Postabortion Care Curriculum

Participant Guide

2024
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* Deceased, October 27, 2010
Preface

Postabortion care (PAC) is a package of lifesaving interventions that combines maternal healthcare (emergency treatment for complications of induced or spontaneous abortion) and family planning (voluntary counseling and service delivery) before a PAC client is discharged from the facility.¹

Not only is PAC lifesaving, it is also commonly and widely needed. Globally, 6 out of 10 unintended pregnancies and 5 out of 10 of all pregnancies end in induced abortion. The World Health Organization estimates that 45% of all abortions are “unsafe,” meaning that they are carried out by a person lacking the necessary skills or in an environment that does not conform to minimum medical standards of care, or both.² Each year, 4.7 to 13.2% of maternal deaths can be attributed to unsafe abortions.³

When PAC is accessible, affordable, of high-quality, and performed by capable healthcare providers, it can prevent maternal deaths and disabilities and improve access to contraception. Since 1994, the United States Agency for International Development (USAID) has supported PAC programs in more than 40 countries. USAID’s holistic PAC program model includes emergency treatment, contraceptive counseling and method provision, and community mobilization. Because PAC clients can become pregnant almost immediately after abortion, offering voluntary contraceptive counseling and services is important to helping individuals prevent unintended pregnancies and achieve healthy timing and spacing of pregnancies.

This revised curriculum for service providers builds on an earlier version published in 2010. It incorporates key updates from the following resources: Abortion Care Guideline,⁴ Medical Eligibility Criteria for Contraceptive Use,⁵ Family Planning: A Global Handbook for Providers,⁶ as well as evidence from decades of PAC programming and implementation research around the world.⁷ This revision also reflects learnings from the COVID-19 pandemic, including the need for increased attention to infection prevention and control for healthcare workers and those seeking care, as well as the importance of providing integrated services to clients who do reach health facilities for care.⁸ Stronger, more integrated primary healthcare systems are imperative for delivering services that are responsive, people-centered, well-financed, affordable, accessible, and reliable.⁹

The revised curriculum and other evidence-based PAC implementation resources and program research reports are available at www.postabortioncare.org. Such resources include tools to strengthen national guidelines and policies, provider performance support materials, and lessons from PAC programs in many countries. These resources are available in multiple languages and can be downloaded for free for immediate use.

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Overview

Before Starting this Training Course

The technical content of this curriculum incorporates the most recent evidence-based information possible. Local protocols will ideally support the evidence and principles presented in the curriculum. Where local protocols conflict with evidence-based content—often due to a lapse in updating protocols—trainers should obtain agreement in advance of the training from the Ministry of Health or other relevant authority for provisional approval pending an update of protocols in order to support providers in carrying out new practices.

This curriculum uses a training approach based on principles of adult learning and with competency-based learning techniques. These principles assume that people participate in training courses because they:

- Are interested in the topic
- Wish to improve their knowledge, skills, and/or job performance
- Seek to be actively involved in course activities

The training approach stresses the importance of cost-effective use of resources and application of relevant educational technologies, including use of humanistic training techniques. This involves the use of anatomic models, such as the ZOE® pelvic model, to minimize client risk and facilitate learning.

Reorganization of Services: A Note for Program Managers

Before healthcare providers can offer postabortion care (PAC), services must be redesigned or expanded to accommodate all components of PAC. A supportive policy environment is of the utmost importance. PAC policies must reflect evidence-based standards and service delivery guidelines must be consistent with these policies—this may require review and revision. Operational policies may also require review and revision.

PAC delivery models must provide a range of care needed by clients experiencing the effects of incomplete abortions and other abortion-related complications, and by their families and communities, to ensure that clients receive the care and support they need. For example, a PAC delivery model may require restructuring the environment; training providers in infection prevention, counseling, and contraceptive technology; providing accurate information to clients regarding emergency treatment, complications, self-care, contraceptive methods, and return to fertility; and improving contraceptive method availability at the site of emergency treatment. This can improve provider attitudes and counseling skills, increase the number of clients discharged with a voluntary family planning (FP) method, increase referrals for methods not available on-site, and increase quality of care and client satisfaction. Lastly, employing an enhanced PAC model that incorporates community empowerment through mobilization and awareness raising, in conjunction with PAC staff, will help reduce stigma and minimize client delays in seeking care.

For additional information on policies and systems for PAC, consult the Postabortion Care Curriculum: Reference Manual available at: [https://www.postabortioncare.org](https://www.postabortioncare.org).

Selection of Participants

This course is designed for skilled healthcare personnel, such as midwives, nurses, clinical officers or health officers, and medical assistants and physicians. Community health workers and individual clients are playing an increasing role in PAC, including self-care (e.g., emergency treatment of an incomplete abortion using misoprostol) and high-impact practices, such as task-sharing. However, it is essential that participants selected for this course be currently working in a relevant clinical setting and competent in the following skills:

- FP counseling and service provision
- Pelvic assessment, including:
  - Sizing of nonpregnant and early pregnant uteri
  - Use of a speculum
As a participant, you should have received an invitation letter with clear instructions detailing what will you need to bring to the training to be prepared for the clinical experience.

