5	60 minutes	• Providing uterine evacuation with mifepristone and/or misoprostol	• Demonstration • Role plays
5	15 minutes	• Follow-up	• Presentation
	15 minutes	• Summarize/end Day 1	• Daily process evaluation
Day 2: 7 hours 30 minutes			
	30 minutes	• Welcome participants back • Overview of Day 2 • Respond to any questions from Day 1	
6	30 minutes	• MVA instrument facts and features	• Interactive presentation and demonstration
6	45 minutes	• Processing Ipas MVA Plus© and Ipas EasyGrip Cannulae©	• Video • Presentation
	15 minutes	**BREAK**	
6	60 minutes	• Uterine evacuation with the Ipas MVA Plus© • Review MVA steps	• Video • Presentation
	60 minutes	**LUNCH**	
6	60 minutes	• MVA Demonstration • Simulated practice	• Pelvic models
6	15 minutes	• Technical problems during MVA	• Interactive presentation
6	15 minutes	• Pain management plan	• Interactive presentation
	15 minutes	**BREAK**	
6	60 minutes	• Simulated practice	• Pelvic models
6	30 minutes	• Post-procedure care and follow-up	
	15 minutes	• Summarize/end Day 2	• Daily process evaluation

Unit	Time	Content	Training Method
Day 3: 8 hours			
	30 minutes	• Welcome participants back • Overview of Day 3 • Respond to any questions from Day 2	
7	45 minutes	• Managing complications and assessment of shock and underlying causes in postabortion care	• Interactive presentation
7	45 minutes	• Identifying and Managing Complications of Uterine Evacuation with Medications	• Case studies and group discussion
	15 minutes	**BREAK**	
8	30 minutes	• Using a monitoring plan to ensure quality of care and to sustain uterine evacuation services	• Interactive presentation
8	30 minutes	• Review a work plan to integrate uterine evacuation into crisis settings	• Worksheet activity
	60 minutes	**LUNCH**	
	90 minutes	Additional simulated practice	
	15 minutes	**BREAK**	
	60 minutes	Skills evaluation *Optional: Skills evaluations can take place during the practice time after lunch instead of during this hour.*	
9	20 minutes	• Closing Activities • Review course objectives • Review participant expectations • Summary points • Course evaluation	
9	30 minutes	• Knowledge post-test	
9	10 minutes	• Certificate of completion ceremony	

ANNEX 2: PARTICIPANT PRE- AND POST-TEST ANSWER KEY

1. Which of the following is **NOT** a recommended method for induced abortion prior to 13 weeks gestation according to the World Health Organization?
   a. Mifepristone plus misoprostol
   b. Sharp curettage
   c. Vacuum aspiration
   d. Misoprostol

2. Which of the following is **NOT** a recommended method of uterine evacuation for treatment of incomplete abortion with a uterine size of less than 13 weeks, according to the World Health Organization?
   a. Sharp curettage
   b. Vacuum aspiration
   c. Misoprostol

3. Use of a certain method of uterine evacuation depends on all the following **except** for:
   a. Staff skills
   b. Preference of the woman's family members
   c. Equipment, supplies, and drugs available
   d. The woman's clinical condition

4. Which one of the following is **NOT** a contraindication to misoprostol for induced abortion?
   a. Suspected ectopic pregnancy
   b. Allergy to misoprostol
   c. Breastfeeding

5. Which of the following is **NOT** a an expected effect of using misoprostol?
   a. Uterine cramping stronger than a period
   b. Foul smelling vaginal discharge
   c. Vaginal bleeding usually heavier than a period and often accompanied by clots

6. Which of the following is **NOT** a warning sign of complications when using mifepristone and/or misoprostol for uterine evacuation?
   a. Fever on the day misoprostol is used
   b. Vaginal bleeding that soaks more than 4 extra-large sanitary pads over 2 hours
   c. Foul smelling vaginal discharge

7. Which of the following contraceptive methods cannot be started at the same time medications for uterine evacuation are begun?
   a. Combined oral contraceptives
   b. Contraceptive injection
   c. Contraceptive implant
   d. Intrauterine device

8. **True** or False: An IUD can be placed immediately following an uncomplicated manual vacuum aspiration (MVA), but must be delayed after mifepristone and/or misoprostol until reasonably certain the woman is no longer pregnant.

