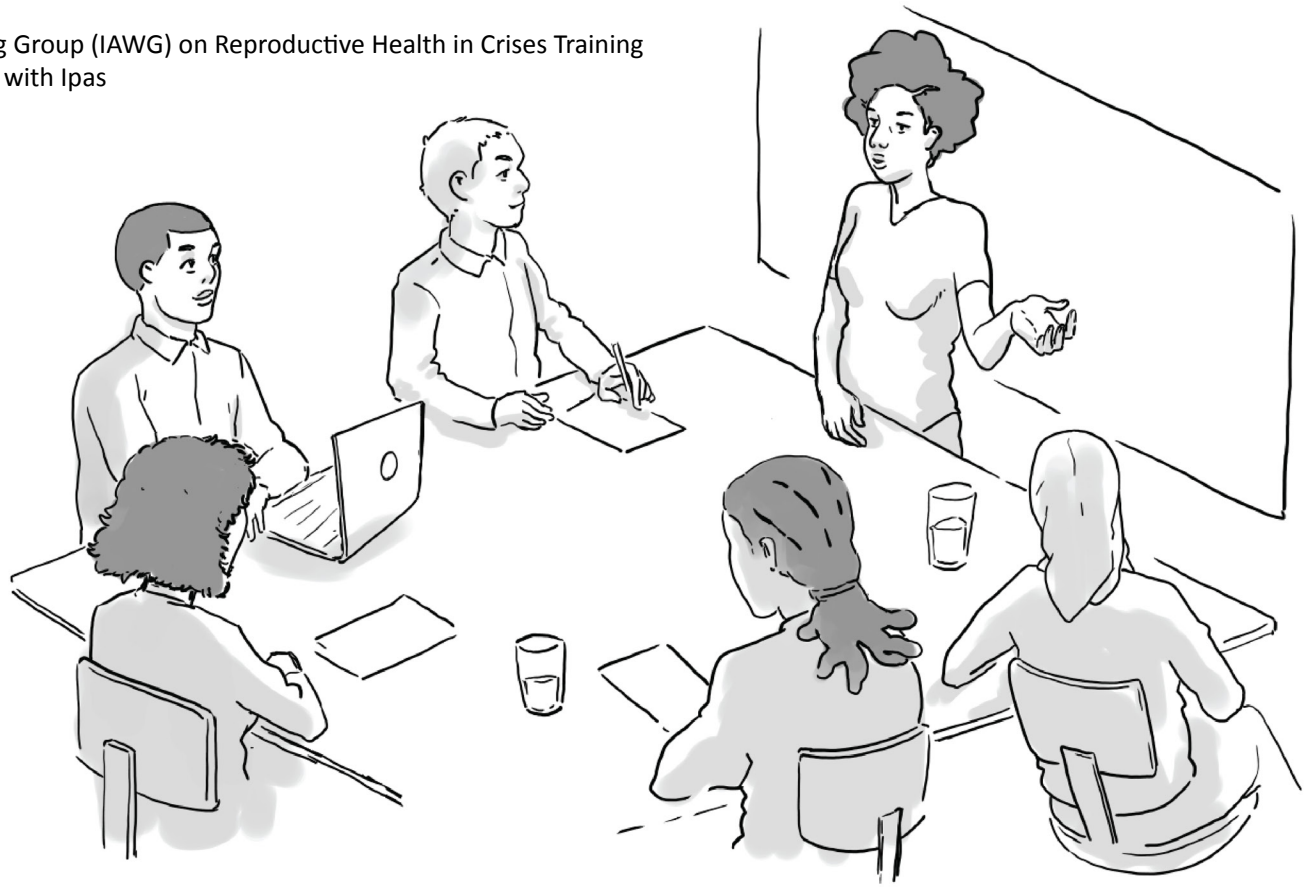
# UTERINE EVACUATION IN CRISIS SETTINGS USING MANUAL VACUUM ASPIRATION

## 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



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

## LIST OF ABBREVIATIONS

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

## 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 Evacualtion in Crisis Settings Using Manual Vacuum Aspiration* is one of these modules. It was designed to be either a stand-alone training in uterine evacuation with medical methods, or to be combined with the module on *Uterine Evacuation in Crisis Settings Using Medications*. When combined, the modules provide a training on both uterine evacuation technologies for the crisis setting. Please visit www.iawg.net/scorts to access all training materials in the series and for 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 Using Manual Vacuum Aspiration* clinical outreach refresher training module is intended to be used by clinical trainers leading a refresher course for clinicians already familiar with intrauterine procedures, including manual vacuum aspiration (MVA). The audience for this training is clinical service providers who meet established pre-requisites regarding reproductive health care knowledge and skills. 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 and activities designed to help health care workers learn the knowledge and skills they need to provide first-trimester uterine evacuation using Ipas MVA Plus® and EasyGrip® Cannulae. 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 manual vacuum aspiration (MVA)
4. Recognize and manage women who develop complications from uterine evacuation with MVA
5. Integrate uterine evacuation with MVA into their present reproductive health services and organize and monitor the services

Please note that this course focuses on use of MVA, rather than comprehensive abortion or postabortion care. Additionally, it does not cover uterine evacuation with medications unless combined with the *Uterine Evacuation in Crisis Settings Using Medications* module. For broader training materials on comprehensive abortion care and comprehensive postabortion care, refer to the Ipas *Woman-Centered, Comprehensive Abortion Care Trainer's Manual* (2nd ed.) and other Ipas curricula, available at www.ipas.org.