Please note that due to the limited duration of the course, additional clinical time may be needed after this initial training. Participants may need to be available for on-the-job training, clinical mentorship, or other practice opportunities before being assessed and declared competent.

**Rationale for Postabortion Care Clinical Skills Training**

Training reproductive health providers will help to:

- Introduce PAC as a tool for ending preventable maternal and child deaths.
- Ensure the accessibility, acceptability, and delivery of high-quality PAC for all clients in need.
- Ensure PAC is available 24 hours a day, seven days a week.
- Update those who are currently providing PAC.
- Sensitize providers to the magnitude of the problem of incomplete abortion and to PAC clients’ needs for high-quality medical, emotional, and supportive care.
- Encourage provider partnerships and linkages with the community, including private voluntary organizations and nongovernmental organizations.
- Introduce PAC into larger reproductive health training programs and possibly to preservice faculty programs.
- Equip reproductive health workers to provide FP, sexually transmitted infection (STI), and HIV services as integral parts of PAC.
- Equip providers to offer appropriate counseling throughout PAC and to include clients’ partners and/or family members when appropriate, with clients’ consent.
- Equip providers to be sensitive to vulnerable populations.
- Equip providers with skills to capacitate communities through mobilization and awareness raising for timely referrals, providing support for postabortion contraception, and mitigating stigma associated with abortion and related complications. **Note:** This is not a clinical skill but an essential component of PAC that aims to effect behavior change among community members to ensure timely referrals, reduction of stigma, uptake of contraceptive methods, and continuous resupply.

**Mastery Learning**

The mastery learning approach to clinical training assumes that all participants can master, or learn, the required knowledge, attitudes, and skills—provided that sufficient time is allowed and appropriate training methods are used. The goal of mastery learning is that 100% of those trained will “master” the knowledge and skills on which the training focuses.

While some participants may acquire new knowledge or skills immediately, others may require additional time or alternative learning methods before being able to demonstrate mastery. Not only do people vary in their ability to absorb new material, but individuals learn best in different ways—through written, verbal, or visual means. The mastery learning approach recognizes these differences and thus uses a variety of teaching and training methods.

The mastery learning approach also enables participants to have self-directed learning experiences. This is achieved by having a trainer serve as a facilitator and by changing the concept of testing and how test results are used. In courses that use traditional testing methods, a trainer administers pre- and posttests to document increases in participants’ knowledge, often without regard for how this change affects job performance. By contrast, the philosophy underlying the mastery learning approach is one of continual assessment of participant learning. With this approach, it is essential that the trainer regularly informs participants of their progress in learning new information and skills, rather than allow this information to remain the trainer’s secret.

With the mastery learning approach, assessment of learning is:

- Competency-based, which means assessment is keyed to course objectives and emphasizes acquiring the essential knowledge, attitudinal concepts, and skills needed to perform a job, rather than simply acquiring new information.
• Dynamic, because it enables trainers to provide participants with continual feedback on how successful they are in meeting the course objectives and, when appropriate, to adapt the course to meet learning needs
• Less stressful, because, from the outset, participants, individually and as a group, know what they are expected to learn, where to find the information, and have ample opportunities for discussion with the trainer

**Key Features of Effective Clinical Training**

Effective clinical training is designed and conducted according to adult learning principles—learning is participatory, relevant, and practical. In addition, it:

• Uses behavior modeling
• Is competency-based
• Incorporates humanistic training techniques

Additional information about adult learning principles is available from the Training Resource Package for Family Planning at: [https://www.fptraining.org/training-guides#](https://www.fptraining.org/training-guides#).

**Behavior Modeling**

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform, or model, a skill or activity. For modeling to be successful, the trainer must clearly demonstrate the skill or activity so that participants fully understand the performance expected of them.

Learning to perform a skill takes place in multiple stages. In the first stage, skill acquisition, the participant sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the participant attempts to perform the procedure on a model, with supervision, until they become proficient.

**Skill Acquisition**

The participant knows the steps and the correct sequence (if necessary) to perform the required skill or activity but needs assistance to perform the skill or activity independently.

**Skill Competency**

The participant knows the steps and correct sequence and can perform the required skill or activity. Only when skill competency has been demonstrated with models, however, should a participant have contact with clients.

**Skill Proficiency**

The participant knows the steps and correct sequence and efficiently performs the required skill or activity. This final stage only occurs with repeated practice over time.

**Competency-Based Training**

Competency-based training is distinct from traditional educational processes in that it involves learning by doing. It focuses on the specific knowledge, attitudes, and skills needed to carry out a procedure or activity. How the participant performs (i.e., combines knowledge, attitudes, and, most importantly, skills) takes priority over what information the participant has acquired. Moreover, competency-based training requires that the trainer facilitate and encourage learning rather than serve in a more traditional role of instructor or lecturer. Competency in the new skill or activity is assessed objectively by evaluating overall performance.

