

UTERINE EVACUATION IN CRISIS SETTINGS USING MANUAL VACUUM ASPIRATION

PARTICIPANT WORKBOOK

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

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



ACKNOWLEDGEMENTS

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

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

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

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

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

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

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

INTRODUCTION	4
HOW TO USE THIS WORKBOOK	6
UNIT 1: COURSE OVERVIEW	7
UNIT 2: UTERINE EVACUATION IN CRISIS SETTINGS	8
UNIT 3: UTERINE EVACUATION METHODS	14
UNIT 4: MVA REFRESHER	18
UNIT 5: PAIN MANAGEMENT AND CONTINUED SIMULATED PRACTICE	29
UNIT 6: AFTER UTERINE EVACUATION	33
UNIT 7: SERVICE DELIVERY	49
UNIT 8: EVALUATION AND CLOSING	55

INTRODUCTION

THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

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

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

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

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

Nurses, midwives, and physicians working in emergencies provide the sexual and reproductive health services needed to achieve the objectives of the MISP. IAWG has designed a series of short clinical outreach refresher trainings (S-CORTs) in order to reinforce previously acquired knowledge and skills of health care staff tasked with providing these priority services. *Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration: Refresher Course for Health Care Providers* 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: Training Course for Health Care Providers*. When combined, the modules provide a training on both uterine evacuation technologies for the crisis setting. Please visit www.iawg.net/scorts to access all trainings in the series and more information on their use.

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

Words matter when describing and caring for individuals who need access to health care information and services and, in particular, the services presented in the S-CORT series. Language can have a significant impact on sexual and reproductive health and wellbeing as well as access to related information and services. At times, the terminology used in guidance, programs, and policies can be 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

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: www.iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition.

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

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

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

WHAT CAN HEALTH STAFF DO?

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

- **Engage and ask people and respect their preferences.** As terminology requires adaptation in local languages and cultures, each linguistic and professional community should be engaged in discussing and contextualizing diversity-inclusive terms so that they are acceptable in the circumstances they are to be used. For example, avoid assuming the person's gender ("Miss" or "Mister") and ask instead: "Hello and welcome. My name is B and I am your provider today. Could you please tell me how I should address you?".
- **Use stigma-free, respectful, and accurate language.** Avoid using judgmental terms that are not person-centered. Favor the use of humane and constructive language that promotes respect, dignity, understanding, and positive outlooks (for example, prefer "survivor of sexual violence" to "victim").
- **Prioritize the individual.** It is recommended to place individuals at the center, and their characteristics or medical conditions second in the description (for example,

persons living with disability or persons living with HIV). Therefore, the use of person-centered language should be preferred to describe what people have, their characteristics, or the circumstances in which they live, which should not define who they are and how health staff treats them.

- **Cultivate self-awareness.** Professionals working with persons from diverse backgrounds should be conscious of the language they use as it can convey powerful images and meanings. They should develop cultural humility and self-reflection, be mindful, and refrain from repeating negative terms that discriminate, devalue, and perpetuate harmful stereotypes and power imbalances. They should also encourage colleagues, friends, and their community to do so. Values clarification workshops for health (and non-health) staff working with people with diverse backgrounds and characteristics could be transformative in clarifying values and changing attitudes to improve interactions.

OBJECTIVE

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

Please note that this course focuses on use of manual vacuum aspiration (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.

TRAINING OVERVIEW

Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration is a refresher course for clinicians already familiar with intrauterine procedures, including 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.

HOW TO USE THIS WORKBOOK

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

SUPPLEMENTARY MATERIALS FOR THIS TRAINING

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

- [*The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*](#)
- [*COPE® for Comprehensive Abortion Care Handbook*](#)
- Video: [*Processing the Ipas instruments*](#) (Ipas, 2019), 17 minutes

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

FEEDBACK ON THE TRAINING MATERIALS

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

NOTES:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

UNIT 1

COURSE OVERVIEW

At the end of this unit, participants will:

NOTES:

MY EXPECTATIONS FOR THIS TRAINING

[illegible]

COURSE OBJECTIVES

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

1. Explain why uterine evacuation is an essential part of reproductive health services in crisis settings
2. Counsel women seeking 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

TOPICS I WANT TO REVISIT

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

UNIT 2 UTERINE EVACUATION IN CRISIS SETTINGS

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

- NOTES:

The current abortion law in my country is...

"Abortion is legal up to _____ weeks gestational age.