## TARGET AUDIENCE

The training program is designed for health care providers, including midwives, nurses, general practice physicians, and obstetrician/gynecologists 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 necessary 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 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 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:

- Demonstrate knowledge of the female reproductive system
- Know how to take a medical history and conduct a physical exam
- Accurately assess the gestational age of an early pregnancy using 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
- Have previous exposure to uterine evacuation with MVA

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 eight units:

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

Each unit focuses on one component of uterine evacuation with medications 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 | Matching cards for icebreaker | 1 per participant | |
| 1,3 | Sheets of paper, at least 2 colors | Multiple per participant | |
| 4,5 | Pelvic model(s) | 2 at least (ideal is 1 per 5 participants) | |
| 4,5 | Ipas MVA aspirators (and product insert)* | 1 per participant, or at least one per site | |
| 4,5 | 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* | |
| 4,5 | Specula (various sizes including small) | One per pelvic model | |
| 4,5 | Dilators | One set per pelvic model; can substitute the different sized cannulae if dilators are not available | |
| 4,5 | Tenaculae | One per pelvic model | |
| 4,5 | Sponge holding forceps | One per pelvic model | |
| 4,5 | Gloves | 1 – 2 boxes of non-sterile exam gloves | |
| 4 | Samples of worn aspirators and cannulae that need to be replaced (if possible) | 2 at least | |
| 5 | Syringes and needles | One syringe and one needle per pelvic model; ideally 10-20mL. syringe and 21-23 gauge needle at least 3cm. (1in.) | |
| 6 | Samples of contraceptive methods approved for use by women after having had a uterine evacuation | | |