In competency-based training, the clinical skill or activity is first divided into its essential steps. Each step can then be analyzed to determine the most efficient and safe way to learn and perform it. This process is called standardization. Once a procedure, such as an IUD insertion, is standardized, competency-based skill development and assessment instruments, such as learning guides and checklists (respectively), can be designed. These instruments make learning the necessary steps or tasks easier and evaluating the participant’s performance more objectively.
An essential component of competency-based training is coaching, which uses positive feedback, active listening, questioning, and problem-solving skills to encourage a positive learning climate. To use coaching, the trainer should first explain the skill or activity, and then demonstrate it using an anatomic model or other training aid, such as a video. Once participants have seen the skill demonstrated and discussed the skill, the trainer then observes and interacts with the participants to provide guidance in learning the skill through return demonstrations, monitors progress, and helps the participants to overcome any problems.

The coaching process ensures that the participant receives feedback regarding performance:

- **Before practice:** The trainer and participant meet briefly before each practice session to review the skill or activity, including the steps and tasks outlined in the learning guide that will be emphasized during the session.
- **During practice:** The trainer observes, coaches, and provides feedback as the participant performs the steps and tasks.
- **After practice:** Immediately after practice, using the learning guide, the trainer discusses the strengths of the participant’s performance and offers specific suggestions for improvement, as needed.

**Humanistic Training Techniques**

The use of more humane or humanistic techniques also contributes to more effective clinical training. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids, such as videos. The effective use of models facilitates learning, reduces training time required, and minimizes risks to clients. By starting with anatomic models, participants more easily reach the performance levels of skill competency and initial skill proficiency before they begin working with clients.

Before participants attempt a clinical procedure with clients, three learning activities should occur:

1. The trainer demonstrates the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (such as videos).
2. While the trainer supervises, participants practice the required skills and client interactions using models and actual instruments in a simulated setting that is as similar as possible to the real situation.
3. Once participants feel comfortable and confident with the level of competency they have acquired, the trainer assesses their performance using the model.

Only when skill competency and a degree of skill proficiency is demonstrated with models should participants have contact with clients.

Integrating mastery learning, which is based on adult learning principles and behavior modeling, with competency-based training, results in a powerful and extremely effective method for providing clinical training. When humanistic training techniques are incorporated, such as using anatomic models and other learning aids, training time and costs can be reduced significantly.

**Clients’ Rights during Clinical Training**

*Note:* The content contained within this section is adapted from Programming for Training: A Resource Package for Trainers, Program Managers, and Supervisors.10

Clients’ rights to privacy and confidentiality must always be considered during any clinical training course. When a client undergoes a physical examination, the examination should be carried out in an environment in which their right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of everyone inside the room, including the service provider, training participants, supervisors, instructors, and researchers.

Clients must be allowed to consent to having a clinician-in-training (i.e., training participant) observe, assist with, or perform any services. The client should understand that they have the right to refuse care from a clinician-in-training and their care should not be rescheduled or denied if they do not permit a clinician-in-training to be present or provide services. In such cases, the trainer or another trained staff member should perform the procedure. Finally, the trainer should be present for any client contact during a training situation.

Trainers should be discreet in coaching and providing feedback during training activities completed with clients. Corrective feedback in these situations should be limited to errors that could cause harm or discomfort to the client. Excessive negative feedback can create anxieties for both the client and clinician-in-training.

It can be difficult to maintain strict confidentiality in a training situation when specific cases are used in learning activities, such as case studies and clinical conferences. Such discussions should always take place in private spaces where other staff or clients cannot hear and should be conducted without referring to the client by name.

Other core components of client rights that must be observed to adhere to guidance from the World Health Organization\(^\text{11}\) include:

- **Availability of care**
- **Accessibility of care, across four dimensions:**
  - Economic access
  - Information access
  - Nondiscriminatory access
  - Physical access
- **Acceptability of care**
- **Quality of care, with the following dimensions:**
  - Effective
  - Efficient
  - Equitable
  - Integrated
  - Client-centered (responding to people’s needs, preferences, and values)
  - Safe
  - Timely

### Components of the Postabortion Care Training Curriculum

This curriculum is built upon and incorporates the following:

- **Need-to-know information from:**
  - Postabortion Care Curriculum: Reference Manual\(^\text{12}\)
  - Family Planning: A Global Handbook for Providers\(^\text{13}\)
  - Medical Eligibility Criteria for Contraceptive Use, Fifth Edition\(^\text{14}\)
- This Participant Guide containing a questionnaire and practice checklists, which divide skills and activities (such as vacuum aspiration procedures, use of misoprostol for PAC, and FP counseling provision) into essential steps
- A Trainer Guide, which includes questionnaires and answer keys as well as detailed information for conducting the course, including session plans that outline objectives, time allocations, materials required for each activity, advanced preparations guidance, and suggested training methodologies
- Well-designed teaching aids and audiovisual materials, such as presentations, videos, and anatomic models
- Competency-based performance evaluation


The Postabortion Care Curriculum: Reference Manual, which is organized into four modules and 13 sessions that correspond with the modules and sessions in the Trainer Guide and Participant Guide, contains essential information on the following topics: components of PAC, initial assessment, pain management, treatment of incomplete abortion, management of complications, postabortion FP counseling and services, STI and HIV screening and management, community empowerment, and recommended infection prevention practices.