Additional notes:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

iawg.net/IAFM

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

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

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

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

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

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

IARH Kit 3

IARH Kit 5

IARH Kit 8

IARH Kit 9

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

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

IARH Kit 1

IARH Kit 3

IARH Kit 5

IARH Kit 12

Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

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

IARH Kit 1

IARH Kit 3

IARH Kit 4

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

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

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

IARH Kit 2

IARH Kit 6

IARH Kit 8

IARH Kit 9

IARH Kit 10

IARH Kit 11

IARH Kit 12

IARH Kit 8

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



The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH)

is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess

sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

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

Fundamental principles for SRH programming in humanitarian settings

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

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

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

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

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

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

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

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

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

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

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

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

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

UNFPA Humanitarian Office

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

UNFPA Procurement Services Branch

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

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

UTERINE EVACUATION AND THE MISP

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

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

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

CASE STUDIES

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

NOTES:

Scenario 2: A 25-year-old woman comes to the clinic pleading for her uterus to be emptied. It has been nine weeks since her LMP. A bimanual examination confirms this gestational age. She has her four malnourished children with her. Her husband had been taken by enemy forces and has been missing for over a month. She has no means to support herself or her children. She claims that if the clinic cannot help her, she will have to do something herself as she knows she cannot support another child. Her last delivery was very difficult and she suffered complications. She fears that she will not survive childbirth in these conditions. She is the only person on whom her children can depend.

NOTES:

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

NOTES:

5 ELEMENTS OF PAC

1.

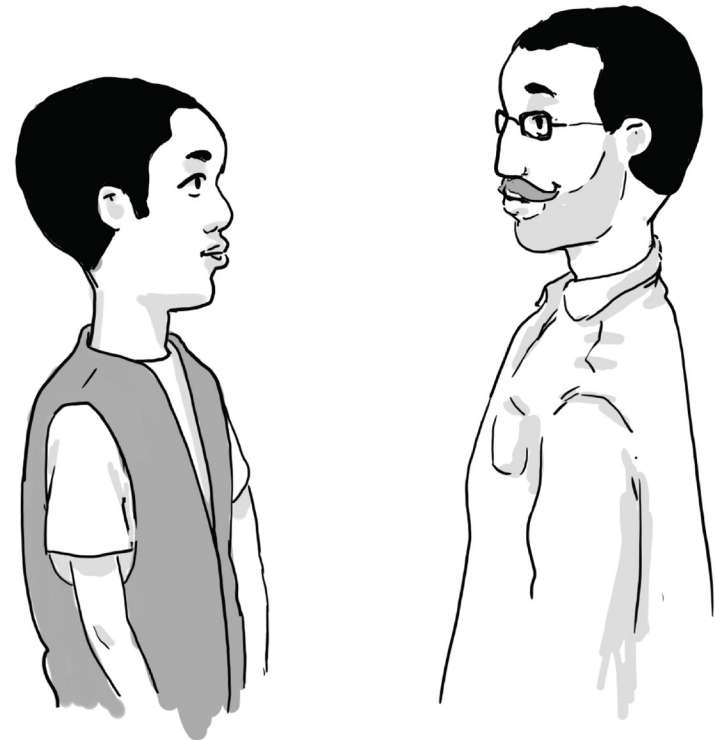
2.

3.

4.

5.

CAC IS



UNIT 3

UTERINE EVACUATION METHODS

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

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

POSSIBLE COMPLICATIONS OF MVA:

UTERINE EVACUATION TREATMENT OPTIONS²

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

2. Used with permission from Ipas.

How effective is it?	98-100% effective	95-98% effective	85% effective
Safe and effective for young women and adults?	Yes	Yes	Yes
What are the side effects?	Bleeding and cramping	Bleeding and cramping are expected effects. Possible side effects include nausea/vomiting, diarrhea, fever/chills, or dizziness.	Bleeding and cramping are expected effects. Possible side effects include nausea/vomiting, diarrhea, fever/chills, or dizziness.
What are the possible complications?	Rare complications include injury to the cervix or uterus, infection, hemorrhage, painful accumulation of blood in the uterus (hematometra), or incomplete abortion. Failed abortion occurs in less than 1% of cases, especially when performed by a skilled provider.	Rare complications include medication allergy, excessive or prolonged bleeding, infection, or incomplete abortion. Failed abortion (ongoing pregnancy) occurs in less than 2% of women. About 5% of women require vacuum aspiration for any reason.	Rare complications include medication allergy, excessive or prolonged bleeding, infection, or incomplete abortion. Failed abortion (ongoing pregnancy) occurs in 3-10% of women. About 15% of women require vacuum aspiration for any reason.
What if the abortion fails?	The procedure is repeated.	Vacuum aspiration is performed. If aspiration is not available, a second dose of misoprostol can be offered with close follow-up.	Vacuum aspiration is performed.
When can contraception be started?	Following an uncomplicated vacuum aspiration, all modern contraceptive methods can be used immediately; intrauterine devices (IUDs) can be inserted immediately after the procedure. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.	IUDs can be inserted when it is reasonably certain the woman is no longer pregnant. All other modern methods (such as pills, injectables, and implants) can be started with the first pill of the abortion regimen. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.	IUDs can be inserted when it is reasonably certain the woman is no longer pregnant. All other modern methods (such as pills, injectables, and implants) can be started with the first pill of the abortion regimen. Fertility awareness methods are not recommended until a normal menstrual pattern resumes.

2. Postabortion Care

	Vacuum Aspiration	Misoprostol	Expectant Management
How does it work?	The products of conception are removed through a tube (cannula) with suction created by an electric pump or handheld aspirator. The procedure takes two to ten minutes. Completion of the procedure is immediately confirmed.	Misoprostol causes uterine contractions that expel the products of conception. Misoprostol is either swallowed, placed under the tongue, or in the vagina, and can be repeated.	The products of conception are expelled through spontaneous uterine contraction without provider intervention.
How effective is it?	98-100% effective	91-99% effective	Up to 85% effective
How safe is it?	Rare complications include injury to the cervix or uterus, infection, hemorrhage, painful accumulation of blood in the uterus (hematometra), or incomplete abortion.	Rare complications include medication allergy, excessive or prolonged bleeding, infection, or incomplete abortion.	Rare complications include excessive or prolonged bleeding, infection, or incomplete abortion.

UTERINE EVACUATION METHOD OPTIONS COUNSELING CASE STUDIES

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

NOTES:

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

NOTES:

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

NOTES:

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

NOTES:

UNIT 4 MVA REFRESHER

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

NOTES:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

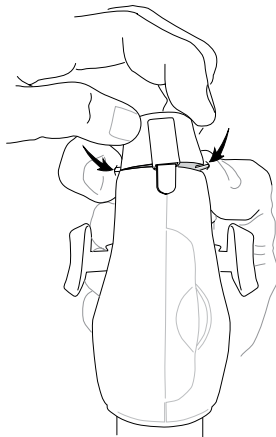
TIPS FOR USING THE IPAS MVA PLUS®⁴



Tips for using the Ipas MVA Plus®

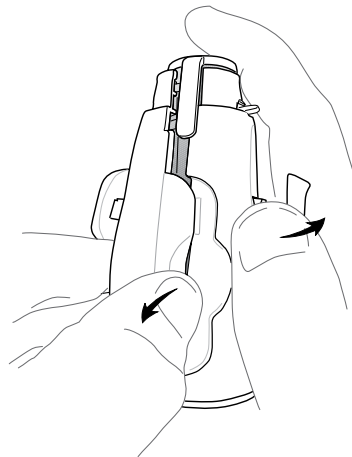
Cap removal

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



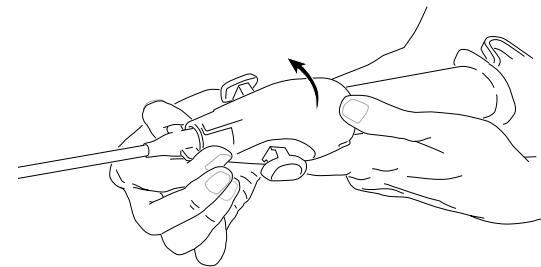
Opening the valve body

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



Removal and insertion of Ipas EasyGrip® cannula

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

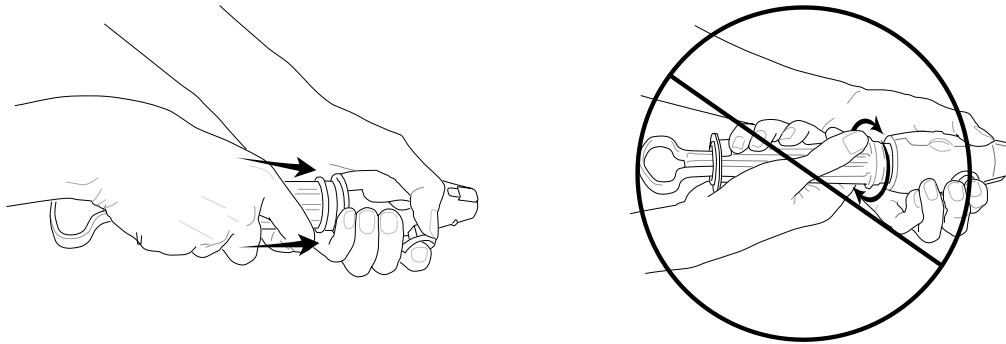


4. Ipas. "Tips for Using the Ipas MVA Plus," n.d. www.ipas.org.

TIPS FOR USING THE IPAS MVA PLUS (Cont.)

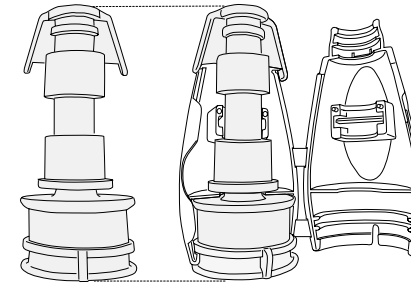
Aspirator assembly

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



Reassembly of Ipas aspirators

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



Processing tips

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

INSTRUMENT PROCESSING SKILLS CHECKLIST: IPAS MVA PLUS® AND IPAS EASYGRIP® CANNULAE⁵

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

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

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

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

FOUR STEPS FOR PROCESSING INSTRUMENTS:

1. Point-of-use preparation:

2. Cleaning:

3. Sterilization or high-level disinfection:

4. Storage:

UTERINE EVACUATION PROCEDURE WITH IPAS MVA PLUS® SKILLS CHECKLIST⁶

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

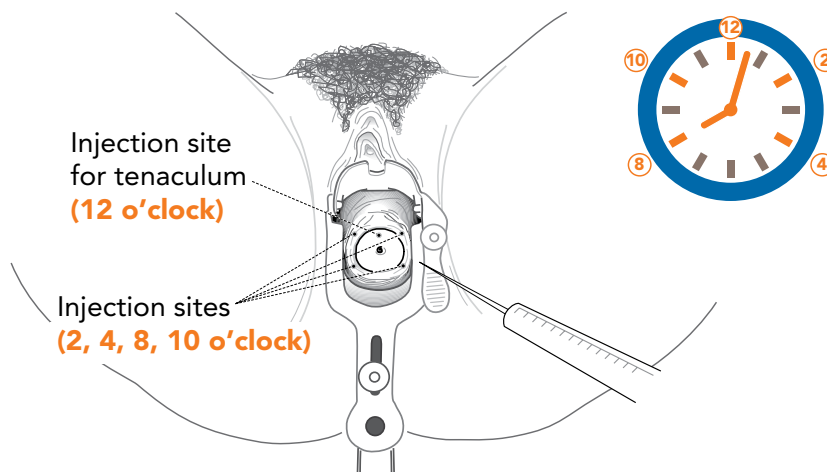
6. Ipas. "Instrument Processing Skills Checklist." In *Woman-Centered, Comprehensive Abortion Care Trainer's Manual*, Second Edition, 222–23. Chapel Hill, NC, 2014. www.ipas.org/resource/woman-centered-comprehensive-abortion-care-trainers-manual-second-edition.