## 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 | |
| 1,8 | Print copies of the knowledge *Pre-test* and *Post-test* | |
| 1,2,7 | Prepare flip charts | |
| 1 | Prepare cards with be matching words, photos, pictures, or symbols | |
| 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 PowerPoint 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*:<br>• Chapter 8, "Comprehensive Abortion Care," Section 8.3.2 Needs Assessment (p. 147)<br>• Chapter 8, "Comprehensive Abortion Care," Section 8.4 Human Rights & Legal Considerations (p. 160-2) | |
| 2 | Note anything applicable in the readings above to your training setting and share this information with participants | |
| 2 | Make large signs titled: "Not at all,""A little," and "A lot" | |
| 4 | Download/access videos using links below:<br>Video: *Processing the Ipas instruments* (Ipas, 2019), 17 minutes<br>Video: *Manual Vacuum Aspiration Technique Using the Ipas MVA Plus® Aspirator and Ipas EasyGrip® Cannulae*, 8 minutes<br>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<br>** 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.* | |
| 4 | Assess which method(s) of instrument processing is used and tailor Section 2 accordingly | |
| 4,5,6 | Arrange to ship or carry with you the MVA supplies and contraceptive methods, ensuring they make it through customs and other potential barriers in time for the training | |
| 7 | Be familiar with any monitoring practices in the participants' facilities | |
| 7 | Be prepared with examples of monitoring for abortion-related services | |
| 7 | Review the medical abortion and MVA calculators<br>• Medical abortion calculator: www.ipas.org/supply-calculators/ma<br>• MVA calculator: www.ipas.org/supply-calculators/mva | |
| 7 | Familiarize yourself with the Medical Abortion Commodities Database at www.medab.org before the training | |
| 8 | Fill out participants' names on 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 PowerPoint 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:**
45 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: Ice-breakers/Introductions
- 15 minutes: Group Discussion: Housekeeping, Ground Rules, Expectations, and Agenda
- 15 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 pairs of matching cards for icebreaker activity
- Prepare flip chart with a list of icebreaker questions
- 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
- ☐ Bell
- ☐ Cards for icebreaker activity
- ☐ Pens, markers, or crayons

# DETAILED SESSION GUIDE

## INTRODUCTION/ICEBREAKER

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

**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.

**Pass** out a random card to each participant. The cards can be matching words, photos, pictures, or symbols. **Make sure** there are an even number of participants – the facilitator can take a card if necessary. **Ask** participants to walk around the room and **find** their match. Once they find their partner, **ask** them to spend two minutes interviewing each other (no notes!).

**Prepare** and **post** a flip chart paper with these (or your own) interview questions:

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

After two minutes **ring** a bell and **ask** them to switch. After two more minutes **ask** participants to **introduce** their partner to the whole group in 30 seconds or less

## 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** to the participant expectations posted on the wall and **circle** what will be covered in this course. **Point out** any expectations that may be beyond the scope of the course. **Keep** the list to **review** with participants at the end of the course 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. This allows for results to be shared anonymously.

# UNIT 2 UTERINE EVACUATION IN CRISIS SETTINGS

## Time:
60 minutes (1 hour)

## 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: Comfort Continuum
- 15 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
- ☐ 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 PowerPoint 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
- Make large signs titled: “Not at all,”“A little,” and “A lot” to post in different places in the room

# 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: COMFORT CONTINUUM

**Introduce** the Comfort Continuum Activity. **Explain** that this activity asks participants to reflect on their level of comfort discussing, explaining options, and providing uterine evacuation.

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

**Not at all** | **A Little** | **A Lot**

**Read** the *Comfort Continuum Statements* aloud one at a time. **Ask** participants to physically **move** to the point along the continuum that best represents their feelings. **Encourage** participants to be honest and to resist being influenced by where others are standing.

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

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

As you **facilitate** a brief discussion about the different responses and comfort levels in the room, **refer** to the reasons given for choosing a certain place on the continuum. Some discussion questions could include:

- What observations do you have about your responses? Other people's responses?
- Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?
- What about your responses surprised you? How about other people's responses?
- What did you learn about your own and others' comfort levels about providing uterine evacuation services?
- Did you feel differently about providing uterine evacuation for incomplete abortion or spontaneous abortion (miscarriage) than induced abortion? How did other people feel about this?
- Would your response about providing contraceptives have been different for married women? Why or why not?
- What observations do you have about the group's overall level of comfort with providing uterine evacuation services to the fullest extent of the law (focus on the group as a whole, not individual people's responses)?