Because one major objective of PAC is to reduce maternal mortalities by reducing the unmet need for FP that can result in additional unintended pregnancies, FP counseling and service provision are included in this training. Therefore, providers who are currently delivering FP services and have completed updated training on currently available methods are strongly recommended to participate in this training. For other healthcare provider participants, trainers are advised to conduct a one- or two-day FP update prior to the workshop or incorporate the content into the PAC training schedule. The primary recommended text for such an update is the aforementioned Family Planning: A Global Handbook for Providers. However, other appropriate content may also be used, such as the material from the Training Resource Package for Family Planning (https://www.fptraining.org/). Any such FP update should be tailored to the learning needs of participants.
Introduction

Postabortion Care Training

Delivery of postabortion care (PAC) is a team effort, requiring the knowledge and skills of trained clinicians, family planning (FP) counselors, and support staff. Although this curriculum is primarily designed for conducting group training sessions in all aspects of PAC, it can be easily adapted for individual mentorship or structured on-the-job training. In such settings, the pace of the training should be tailored to the time available and needs of the learner. One example of a PAC curriculum specifically designed for on-the-job-training was developed in Nepal15 and includes resources for trainers, participants, and supervisors.

The person who provides PAC may vary by country, depending on national and programmatic policies. Thus, while one individual (or team member) may need more opportunities for learning and practicing vacuum aspiration (VA) and/or FP counseling, other team members can spend more time on counseling techniques, infection prevention, and follow-up care. Even if a participant will not carry out a specific task, they should be familiar with it to support high-quality service delivery. Therefore, all course participants should have opportunities to observe and perform on models all the skills and activities associated with the safe delivery of PAC included in this curriculum.

Training Design

This training curriculum is designed for service providers, including physicians, clinical officers, health officers, assistant medical officers, medical assistants, nurses, and midwives. It builds on participants’ past knowledge and takes advantage of their motivation to accomplish the learning tasks in a minimum amount of time. This training emphasizes practical experience, in addition to basic knowledge acquisition, and uses a competency-based evaluation of performance. This training differs from traditional courses in several ways.

- During the morning of the first day, the trainer introduces participants to the key features of mastery learning before they complete a brief test (Pre-Course Questionnaire) to determine participants’ individual and group knowledge of PAC.
- Classroom and clinic sessions focus on key aspects of service delivery.
- The trainer measures participants’ progress in knowledge-based learning during the course using a standardized written assessment (Mid-Course Questionnaire).
- Clinical skills training builds on the participants’ previous experience. Participants first practice on anatomic models using learning guides that list the key steps; thus, they learn the skills needed quickly and in a standardized way.
- Participants track progress in learning new skills using the counseling and clinical skills learning guides.
- The trainer evaluates participants’ individual performance using competency-based skills checklists.

Successful completion of the course is based on mastery of the knowledge and skills components, as well as satisfactory overall performance in providing PAC to clients.

Evaluation

This training is designed to produce qualified PAC providers. Qualified providers are those whom the training institution or program has determined to have met the requirements of the course in knowledge, skills, and practice. To determine if a participant is qualified, the trainer will observe and rate their performance for each step of the skill or activity. The participant must be rated “satisfactory” in each skill or activity to be evaluated as qualified. Qualification does not imply certification; only an authorized organization or agency can certify healthcare personnel. Qualification is based on the participant’s achievement in three areas:

- **Knowledge:** A score of at least 85% on the mid- or end-of-course questionnaire
- **Skills:** Satisfactory performance of PAC clinical skills and FP counseling
- **Practice:** Demonstrated ability to provide PAC services in the clinical setting

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Responsibility for participants becoming qualified is shared by the participants and the trainer.