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

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

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

PARACERVICAL BLOCK TECHNIQUE



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

PRACTICE TIPS

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

PAIN MANAGEMENT AND CONTINUED SIMULATED PRACTICE

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

- 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

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

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

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

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

PHARMACOLOGIC APPROACHES TO PAIN MANAGEMENT DURING MVA

Drug Type	Generic Drug Name	Dose and Timing	Half-life	Side Effects	Comments
Local anesthetic	Xylocaine	15-20ml of 0.5%-1% solution in a paracervical block not to exceed 4.5mg/kg	60-90 minutes	Buzzing in ears, dizziness, numbness in lips, mouth and tongue, metallic taste, seizures (rare)	<ul style="list-style-type: none"> • Pull back plunger before injecting to avoid intravascular injection. Wait three minutes for medication to take effect. • Mild reaction (itching, rash, hives) can be treated with 25-50mg diphenhydramine IM or IV. • For intense reaction or respiratory distress obtain IV access immediately. Give epinephrine 0.4mg subcutaneously and diazepam 5mg slow IV push. Support respiration. If wheezing is present, inhaler may be helpful. • Allergic reaction is very rare. Reactions that do occur may be due to preservatives in multi-dose vials. Preservative-free lidocaine allergy is extremely rare.
	Ibuprofen	Oral: 400 to 800mg one hour before the procedure	4-6 hours	Possible gastrointestinal upset	<ul style="list-style-type: none"> • Do not use in women with active peptic ulcer disease or renal failure
	Naproxen	Oral: 550mg one hour before the procedure	4-6 hours	Possible gastrointestinal upset	<ul style="list-style-type: none"> • Do not use in women with active peptic ulcer disease or renal failure
NSAID	Ketorolac	Oral: 20mg one hour before procedure IV: 30 mg over at least 15 seconds 30 to 60 minutes before procedure IM: 60 mg 30 to 60 minutes before procedure <i>* For women less than 50kg, all doses should be halved</i>	4-6 hours		<ul style="list-style-type: none"> • Single dose IM ketorolac prior to surgery may reduce opioid use and post-operative pain (de Oliveira 2012, Roche 2012) • Do not use in women with active peptic ulcer disease, renal failure, breastfeeding or sensitivity to other NSAIDs. • Breakthrough pain should be managed with narcotics rather than increasing ketorolac beyond the recommended doses.
	Acetaminophen	Oral: 500 to 1000mg 30 to 60 minutes before procedure	3-6 hours		<ul style="list-style-type: none"> • Not a first-line pain medication for vacuum aspiration or medical abortion. May be used as an antipyretic. • Liver toxicity from overdose (maximum dose = 4000mg/day) is a risk.

Drug Type	Generic Drug Name	Dose and Timing	Half-life	Side Effects	Comments
Narcotic/ analgesic combination	Acetaminophen 300mg + codeine 30mg	Oral: 1-2 tablets one hour before procedure	3-6 hours	Drowsiness, light- headedness, nausea and vomiting, CNS and respiratory depression	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). Be aware of combining with other acetaminophen containing products. Liver toxicity from overdose of acetaminophen (maximum dose = 4000mg/day)
	Acetaminophen 500mg + hydrocodone 5mg	Oral: 1-2 tablets one hour before procedure	4-6 hours	Drowsiness, light- headedness, nausea and vomiting, CNS and respiratory depression	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). Be aware of combining with other acetaminophen containing products. Liver toxicity from overdose of acetaminophen (maximum dose = 4000mg/day)
Narcotic	Meperidine	Oral: 100-150mg 30 to 60 minutes before procedure IV: 25-50mg 5-15 minutes prior to procedure IM/SC: 50-100mg 30 to 90 minutes prior to procedure	4-6 hours	Drowsiness, light- headedness, nausea and vomiting, CNS and respiratory depression, hypotension, seizures	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). More rapid onset and shorter duration of action than morphine. Meperidine 60-80mg = morphine 10mg
	Fentanyl	IV: 50-100mcg immediately before procedure (may repeat every 10-15 minutes, not to exceed 250mcg) IM: 50-100mcg 30 to 60 minutes before procedure	30-60 minutes	Drowsiness, light- headedness, weakness, bradycardia, CNS and respiratory depression, hypotension, seizures	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). More rapid onset and shorter duration of action than meperidine Fentanyl 100mcg = meperidine 75mg = morphine 10mg Onset of action is 2-7 minutes when given IV
	Tramadol	IV/IM: 50-100mg 15-30 minutes prior to procedure. Oral/suppository: 50-100mg 60-90 minutes prior to procedure.	4-6 hours	Drowsiness, light- headedness, weakness, sweating, fatigue, seizures	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with naloxone (see below). Less respiratory depression than morphine or meperidine Tramadol 100mg = morphine 10mg