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

### COMFORT CONTINUUM STATEMENTS

1. **How comfortable are you with uterine evacuation services being provided in your facility?**
2. **How comfortable are you discussing uterine evacuation with colleagues at work?**
3. **How comfortable are you discussing uterine evacuation outside of your work setting?**
4. **How much disapproval would you expect to feel from your family and friends if you provided (or assisted with) uterine evacuation services?**
5. **How comfortable are you performing (or assisting with if you are not authorized to perform) a uterine evacuation?**
6. **How comfortable are you with women choosing manual vacuum aspiration to treat their incomplete abortion for a pregnancy that was desired?**
7. **How comfortable are you using manual vacuum aspiration for women who have induced their own abortion and are experiencing complications (incomplete uterine evacuation)?**
8. **How comfortable are you with adolescent and young women seeking uterine evacuations?**
9. **How comfortable are you advocating for women's access to safe abortion?**
10. **How comfortable are you providing unmarried women with contraceptives after a uterine evacuation?**

## FACILITATOR PRESENTATION AND CASE STUDIES

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

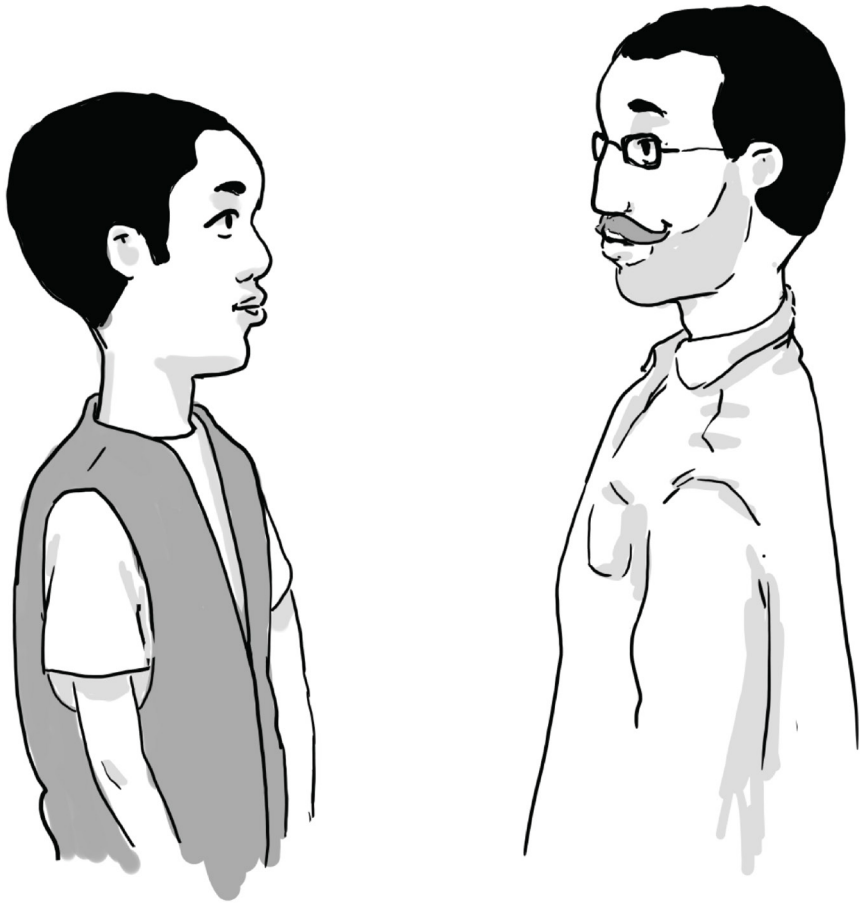
**Show** slide 17: *Case Studies*. **Read** the following three scenarios aloud. **Facilitate** a discussion about how each woman can be treated within the fullest extent of the law. If time allows, **divide** participants into small groups to **discuss**. **Appoint** someone in each group to report 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:
60 minutes (1 hour)

## Unit Objectives:

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

- Describe the various uterine evacuation options and explain why they are especially useful in crisis settings.
- Describe the safety, effectiveness, and possible complications MVA.
- Explain how medical abortion and misoprostol for incomplete abortion may be useful options for some women in crisis settings with MVA backup.
- Provide uterine evacuation procedure options counseling for women seeking uterine evacuation.
- Obtain informed consent prior to uterine evacuation.