9. Which of the following tests/examinations is recommended for all women undergoing treatment for incomplete abortion?
   a. Rh (rhesus) testing
   b. Hemoglobin/hematocrit
   c. Ultrasound
   d. Bimanual examination

10. Which of the following is **NOT** a useful approach for pain management during uterine evacuation with medications?
    a. Hot water bottle, heating pad or hot cloths to the abdomen or lower back
    b. Nonsteroidal anti-inflammatory drugs such as ibuprofen
    c. Narcotic analgesics
    d. Paracetamol

11. Which of the following is **NOT** a sign that a woman may have a continuing pregnancy after using mifepristone and/or misoprostol for medical abortion?
    a. She had heavy bleeding with clots the day after using misoprostol
    b. She feels breast tenderness and nausea two weeks after using the medications
    c. She did not have bleeding after using misoprostol

12. Which of the following are advantages of using vacuum aspiration for uterine evacuation instead of medications?
    a. Painless
    b. More effective
    c. Allows for inspection of POC
    d. Less invasive
    e. b & c

13. Which of the following does **NOT** indicate a successful uterine evacuation with medications?
    a. Uterine size smaller than at initial visit
    b. Women believes uterine evacuation was successful
    c. Woman denies vaginal bleeding after misoprostol use
    d. Woman's pregnancy symptoms have improved

14. It is important to understand the signs and symptoms of ectopic pregnancy because…
    a. …ectopic pregnancy is a life-threatening condition.
    b. …neither medical methods of uterine evacuation or vacuum aspiration can treat ectopic pregnancy.
    c. …ectopic pregnancy can present similarly to incomplete abortion.
    d. All of the above.

15. **True** or False: Accurately determining the length of pregnancy is a critical factor in both selecting a uterine evacuation method and preventing complications.

16. **True** or False: Where possible, prophylactic antibiotics should be administered at the time of vacuum aspiration to reduce the risks of post-procedure infection.

17. Ultrasound is not required for provision of first-trimester abortion-related care, but it may be helpful for:
    a. Accurate gestational dating
    b. Detecting ectopic pregnancies
    c. Managing certain pre-existing conditions
    d. All of the above

18. The Ipas MVA Plus® Aspirator:
    a. Can be used after cleaning
    b. Cannot be autoclaved or boiled
    c. Must be high-level disinfected or sterilized between each patient
    d. Cannot be reused in any setting

19. Ipas EasyGrip Cannulae®:
    a. Can be used after cleaning
    b. Cannot be autoclaved or boiled
    c. Must be high-level disinfected or sterile before entering the sterile uterus
    d. Cannot be reused in any setting

20. Which of the following is **not** true about pain and its management during a uterine evacuation procedure?
    a. WHO recommends that all women routinely be offered pain medication during both medical and surgical abortions
    b. Non-pharmacologic measures and a calm environment are adequate substitutions for pain medications
    c. Anxiety and/or depression may be associated with increased pain
    d. Paracervical block is safe, easy to do and may be done by midlevel providers

21. The already very low risk of serious complications of paracervical block can be reduced by:
    a. Injecting anywhere in the cervix
    b. Using more than 200mg of lidocaine
    c. Only using paracervical block when the os is open
    d. Pulling the plunger back (aspirating) before injecting

22. No Touch Technique means:
    a. The provider should not touch the woman
    b. If the aspirator is not sterile, the provider's fingertips can be used to unclog a cannula
    c. The vaginal walls are sterile and cannot be touched
    d. The tip of the cannula should not touch anything that is not sterile or high-level disinfected

23. Uterine perforation is a risk that can be minimized by:
    a. Firmly inserting a larger cannula all the way into the uterus
    b. Underestimating the length of pregnancy
    c. Using gentle operative technique
    d. Estimating size and position of the uterus based on the woman's weight

24. Continuing pregnancy:
    a. Is suggested by a lack of vaginal bleeding, persistent pregnancy symptoms and/or increasing uterine size after medical abortion
    b. Risk after vacuum aspiration can be decreased by examining the aspirate immediately after the procedure
    c. Both a & b

25. In postabortion care, suspect ectopic pregnancy in a woman who presents with the following:
    a. Ongoing bleeding and abdominal pain after a uterine evacuation procedure
    b. Uterine size smaller than expected
    c. Minimal vaginal bleeding after taking medications for abortion
    d. All of the above