Drug Type	Generic Drug Name	Dose and Timing	Half-life	Side Effects	Comments
Anxiolytic (Benzodiazepine)	Diazepam	Oral: 10mg one hour before procedure IV: 2-5mg IV 20 minutes before procedure	21-37 hours	Blurred vision, dizziness, disorientation, pain and redness on injection, CNS and respiratory depression	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with flumazenil (see below). Has a mild amnestic effect. Onset of action is 2-10 minutes when given IV.
	Midazolam	IV: 1-2mg immediately before the procedure then 0.5-1mg IV every five minutes as needed, not to exceed 5 mg IM: 0.07-0.08mg/kg or about 5mg up to one hour before procedure	1-4 hours	Blurred vision, dizziness, disorientation, CNS and respiratory depression	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with flumazenil (see below). Midazolam 2.5mg = diazepam 10mg Stronger amnestic effect than diazepam. Onset of action is 1-5 minutes when given IV and 15-30 minutes when given IM.
	Lorazepam	Oral: 1-2mg 30-60 minutes before procedure IV: 2mg given over one minute before the procedure IM: 0.05mg/kg up to a maximum of 4mg within 2 hours before the procedure	14 hours	Blurred vision, dizziness, disorientation, CNS and respiratory depression	<ul style="list-style-type: none"> If respiration is compromised, assist with breathing (airway management, oxygen and ambu bag) and reverse with flumazenil (see below). Amnestic effect. Occasionally may increase patient anxiety.
Reversal agent for narcotic	Naloxone	IV: 0.4mg vial mixed in 10mL saline. Give 1mL (40mcg/mL) every two minutes until reversal is seen			<ul style="list-style-type: none"> Naloxone's duration of action is one hour and may wear off before the narcotic. Therefore, patients treated with naloxone must be monitored closely for several hours. Maintain airway and respirations while giving naloxone.
Reversal agent for benzodiazepine	Flumazenil	IV: 0.2mg every minute until respirations return. Do not exceed 1mg			<ul style="list-style-type: none"> Flumazenil's duration of action is one hour and may wear off before the benzodiazepine. Therefore, patients treated with flumazenil must be monitored closely for several hours. In the event of overdose with narcotic and benzodiazepine, reverse the narcotic first with naloxone and use flumazenil subsequently if needed. Maintain airway and respirations while giving Flumazenil.

References:

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

AFTER UTERINE EVACUATION

[illegible]This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Skill	Yes	No	Comments
Monitors the woman's physical status			
Ensures the woman is resting comfortably			
Takes vital signs immediately			
Reviews chart for condition and history			
Monitors physiological status, including vital signs			

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

Skill	Yes	No	Comments
Evaluates bleeding and cramping at least twice			
Continues therapy for any existing problems			
Assesses and manages complications			
Manages pain			
Evaluates pain levels			
Administers and monitors desired options for pain relief			
Addresses other physical-health issues			
Addresses other physical-health needs and provides referrals if needed for: anemia, RTIs/ HIV, cervical cancer, violence, infertility			
Administers Rh-immunoglobulin, if protocol			
Provides emotional monitoring and support			
Responds sensitively to emotions			
Monitors emotional status			
Provides counseling and referrals for emotional-health needs			
Provides contraceptive counseling (if not done before the procedure)			
Determines desire for future pregnancy and reproductive needs			
Provides contraceptive counseling, methods and resupply information			
Makes sure that the woman knows how to use the method of contraception she has chosen and answer any of her questions			
Arranges for follow-up care as desired or needed			
Schedules follow-up appointment according to her condition and/or request			
Secures her consent before releasing records to other providers			
Discharges the woman			
Ensures recovery before discharging according to protocols			
Provides instructions on: self-monitoring normal recovery; pain relief/medications; behaviors that increase problems; when and how to seek treatment for complications; follow-up care			

DISCHARGE INFORMATION SHEET¹⁰

How to Take Care of Yourself

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

Other medications:

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

What to Avoid

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

What is Normal

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

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

What is Abnormal

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

POSTABORTION CONTRACEPTION MEDICAL ELIGIBILITY¹¹

WORLD HEALTH ORGANIZATION MEDICAL ELIGIBILITY CRITERIA FOR POSTABORTION CONTRACEPTION

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

*See clarifications below.

World Health Organization categories for contraceptive eligibility:

- (1) A condition for which there is no restriction for the use of the method;
- (2) A condition where the advantages of using the method generally outweigh the theoretical or proven risks;
- (3) A condition where the theoretical or proven risks usually outweigh the advantages of using the method;
- (4) A condition which represents an unacceptable health risk if method is used.

ADDITIONAL INFORMATION RELATED TO SPECIFIC CONTRACEPTIVE METHODS

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

Intrauterine Device (IUD): When compared to short-acting methods, long-acting reversible methods of contraception (LARC), such as IUDs and implants, have higher continuation rates and lower pregnancy and abortion rates. IUD insertion immediately following an uncomplicated vacuum aspiration is safe and practical. There is no increase in the rate of serious adverse events, such as infection or uterine perforation, when IUDs are inserted immediately after vacuum aspiration. There is a very small increased risk that an IUD inserted immediately following a vacuum aspiration procedure will expel. When women desiring an IUD are unable to have it

placed immediately after vacuum aspiration, and instead must return to the health facility at another time for their IUD, or they are sent to a different health facility for IUD insertion, they are much less likely to receive the IUD. Following uterine evacuation with medical methods, women may have an IUD placed as soon as it is reasonably certain the woman is no longer pregnant. Women using medical methods who expel the pregnancy in a health facility may have the IUD inserted after expulsion. Women who expel the pregnancy at home or in another location may have the IUD inserted at a follow up visit.