## UNIT OVERVIEW

### TIMING AND METHODOLOGY

- 30 minutes: Facilitator Presentation and Group Discussion
- 15 minutes: Small Group Work: Case Studies
- 15 minutes: Facilitator Presentation and Group Discussion

### PREPARATION

- Print, download, and gather materials as listed below
- Bring two pieces of different colored paper for each participant (for example, if you have 20 participants, bring 20 sheets of red and 20 sheets of blue)

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*

DOWNLOAD:
Presentation:
- ☐ Slides 18 through 43

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart paper
- ☐ Markers, pens, or crayons
- ☐ Colored paper – 2 different colors, 1 for each participant

# DETAILED SESSION GUIDE

## FACILITATOR PRESENTATION AND GROUP DISCUSSION

**Show** slides 18-29 and **emphasize** the notes and activities listed below the slides for *Method Options for Uterine Evacuation*.

**Show** slides 30-33 and **emphasize** the notes and activities listed below the slides for *Safety, Efficacy, and Acceptability of MVA*.

**Pause** on slide 34: *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: *Medical Methods for Uterine Evacuation*, 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 37-39 and discuss using instructions included in the presentation 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 40: *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. 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 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 OPTIONS 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 AND GROUP DISCUSSION

**Show** slides 41-43 and **discuss** using notes and activities included in the presentation on *Informed Consent*.

# UNIT 4 MVA REFRESHER

## Time:
210 minutes (3 hours 30 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.

## UNIT OVERVIEW

### TIMING AND METHODOLOGY

- 30 minutes: Facilitator Presentation and Demonstration
- 45 minutes: Video, Presentation, and Practice: Instrument Processing
- 60 minutes: Video, Presentation, and Practice: MVA Procedure
- 60 minutes: Demonstration and Simulated Practice
- 15 minutes: Small Group Practice and Review: Solving Technical Problems Using MVA

Note: Ensure that all the processing chemicals/containers/machines that the crisis setting uses for instrument processing are available for demonstration. Refer to *Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training*[10] for lists of equipment and supplies for training Sections 3 and 4.

### 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 Section 2 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

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*

DOWNLOAD:

Presentation:

- ☐ Slides 44 through 132

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 Plus® 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

- **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 44-50, **discuss** and **demonstrate** using notes included in the presentation on *Facts and Features of Ipas MVA Plus® and Ipas EasyGrip® Cannulae*.
- On slide 51: *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 52-53. At slide 53: *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 54-60.
- **Pause** at slide 60 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 61-66 using the notes and directions in the presentation on *Maintaining Ipas Instruments*. Pause on slide 66: *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 67-70 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 71-93 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 94-125 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[13]

**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 Plus® 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.

**Explain**: 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

13. Adapted from: Ipas. "Training Tips for Using Pelvic Models in Manual Vacuum Aspiration (MVA) Clinical Training," 2009.

**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?

**Close** with slides 127-132, using notes and prompts in the presentation.

# UNIT 5 PAIN MANAGEMENT AND CONTINUED SIMULATED PRACTICE

## Time:
90 minutes (1 hour 30 minutes)

## Unit Objectives:

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

- Create a pain management plan with the patient that is sensitive to her situation.
- Be competent simulating a uterine evacuation procedure using Ipas MVA Plus® on a pelvic model.