ANNEX 3: REFERENCES AND RECOMMENDED RESOURCES

1. Barnard, Sharmani, Caron Kim, Min Hae Park, and Thoai D Ngo. "Doctors or Mid-Level Providers for Abortion." Edited by Cochrane Fertility Regulation Group. *Cochrane Database of Systematic Reviews,* July 27, 2015. https://doi.org/10.1002/14651858.CD011242.pub2.
2. Center for Reproductive Rights. "The World's Abortion Laws." Accessed November 19, 2020. https://reproductiverights.org/worldabortionlaws.
3. Corbett, Maureen R., and Katherine Turner. "Essential Elements of Postabortion Care: Origins, Evolution and Future Directions." *International Perspectives on Sexual and Reproductive Health* 29, no. 3 (September 2003). https://doi.org/10.1363/ifpp.29.106.03.
4. Cureless, Melanie S., Chandrakant S. Ruparelia, Elizabeth Thompson, and Polly A. Trexler. *Infection Prevention and Control: Reference Manual for Health Care Facilities with Limited Resources*. Baltimore, Maryland: Jhpiego, 2018. http://resources.jhpiego.org/resources/infection-prevention-and-control-reference-manual-health-care-facilities-limited-resources.
5. EngenderHealth. *COPE Handbook: A Process for Improving Quality in Health Services*. New York, NY: EngenderHealth, 2003.
6. EngenderHealth, and Ipas. *COPE for Comprehensive Abortion Care: A Toolbook to Accompany the COPE Handbook*, 2009. https://www.engenderhealth.org/files/pubs/qi/cope-for-abortion-care.pdf.
7. Inter-Agency Working Group on Reproductive Health in Crises. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings,* 2018. https://iawgfieldmanual.com/.
8. Inter-Agency Working Group on Reproductive Health in Crises. *Minimum Initial Service Package for Sexual and Reproductive Health In Crisis Situations: A Distance Learning Module,* 2019. https://iawg.net/resources/minimum-initial-service-package-distance-learning-module.
9. Inter-Agency Working Group on Reproductive Health in Crises. "MISP Considerations Checklist for Implementation During COVID-19," 2020. https://iawg.net/resources/misp-considerations-checklist-for-implementation-during-covid-19.
10. 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. https://iawg.net/resources/misp-reference.
11. Ipas. *Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences.* Chapel Hill, NC, 2018. https://www.ipas.org/resource/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences/.
12. Ipas. "Abortion Pills in First 12 Weeks since Last Period: Mifepristone and Misoprostol in the Cheek," 2020. https://www.ipas.org/resource/abortion-pills-in-first-12-weeks-since-last-period-mifepristone-and-misoprostol-in-the-cheek/.
13. Ipas. "Abortion Pills in First 12 Weeks since Last Period: Mifepristone and Misoprostol under the Tongue," 2020. https://www.ipas.org/resource/abortion-pills-in-first-12-weeks-since-last-period-mifepristone-and-misoprostol-under-the-tongue/.
14. Ipas. "Abortion Pills in First 12 Weeks since Last Period: Misoprostol in the Cheek," 2020. https://www.ipas.org/resource/abortion-pills-in-first-12-weeks-since-last-period-misoprostol-in-the-cheek/.
15. Ipas. "Abortion Pills in First 12 Weeks since Last Period: Misoprostol under the Tongue," 2020. https://www.ipas.org/resource/abortion-pills-in-first-12-weeks-since-last-period-misoprostol-under-the-tongue/.
16. Ipas. "Ipas Clinical Updates in Reproductive Health 2020," 2020. www.ipas.org/clinicalupdates.
17. Ipas. "MA Supply Guidance Tool," 2016. https://www.ipas.org/resource/ma-supply-guidance-tool-zip/.
18. Ipas. *MVA Calculator*, n.d. https://www.ipas.org/supply-calculators/mva/.
19. Ipas. "Paracervical Block Technique," 2018. www.ipas.org/clinicalupdates.
20. Ipas. "Protocols for Medical Abortion [Dosage Card]," 2019. https://www.ipas.org/resource/protocols-for-medical-abortion-dosage-card/.
21. Ipas. "Supply and Equipment Checklist for First Trimester (<13 Weeks) Comprehensive Abortion Care," 2019.
22. Ipas. "Tips for Using the Ipas MVA Plus®," n.d. www.ipas.org.
23. Ipas. "Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training," 2009.
24. Ipas. *Woman-Centered, Comprehensive Abortion Care Reference Manual, Second Edition*. Chapel Hill, NC, 2015. https://www.ipas.org/resource/woman-centered-comprehensive-abortion-care-reference-manual-second-edition/.
25. Ipas. *Woman-Centered, Comprehensive Abortion Care Trainer's Manual, Second Edition.* Chapel Hill, NC, 2014. https://www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition/.
26. IPPF. "Medical Abortion Commodities Database." Accessed December 22, 2020. https://www.medab.org/.
27. JSI, and Ipas. "MVA Initial Supply and Re-Supply," 2009.
28. Powell, Bill, and Nathalie Kapp. "Validation of Instrument Reprocessing Methods for the Ipas Manual Vacuum Aspiration Devices". *International Journal of Gynecology & Obstetrics* 147, no. 1 (2019): 89–95. https://doi.org/10.1002/ijgo.12908.
29. Tran, Nguyen Toan, Alison Greer, Talemoh Dah, Bibiche Malilo, Bergson Kakule, Thérèse Faila Morisho, Douglass Kambale Asifiwe, et al. "Strengthening Healthcare Providers' Capacity for Safe Abortion and Post-Abortion Care Services in Humanitarian Settings: Lessons Learned from the Clinical Outreach Refresher Training Model (S-CORT) in Uganda, Nigeria, and the Democratic Republic of Congo." Preprint. In Review, October 26, 2020. https://doi.org/10.21203/rs.3.rs-45342/v1.