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

Implants: Women may have their implant placed at the time of vacuum aspiration or, for those using medications for uterine evacuation, at the time medications are prescribed, dispensed, or

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

administered. When placement of an implant is delayed until a subsequent visit or when women are referred to a different health facility for placement, they are less likely to receive the implant.

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

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

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

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

NOTES: WHY OFFER EMERGENCY CONTRACEPTION (EC)?

[illegible]

POSTABORTION MEDICAL ELIGIBILITY QUESTIONS AND ANSWERS

Question:

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

Answer:

Question:

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

Answer:

Question:

When can an IUD be placed after an abortion?

Answer:

CONTRACEPTIVE COUNSELING SKILLS CHECKLIST¹²

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

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

12. Ipas. “Contraceptive Counseling Skills Checklist.” In *Woman-Centered, Comprehensive Abortion Care Trainer’s Manual*, Second Edition, 143–45. Chapel Hill, NC, 2014.

SPECIAL CONTRACEPTIVE COUNSELING CONSIDERATIONS¹³

YOUNG WOMEN (AGES 10–24)

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

Contraceptive counseling should also include information on fertility awareness, by asking what the client knows about her menstrual cycle and fertility and building on that to educate her about the fertile and infertile points in her cycle. Fertility awareness-based methods are not recommended for young women with erratic or irregular menstrual cycles. As with abortion, young women may have concerns about the safety or efficacy of contraceptive methods, which may be based on misinformation. They may not know how pregnancy occurs or is prevented. For example, they may have heard that pregnancy will not occur if they have intercourse in certain positions, in water, or during menstruation, or believe that contraception will cause future permanent infertility. Because of misinformation like this, it is important that providers explain how a contraceptive works, including efficacy, potential side effects such as weight gain or breast tenderness and their incidence, and the long-term clinical implications of any such side effects. Providers can ask indirect questions, such as "What are some things your friends say about how you can and cannot get pregnant?" and "What are some things you heard about this method?" to find out whether a young woman is misinformed.

Contraceptive counseling should be reality-based. That is, it should begin by uncovering and addressing what clients believe, whether or not it is accurate, in order to avoid the method's discontinuation. Providers should also learn from the young woman what barriers she may face in using different contraceptive methods and help the young woman identify the most appropriate option for her. A young woman's privacy needs can also influence her selection of a contraceptive method. For example, injectables, implants, or an intrauterine device may suit a young woman with high privacy needs, even if her preferred method might otherwise be something else.

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

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

Medical eligibility for young women

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

Sterilization

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

Long-acting contraceptive methods

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

Intrauterine devices (IUDs)

Young women are medically eligible to use IUDs. There are no clinical contraindications based on age alone. IUDs are less likely to be selected by young women than by older women in some countries. It is unclear whether this is in part due to providers' reluctance to offer IUDs to young women, or young women's reluctance after being given accurate, unbiased information on the method. In studies that have examined IUD use among young women, where young women were

13. Used with permission from Ipas.

provided non-directive counseling and IUDs at no cost, rates of IUD acceptance and continuation were comparable to those of older women. Use of IUDs by young women decreases the rates of pregnancy, birth, and induced abortion in this group.

Injectables

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

WOMEN WITH MULTIPLE ABORTIONS

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

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

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

WOMEN WHO HAVE EXPERIENCED VIOLENCE

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

WOMEN LIVING WITH HIV

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

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

WOMEN WHO ENGAGE IN SEX WORK

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

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

WOMEN WITH COGNITIVE AND DEVELOPMENTAL DISABILITIES AND/OR MENTAL ILLNESS

The provider should begin by assessing what knowledge and experience the woman already has regarding contraception. The provider can then assist her in determining which method is most suitable for her by asking who she has sex with and under what circumstances.