## UNIT OVERVIEW

### TIMING AND METHODOLOGY

- 30 minutes: Facilitator Presentation and Group Discussion
- 60 minutes: Simulated Practice with Pelvic Models

### 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
- 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

PRINT:
Participant Workbook:
- ☐ *Pharmacologic Approaches to Pain Management During MVA*

DOWNLOAD:
Presentation:
- ☐ Slides 133 through 146

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart papers
- ☐ Pens, markers, or crayons

Minimum 2 of each, more if possible:
- ☐ Pelvic model(s)
- ☐ Ipas MVA Plus® aspirators (and product insert)*
- ☐ Ipas EasyGrip® Cannulae
- ☐ Specula (various sizes including small)
- ☐ Dilators
- ☐ Tenaculae
- ☐ Sponge holding forceps
- ☐ Gloves
- ☐ Syringes and needles
- ☐ Sharps box

# DETAILED SESSION GUIDE

## FACILITATOR PRESENTATION AND GROUP DISCUSSION

**Show** slides 133-145 and discuss using notes and activities included in the presentation on *Pain Management*.

**Pause** on slide 139: *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 144. **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** with slide 145 using notes in the presentation.

## SIMULATED PRACTICE WITH PELVIC MODELS

**Continue** where you left off the day before with Unit 4: *Simulated Practice*.

# UNIT 6 AFTER UTERINE EVACUATION

## Time:
90 minutes (1 hour 30 minutes)

## Unit Objectives:

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

- Identify and explain how to recognize signs and symptoms of complications.
- Discuss medical eligibility for select methods of postabortion contraceptionincludingemergency contraception.
- Provide referrals to other reproductive health services.

## UNIT OVERVIEW

### TIMING AND METHODOLOGY

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

### PREPARATION

- Print, download, and gather materials as listed below
- Arrange to ship or carry contraceptive methods with you to ensure they make it through customs and other potential barriers in time for the training

PRINT:
Participant Workbook:
- ☐ *Post Procedure Care Skills Checklist*
- ☐ *Discharge Information Sheet*
- ☐ *Postabortion Contraception Medical Eligibility*
- ☐ *Contraceptive Skills Counseling Checklist*
- ☐ *Special Contraceptive Counseling Considerations*
- ☐ *Management of Complications (CAC) Skills Checklist*
- ☐ *Management of Complications (PAC) Skills Checklist*

DOWNLOAD:
Presentation:
- ☐ Slides 147 through 241

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

# DETAILED SESSION GUIDE

## FACILITATOR PRESENTATION AND GROUP DISCUSSION

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.

**Begin** with slides 147-150, using notes and prompts in the presentation on *Post-Procedure Care*. **Pause** on slide 150 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 151-165. On slide 166 **refer** participants to *Discharge Information Sheet* in their *Participant Workbook*.

**OPTIONAL: Ask participants to practice giving discharge instructions in pairs.**

**Pause** on slide 167: *Before Discharge*. **Explain**: 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 168, **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 169-172 using notes and instructions in the presentation on *Follow-up Care*.

**Present** slide 173: *Contraceptive Counseling and Services*. **Say**: Offering on-site contraceptive counseling and method provision in the unit where abortion-related care is provided as an integrated part of abortion-related services can improve contraceptive acceptance and help break the cycle of multiple unwanted pregnancies. All women receiving abortion-related care, regardless of their age, marital status, or number of children, should be offered contraceptive services. **Refer** participants to *Postabortion Contraception Medical Eligibility*, *Contraceptive Counseling Skills Checklist*, and *Special Contraceptive Counseling Considerations* in the *Participant Workbook*.

**Move through** slides 174-188. **Pause** on slide 189: *Supply EC Pills* and **ask**: Why is it particularly important to offer EC in advance of or 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.

## CASE STUDIES: OTHER SPECIAL CONSIDERATIONS

**Show** slide 190: *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 191: *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 192-196 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.

## 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.

## FACILITATOR PRESENTATION AND GROUP DISCUSSION

**Show** slides 197-228 and discuss using notes and instructions in the presentation on *Management of Complications*. **Pause** on slide 224: *How is vasovagal reaction treated?*

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 229-241 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 231: *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 241. 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 unit.