30. Tran, Nguyen Toan, Kristen Harker, Wambi Maurice E. Yameogo, Seni Kouanda, Tieba Millogo, Emebet Dlasso Menna, Jeevan Raj Lohani, et al. "Clinical Outreach Refresher Trainings in Crisis Settings (S-CORT): Clinical Management of Sexual Violence Survivors and Manual Vacuum Aspiration in Burkina Faso,cNepal, and South Sudan." *Reproductive Health Matters 25*, no. 51 (November 30, 2017): 103–13. https://doi.org/10.1080/09688080.2017.1405678.
31. UNFPA. *Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings: Manual 6th Edition,* 2019.
32. United Nations Population Division | Department of Economic and Social Affairs. "World Abortion Policies," 2013. https://www.un.org/en/development/desa/population/publications/policy/world-abortion-policies-2013.asp.
33. Wegs, Christina, Katherine Turner, and Betsy Randall-David. *Effective Training in Reproductive Health: Course Design and Delivery. Reference Manual*. Chapel Hill, NC: Ipas, 2011. https://www.ipas.org/resource/effective-training-in-reproductive-health-course-design-and-delivery-reference-manual/.
34. World Health Organization. *Abortion care guideline.* World Health Organization, 2022. https://apps.who.int/iris/handle/10665/349316.
35. World Health Organization. *Clinical Practice Handbook for Safe Abortion*. World Health Organization, 2014. https://apps.who.int/iris/handle/10665/97415.
36. World Health Organization. *Decontamination and Reprocessing of Medical Devices for Health-Care Facilities*. World Health Organization, 2016. https://www.who.int/publications/i/item/9789241549851.
37. World Health Organization. *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception*. World Health Organization, 2015. https://srhr.org/safeabortion/.
38. World Health Organization. *Medical Eligibility Criteria for Contraceptive Use*. 5th ed., 2015. https://www.who.int/publications/i/item/9789241549158.
39. World Health Organization. Medical Management of Abortion. World Health Organization, 2018. https://apps.who.int/iris/handle/10665/278968.
40. World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems*. World Health Organization, 2012. https://fctc.who.int/publications/i/item/safe-abortion-technical-and-policy-guidance-for-health-systems.
41. World Health Organization. Abortion care guideline. World Health Organization, 2022. https://www.who.int/publications/i/item/9789240039483.

Suggested citation:
Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and Ipas. Uterine Evacuation in Crisis Settings Using Medications and Manual Vacuum Aspiration. New York: 2023.

Ipas
P.O. Box 9990
Chapel Hill, NC 27515 USA 1-919-967-7052
ipas@ipas.org
www.ipas.org

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

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises
Training Partnership Initiative
Women's Refugee Commission
15 West 37th Street, New York, NY 10018
info.iawg@wrcommission.org
www.iawg.net

IAWG Inter-Agency Working Group on Reproductive Health in Crises

Ipas