The following information should be considered when discussing contraception with women who have cognitive disabilities and/or mental illness:

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

WOMEN WHO HAVE EXPERIENCED GENITAL CUTTING

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

WOMEN WHO PARTNER WITH WOMEN

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

CASE STUDIES

Case Study 1:

Violence: A 22-year-old married mother of one discloses that she is frequently beaten by her husband. The last beating occurred when she was pregnant. She has come to the facility with a lot of vaginal bleeding and cramping. She is afraid to discuss contraception with her husband.

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.

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.

RAPID INITIAL ASSESSMENT AND MANAGEMENT OF SHOCK

NOTES:

ABC SIGNS

A _____

B _____

C _____

C _____

C _____

SIGNS OF SHOCK

[illegible]

HOW TO STABILIZE FOR SHOCK

[illegible]

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on the right side, suggesting it's part of a bound notebook. There is no handwriting or other markings on the page.

MANAGEMENT OF COMPLICATIONS (CAC) SKILLS CHECKLIST¹⁴

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

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

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

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

MANAGEMENT OF COMPLICATIONS (PAC) SKILLS CHECKLIST¹⁵

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

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

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

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

UNIT 7

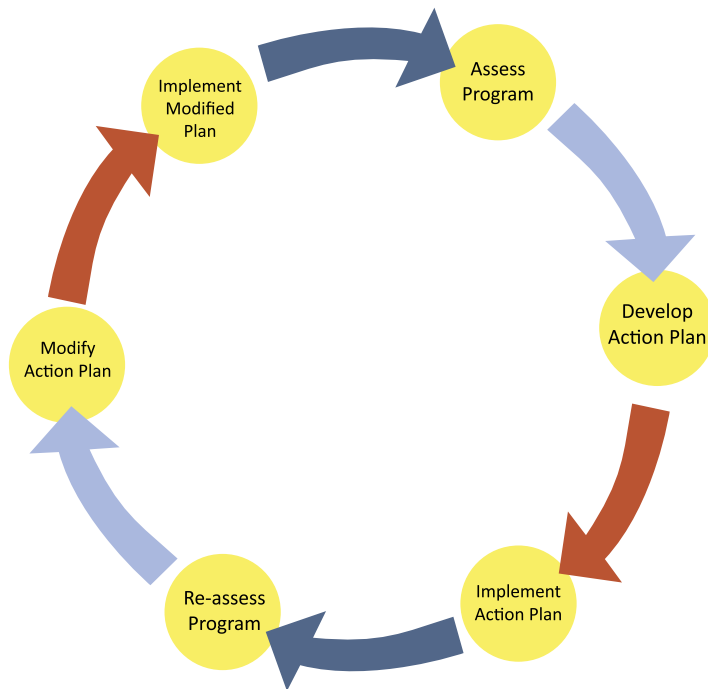
SERVICE DELIVERY

UNIT 7

SERVICE DELIVERY

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

MONITORING IS A CONTINUOUS PROCESS



INDICATORS FOR MONITORING QUALITY OF UTERINE EVACUATION SERVICES:

[illegible]

EXAMPLES OF ABORTION SERVICES MONITORING¹⁶

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

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

WORKSHEET: PRELIMINARY PREPAREDNESS FOR AND IMPLEMENTATION OF SAFE ABORTION CARE (SAC)¹⁷

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

17. Ipas. Chapel Hill, NC. 2018.

SUPPLY AND EQUIPMENT CHECKLIST FOR FIRST TRIMESTER (<13 WEEKS) COMPREHENSIVE ABORTION CARE¹⁸

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

FACILITY

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

EQUIPMENT/SUPPLIES/DRUGS

- ☐ Available contraceptive methods, including IUD/IUS, implants and associated equipment
- ☐ Blood pressure cuff
- ☐ Thermometer
- ☐ Stethoscope
- ☐ Personal protective barriers (for instrument processing: heavy duty gloves, boots/shoe covers, face protection, gown/apron; for procedure/exam: clean and sterile gloves, gown/apron, boots/shoe covers, eye protection) *

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

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

MVA INITIAL SUPPLY AND RE-RESUPPLY CHART¹⁹

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

*Two processings per shift or day

NOTES:

[illegible]

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

UNIT 8 EVALUATION AND CLOSING

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

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

1.

2.

3.

NOTES:

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Suggested citation:

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and Ipas. Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration. New York: 2021.

© 2023 - This resource was updated in 2023. Inter-Agency Working Group (IAWG) on Reproductive Health in Crises

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

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

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



Inter-Agency Working Group on
Reproductive Health in Crises

Ipas