The evaluation methods used in this course include the following:

- Completion of a pre-course assessment.
- Completion of a mid-course questionnaire. Trainers should administer this questionnaire after presenting all subject area content. A score of 85% or more indicates knowledge-based mastery of the material presented in the Reference Manual. For participants scoring less than 85% on their first attempt, the trainer should review the results with the participant individually and guide them on using the Reference Manual to learn the required information. Participants scoring less than 85% can complete this questionnaire again at any time during the remainder of the course.
- Use of case studies as well as question and answer sessions during the training.
- Practice providing services. During the course, it is the trainer’s responsibility to observe each participant’s overall performance in providing PAC; this provides opportunities to observe the impact of each participant’s attitude on clients—a critical component of high-quality service delivery. Only by doing this can the trainer assess how the participant uses what they have learned.
- Use of FP counseling and clinical skills checklists (such as those available through fptraining.org). Trainers should use these checklists to observe and evaluate participants as they perform skills on models and clients and as they communicate with and counsel volunteers during role play exercises and with clients. Ideally, the trainer should evaluate participants’ clinical skills in the final two days of the course, depending on the class size and client caseload.
- Completion of a course evaluation form. At the end of the training, participants have an opportunity to complete a written course evaluation and provide feedback on the organization of the training, what they liked most, what they felt was least useful, any logistical issues and related preparations for the training, and any suggested changes for improving the experience and training outcomes in the future. Participants and trainers should also have opportunities to evaluate and provide feedback for each session.

**Training Syllabus**

This training is designed to prepare participants to provide PAC. Trainers and participants should make arrangements to allow for additional skills practice after the completion of the course. Such practice may occur through mentorship, on-the-job experience, and follow-up support by trainers.

**Overall Training Goal**

The overall goal of this training is to prepare reproductive health service providers to offer client-oriented PAC in partnership with the communities they serve.

**Training Objectives**

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

- Demonstrate supportive and caring attitudes toward PAC clients, regardless of age or other social status.
- Evaluate clients for abortion-related complications and prepare clients with complications for emergency treatment.
- Competently perform VA procedures, use misoprostol, and provide any other form of emergency treatment, on models and on clients.
- Manage complications and problems associated with VA procedures and misoprostol use.
- Demonstrate competencies in counseling and provision of all methods, including long-acting reversible contraceptives, during or following emergency treatment for abortion-related complications.
- Provide risk assessment, management, and/or referral for care for sexually transmitted infections and HIV.
- Reorganize services to ensure clinical quality in PAC.
Training and Learning Methods
- Independent reading
- Illustrated lectures and presentations
- Video and other audiovisual aids
- Group discussions
- Brainstorming sessions
- Case studies
- Individual and group exercises
- Role play exercises
- Demonstration and return demonstration, with coaching and mentoring (where applicable)
- Simulated practice with anatomic models and supervised practice on clients
- Guided clinical activities (for instance, performing VA procedures)
- Energizers

Training Materials
This Participant Guide is designed for use with the following materials:
- Postabortion Care Curriculum package (2024), including:
  » Reference Manual
  » PowerPoint slides, with text from the Reference Manual
  » Handouts, checklists, case studies, and role play exercises
  » Knowledge and training evaluations, to be completed by each participant
- Relevant national PAC guidelines and national FP service provision guidelines
- Infection prevention guidelines, including national and/or global reference materials
- FP counseling manuals and job aids
- Current PAC videos, if available
- Global resources:
  » Misoprostol Use in Postabortion Care: A Service Delivery Toolkit
  » Family Planning: A Global Handbook for Providers
  » Medical Eligibility Criteria for Contraceptive Use, Fifth Edition
  » Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors
- Instruments and equipment for VA, including electric, foot pump, or manual VA kits with aspiration syringe (as designated by the setting) and anatomic models
- Flip chart stands, paper, and markers
- Projector, laptop, and PowerPoint slides
- Case studies and role plays

Training Duration and Class Size
The training is organized into 13 sessions to be completed over a two-week (10-day) period.
The number of participants for each training will be limited by the space available (size of the classroom and number of demonstration areas or rooms) at the training facility and the potential number of clients needing PAC at the clinical training site.