# UNIT 7 SERVICE DELIVERY

**Time:**
30 minutes

## 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

- 30 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 244
- 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 www.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 242 through 263

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 256, 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 259, click on the link to open the medical abortion calculator for a quick tour/demo.
- Slide 261, 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 242-263 and **discuss** using notes and activities included in the presentation. **Pause** on slide 262: *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.

# UNIT 8 EVALUATION AND CLOSING

**Time:**
55 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

- 20 minutes: Facilitator Presentation and Group Discussion
- 10 minutes: Course Evaluation
- 15 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 264 through 270

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

# DETAILED SESSION GUIDE

## FACILITATOR PRESENTATION AND GROUP DISCUSSION

**Review** slide 266: *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 15 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 will help assess participants' readiness to provide uterine evacuation with medications to women.

## CLOSING CEREMONY

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

# ANNEX 1: SAMPLE COURSE AGENDA FOR STAND-ALONE TRAINING

The following are two sample course agendas. The first is for a two-day uterine evacuation with MVA stand-alone training. This template assume 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.

Additionally, this module assume that this is a refresher training. If participants have little or no prior experience with MVA, consider adding extra days to the training for more pelvic model practice and/or a clinical practicum.

## UTERINE EVACUATION IN CRISIS SETTINGS USING MANUAL VACUUM ASPIRATION: STAND-ALONE TRAINING

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

| Unit | Time | Content | Training Method |
|---|---|---|---|
| 3 | 15 min | • Using misoprostol to treat incomplete abortion in crisis settings<br>• Using medical abortion for first trimester uterine evacuation | • Facilitated discussion<br>• Colored paper activity |
| 3 | 15 min | • Uterine evacuation method options counseling<br>• Informed consent | • Presentation<br>• Case studies |
| 4 | 30 min | • Instrument facts and features | |
| | 1 hour | **LUNCH** | |
| 4 | 45 min | • Processing Ipas MVA Plus® and Ipas EasyGrip® Cannulae | • Presentation<br>• Instrument processing video |
| 4 | 1 hour | • Uterine evacuation with the Ipas MVA Plus®<br>• Review manual vacuum aspiration steps | • Procedure video |
| 4 | 1 hour | • Demonstration<br>• Simulated practice | • Pelvic models |
| | 15 min | **BREAK** | |
| 4 | 15 min | • Technical problems during manual vacuum aspiration | • Demonstration / "What if" activity |
| | 15 min | • Summarize and close for Day 1 | • Daily process evaluation |
| **Day 2**: 6 hours | | | |
| | 30 min | • Welcome participants back<br>• Overview of Day 2<br>• Respond to any questions from Day 1<br>• Re-energize<br>• Review manual vacuum aspiration steps | |
| 5 | 30 min | • Pain management plan | |
| 5 | 1 hour | • Simulated practice with pelvic models | |
| 6 | 30 min | • Post-procedure care and follow-up care<br>• Linkages to contraceptive services, reproductive health, STIs, etc | |
| | 15 min | **BREAK** | |
| 6 | 30 min | • Postabortion contraceptive counseling and services | • Positive/negative facilitator demonstration |
| 6 | 30 min | • Management of complications | |
| | 1 hour | **LUNCH** | |

| Unit | Time | Content | Training Method |
|---|---|---|---|
| 7 | 15 min | • Using a monitoring plan to ensure quality of care and to sustain manual vacuum aspiration and postabortion contraceptive services | • Presentation |
| 7 | 15 min | Review a work-plan to integrate manual vacuum aspiration into crisis setting:<br>• Supply/resupply of manual vacuum aspiration instrument and related supplies<br>• Create systems of sustainability<br>• Create mentor relationships and facilitated supervision, if necessary | • Worksheet activity |
| 8 | 30 min | • Closing activities | • Review course objectives<br>• Review participant expectations<br>• Summary points<br>• Daily process evaluation<br>• Course evaluation |
| 8 | 15 min | • Knowledge post-test | |
| 8 | 10 min | • Certificate of completion | |