A Note Regarding Gender-Neutral Language
The curriculum materials employ gender-neutral language when speaking in generalities to respect a diversity of gender identities as well as a diversity of relationship constructs. This includes referring to those seeking PAC and other health services as “clients” and using nonbinary pronouns—such as “they,” “their,” and “them”—to be inclusive of women and girls as well as nonbinary and trans individuals. Similarly, the curriculum includes terms such as “partner” or “spouse” when referencing those engaged in sexual relationships with clients to respect different gender and sexual identities as well as married and unmarried individuals. However, binary language is used selectively, for instance, in case studies and role play exercises and when referencing gender-specific topics, such as sterilization.
### Sample Training Schedule: Week 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</thead>
<tbody>
<tr>
<td>8:00 to 8:30 AM</td>
<td>Registration and welcome</td>
<td>• Agenda</td>
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<td>• Recap</td>
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<tr>
<td>8:30 to 10:30 AM</td>
<td>Course Introduction:</td>
<td>Module 1, Session 2: The Postabortion Care Model</td>
<td>Module 2, Session 2: Uterine Evacuation Methods</td>
<td>Module 2, Session 6: Medical Treatment for Postabortion Care Model 2, Session 7: Postabortion Complications and Management</td>
<td>Module 2, Sessions 3, 4, 5, 6, and 7; Module 3, Session 1 (continued) • Classroom Practice Sessions</td>
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<td>• Introductions</td>
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<td>• Pre-course knowledge assessment</td>
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<td>10:45 AM to 1:00 PM</td>
<td>Course Introduction (continued)</td>
<td>Module 1, Session 3: Values and Attitudes</td>
<td>Module 2, Session 3: Pain Management</td>
<td>Module 2, Session 7: Postabortion Complications and Management</td>
<td>Module 2, Sessions 3, 4, 5, 6, and 7; Module 3, Session 1 (continued) • Classroom Practice Sessions</td>
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<td>• Pre-course skill assessment</td>
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<td>1:00 to 2:00 PM</td>
<td>Lunch</td>
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### Sample Training Schedule: Week 1 (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
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</thead>
<tbody>
<tr>
<td>2:00 to 3:00 PM</td>
<td>Module 1, Session 1: Issues Surrounding Miscarriage, Induced Abortion, and the Delivery of Postabortion Care</td>
<td>Module 2, Session 1: Preparation and Client Assessment</td>
<td>Module 2, Session 4: Uterine Evacuation via Dilatation and Evacuation</td>
<td>Module 3, Session 1: Family Planning Counseling and Service Provision</td>
<td>Module 3, Session 2: Sexually Transmitted Infection and HIV Service Provision</td>
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<tr>
<td>3:00 to 3:15 PM</td>
<td>Break</td>
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<td>3:15 to 5:30 PM</td>
<td>Module 1, Session 1 (continued) Wrap-up</td>
<td>Module 2, Session 1 (continued) Wrap-up</td>
<td>Module 2, Session 5: Uterine Evacuation via Vacuum Aspiration Module 4, Session 1: Infection Prevention including Reprocessing Medical Devices Used for Postabortion Care in Health Facilities Wrap-up</td>
<td>Module 3, Session 1 (continued) Wrap-up</td>
<td>Module 3, Session 2: Sexually Transmitted Infections and HIV Service Provision Wrap-up</td>
</tr>
</tbody>
</table>

**Reading Assignment(s)**
- Module 1, Sessions 1, 2, and 3  
- Module 2, Session 1
- Module 2, Sessions 2, 3, 4, 5, and 6  
- Module 4, Session 1
- Module 2, Sessions 6 and 7  
- Module 3, Session 1

**Notes:**
- Module 4, Session 1, Infection Prevention including Reprocessing Medical Devices Used for Postabortion Care in Health Facilities, may be completed on Week 1, Day 6, if needed.
- Clinical practice sessions may begin in Week One, if participants are ready for certain aspects of observation and practice.
## Sample Training Schedule: Week 2—Classroom and Clinical Practice

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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</table>
| 8:00 to 8:30 AM | • Agenda  
• Warm-up  
• Recap | • Agenda  
• Warm-up  
• Recap | Group discussion (review clinical experiences) | Group discussion (review clinical experiences) | Group discussion (review clinical experiences) |
| 8:30 to 10:30 AM | Classroom practice sessions using models (evaluation of clinical skills) | Clinical practice sessions | Clinical practice sessions | Clinical practice sessions | Clinical practice sessions |
| 10:30 to 11:00 AM | Break | | | | |
| 11:00 AM to 1:00 PM | Orientation to clinical practice sessions  
Review of clinical schedule | Clinical practice sessions | Clinical practice sessions | Clinical practice sessions | Develop action plans to complete clinical practice and follow-up  
Post-course questionnaire |
| 1:00 to 2:00 PM | Lunch | | | | |
| 2:00 to 5:30 PM | As learners are ready, clinical practice sessions begin | Clinical conference | Clinical conference | Clinical conference | Course evaluations  
Wrap up (any unfinished work)  
Closing ceremony |

**Notes:**
- **Clinical practice sessions may need to occur in shifts; late afternoon and evening shifts may be necessary to allow for more practice. An on-call schedule may be useful, with on-call times from daytime to late evening.**
- **Clinical practice sessions may begin in Week One, if participants are ready for certain aspects of observation and practice.**
Using ZOE® Gynecologic Simulators

A ZOE® Gynecologic Simulator is a model of a full-sized, adult female lower torso, including abdomen and pelvis. It is a versatile training tool developed to help teach health professionals the processes and skills needed to perform many gynecologic procedures. ZOE models are ideal for demonstrating and practicing the following procedures:

- Bimanual pelvic examination, including palpation of normal and pregnant uteri
- Vaginal speculum examination
- Visual recognition of normal and abnormal cervices
- Uterine sounding
- Intrauterine device insertion and removal
- Diaphragm sizing and fitting
- Laparoscopic inspection and occlusion of fallopian tubes (Falope rings or other clips)
- Minilaparotomy (interval and postpartum tubal occlusion)
- Treatment of incomplete abortion using vacuum aspiration (VA)

Care and Maintenance of All ZOE Models

The specific model of ZOE Gynecologic Simulator will vary depending on the location of the training site and the procedures performed, but the care and maintenance remains the same for all models.

- ZOE is constructed of material that approximates skin texture. Therefore, in handling the model, use the same gentle techniques that you would when working with a client.
- To avoid tearing ZOE’s skin when performing a pelvic exam, use a diluted soap solution to lubricate the instruments and your gloved fingers. Alternatively, cornstarch works well as a lubricant, is less messy, and does not require washing the entire mannequin at the end of each practice session. Note: Talc powder (containing talc mineral) should not be used as an alternative because of health-related risks that may be associated with talc powder.
- Clean ZOE after every training session using a mild detergent solution and rinse with clean water.
- Do not write on ZOE with any type of marker or pen, as such marks may not wash off.
- Do not use acetone, alcohol, Betadine®, or any other antiseptic that contains iodine on ZOE, as these can cause damage and/or staining.
- Store ZOE in the carrying case and plastic bag provided with your kit. Do not wrap ZOE in other plastic bags or wraps, newspaper, or any other materials, as doing so may discolor the skin.
- Treat the model with respect and cover the mannequin to ensure privacy as if it was a human client.
- Choose an appropriately sized speculum to avoid tearing or having difficulty inserting the speculum and visualizing the cervix.
- Be gentle when grasping the cervix with the tenaculum.
- If you are practicing a VA, the cervix and uterus will not hold the vacuum in the VA equipment.

An Alternative to ZOE: Using a Ripe Fruit

A ripe fruit, such as the pawpaw, may be used as an alternative to ZOE for participants learning to perform VA. For this simulation to be effective, the pawpaw must be ripe. The advantage of using fruit is that it allows participants to feel the evacuation process using the VA equipment. There are, however, limitations to using ripe fruit; for instance, the provider may not be able to perform pelvic assessment and other procedures and tasks, such as demonstrating how to correctly grasp the cervix with a tenaculum.
Pre-Course Questionnaire

Objective of the Questionnaire and Benefits to the Trainer and Participants

The main objective of the pre-course questionnaire is to assist the trainer and the participants as they begin the training by assessing what the participants, individually and as a group, know about each course topic. For the trainer, the questionnaire results will identify topics that may require additional emphasis during the learning sessions. Sharing the results of the pre-course questionnaire with participants enables participants to focus on their individual learning needs. In addition, the questions alert participants to the content that the training will cover. The questions are presented in a true-or-false format.

This questionnaire enables the trainer to identify topics that may require additional emphasis during the course. Conversely, for categories where 85% or more of participants answer the questions correctly, the trainer may elect to use some of the allotted time for related content or other purposes. For example, if the participants as a group answer 85% or more correct of the questions in the Postabortion Family Planning category (questions 22 through 26), the trainer may elect to assign some of the related material as homework rather than spending all of the suggested time in class on this topic. Such a situation may happen, for example, with groups who have recently completed a family planning counseling and service provision training or update.

The module(s), session(s), and learning objective(s) related to each question are noted beside the answer column. To most efficiently use the limited training time, participants are encouraged to address their individual learning needs by studying the designated session(s) independently to enhance their knowledge.
Pre-Course Questionnaire

Instructions: In the space provided, print a capital T if the statement is true or a capital F if the statement is false.

Initial Assessment

1. A client who is admitted with possible complications of an incomplete abortion should first be assessed to determine the presence of shock.

2. Obtaining a complete medical history is the first step in assessing a client with possible complications of an incomplete abortion.

3. An abdominal examination is the best way to determine uterine size.

4. A client presenting with vaginal bleeding and signs and symptoms of pregnancy may have an ectopic pregnancy.

5. Foul-smelling discharge may indicate an infection due to an incomplete abortion.

Infection Prevention

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilized by boiling in water for 20 minutes.

7. High-level disinfection of surgical (metal) instruments, which have been thoroughly cleaned, can be completed by soaking in an 8% formaldehyde solution or a 0.1% chlorine solution prepared with boiled water.

8. To minimize the risk of staff contracting hepatitis B or HIV during the cleaning process, instruments and reusable gloves should first be soaked overnight in an 8% formaldehyde solution.

9. Cannulae should be sterilized by autoclaving for 20 minutes at 121°C.

10. The vacuum aspiration (VA) syringe must be high-level disinfected between clients.
Medical Evacuation Methods

11. All clients who opt for uterine evacuation with misoprostol must be admitted to the gynecological ward.  
   Module 2, Session 2, Objective 1

12. Misoprostol can be used with clients with septic abortion, clients with severe bleeding, clients with first or second trimester incomplete abortions, and clients who cannot give consent for VA.  
   Module 2, Session 2, Objective 1

13. All family planning methods should be provided to the client only after a complete evacuation of the uterus has been confirmed by a pelvic examination.  
   Module 2, Session 2, Objective 1 and Module 3, Session 1, Objective 1

14. The dosage of misoprostol varies with the route of administration and the duration of pregnancy.  
   Module 2, Session 2, Objective 1