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

1. World Health Organization-recommended methods for uterine evacuation in the first trimester are:
   a. Dilatation and curettage and vacuum aspiration
   **b. Vacuum aspiration, medical methods, and expectant management (for incomplete abortion)**
   c. Sharp curettage and dilatation and curettage
   d. Dilatation and medical methods and expectant management (for incomplete abortion)

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

3. In a facility without an anesthetist or reliable electricity, a good solution for providing uterine evacuation services might be to:
   a. Refer women to the nearest traditional abortion provider
   b. Raise funds locally to hire an anesthetist
   c. Buy an electric vacuum aspirator (EVA) machine and work with the electric company to bring electricity to the facility
   **d. Use manual vacuum aspiration (MVA) or medical methods with appropriate pain management**

4. **True** or False: When possible, counseling should take place before any clinical procedure.

5. **True** or False: No one else should participate in counseling without the woman's prior permission, including other health care staff.

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

7. True or **False**: Young women are not eligible for intrauterine devices (IUDs) because of their increased risk for sexually transmitted infections (STIs).

8. Postabortion contraceptive services are more likely to be effective if:
   a. The women using them are already married
   **b. Women choose the method themselves based on their needs and informed choice**
   c. The women already have children
   d. Providers are using contraceptive methods themselves

9. Which of the following is not one of the key messages all women requesting abortion-related care should receive?
   a. She could become pregnant again within two weeks, and as early as eight days after medical abortion with mifepristone and misoprostol
   b. Safe methods to prevent or delay pregnancy are available
   c. Where and how she can obtain contraceptive services and methods
   **d. There are very few contraceptive methods that can be used after a uterine evacuation**

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

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

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

13. It is important to understand the signs and symptoms of ectopic pregnancy because:
   a. It can be challenging to rule out ectopic pregnancy
   b. Methods of uterine evacuation cannot treat ectopic pregnancies
   c. A woman with an ectopic pregnancy can be without symptoms
   **d. All of the above**

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

15. Ipas EasyGrip® Cannulae:
    a. Can be used after cleaning
    b. Cannot be autoclaved or boiled
    **c. Must be HLD or sterile before entering the sterile uterus**
    d. Cannot be reused in any setting

16. Which of the following is not true about pain and its management during a uterine evacuation procedure?
    a. World Health Organization 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

17. 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 HLD**

18. 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 200 mg of lidocaine
    c. Only using paracervical block when the os is open
    **d. Pulling the plunger back (aspirating) before injecting**

19. 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

20. **True** or False: The World Health Organization does not recommend a routine follow-up visit after an uncomplicated uterine evacuation with MVA.

21. During abortion-related care, contraception should be offered to:
    a. Married women
    b. Women 18 years and older
    c. Women who have three or more children
    **d. All women**

22. Incomplete abortion:
    a. Is indicated by vaginal bleeding and pain
    b. Can lead to infection
    c. Is treatable by vacuum aspiration
    **d. All of the above**

23. Continuing pregnancy:
    a. Is suggested by a lack of vaginal bleeding, persistent pregnancy symptoms, and/or increasing uterine size after medical abortion
    b. Risk after vacuum aspiration can be decreased by examining the aspirate immediately after the procedure
    **c. Both a & b**
    d. Is caused by dilatation and curettage (D&C)

24. The first step in treating a woman presenting with postabortion complications is:
    **a. Perform a rapid initial assessment for shock**
    b. Check for pregnancy-related complications
    c. Perform a physical exam
    d. Get voluntary informed consent

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, Nepal, 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://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf.
41. World Health Organization. Abortion care guideline. World Health Organization, 2022. https://www.who.int/publications/i/item/9789240039483.

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