15. Abdominal pain and diarrhea are two side effects and complications associated with misoprostol use. However, they are transient.  
   Module 2, Session 2, Objective 1

16. Oxytocin can be used to evacuate the uteri of clients with abortion-related complications, particularly for second trimester abortions.  
   Module 2, Session 2, Objective 1

Vacuum Aspiration Provision

17. One sign that the VA procedure is complete is visible foam around the cannula.  
   Module 2, Session 5, Objective 4

18. Pain management should be a part of care for all clients requiring uterine evacuation for treatment.  
   Module 2, Session 3, Objective 1

19. The client must return to the clinic if experiencing spotting or bleeding during the few days following treatment to treat complications of incomplete abortion.  
   Module 2, Session 5, Objective 5

20. VA is an effective treatment for an incomplete abortion, if the uterine size is up to 14 weeks.  
   Module 2, Session 2, Objective 4

21. When performing VA procedures, the vacuum will be lost if the uterus is perforated.  
   Module 2, Session 2, Objectives 1 and 2 and Module 2, Session 5, Objective 6
Postabortion Family Planning

22. The goal of postabortion family planning is to help a client choose a method of contraception.

23. Describing adverse side effects is the most important part of postabortion family planning counseling.

24. The doctor is best qualified to choose a contraceptive method for a client in good health.

25. An intrauterine device is not recommended for immediate use by postabortion VA clients.

26. A client’s fertility usually returns only after their first menstrual period following an incomplete abortion.

Module 3, Session 1, Objectives 1, 2, and 3

Community Empowerment and Sexually Transmitted Infection and HIV Counseling and Referral

27. Community empowerment involves the following: strengthening the capacity of communities to understand what postabortion care should achieve through community awareness and mobilization activities.

28. Community empowerment involves working with communities to develop action plans to address the delays in seeking healthcare and to reduce stigma related to bleeding in pregnancy.

29. Involving men is not a priority when working with community groups for addressing delays at the community level.

30. Facility-based staff responsible for postabortion care should not be involved in sexually transmitted infection (STI) and HIV counseling and testing.

31. When completing STI and HIV risk assessments, the postabortion care provider should encourage the client to bring their partner, if possible, to support contact tracing.

Module 1, Session 2, Objective 3

Module 1, Session 2, Objective 3 and Module 3, Session 2, Objective 2

Module 3, Session 2, Objectives 3 and 4
Introduction to the Postabortion Care Training Course

Summary
This introductory session orients participants to the postabortion care (PAC) training and the PAC model. The pre-course questionnaire helps both participants and trainers assess learning needs. Participants begin to actively engage in learning through sharing expectations and norms and through reviewing the objectives and learning approaches used throughout the course. The importance of working in partnership with other providers and the community is emphasized from the start of the training course.

Learning Objectives
By the end of this session, participants will be able to:
1. Note their individual strengths and limitations, based on the pre-course questionnaire.
2. Share their individual expectations about the training.
3. Agree on norms set by participants and facilitators.
4. Explain, in their own words, the rationale behind PAC training and the overall training goal.
Postabortion Care Training

**Rationale for Postabortion Care Skills Training**

Training reproductive health providers will help to:

- Introduce providers to PAC as an intervention that contributes to ending preventable maternal and child deaths.
- Sensitize providers to the magnitude of the problem of incomplete abortion as a complication of abortion and to PAC clients’ needs for high-quality, client-centered care—which includes nonjudgmental and respectful medical, emotional, and supportive care.
- Ensure the accessibility, acceptability, and delivery of high-quality PAC for all clients who need care—including women, adolescents, and other vulnerable groups—24 hours a day, seven days a week.
- Equip providers to deliver appropriate counseling throughout PAC and to include the client’s partner and/or family members with the client’s consent, as appropriate.
- Strengthen health worker skills and attitudes to offer emergency treatment for incomplete abortion, family planning counseling and services, and sexually transmitted infection and HIV services and/or referrals as integral parts of PAC.
- Refresh knowledge, skills, and attitudes of healthcare providers who are currently delivering PAC.
- Encourage provider partnerships and linkages with the community, including private voluntary organizations and nongovernmental organizations.
- Strengthen PAC within larger reproductive health training programs, including possibly in pre- and in-service training programs.

**Overall Postabortion Care Training Goals**

The goals of this training are:

- Positively influence participant attitudes toward PAC.
- Provide participants with the knowledge and skills needed to perform medical management and uterine evacuation (vacuum aspiration or another method, appropriate to the setting), as well as to prevent and manage complications related to the procedure.
- Provide participants with counseling skills for postabortion family planning.
- Provide participants with the knowledge and skills needed to organize and manage high-quality PAC.
- Familiarize the participants with their roles in providing family planning counseling services as a core component of PAC.
Training Journal (Optional)

Purpose
The purpose of a training journal is to record information that is important to you, as the trainer or the participant, during the training and at your worksite after training.

Examples of Important Information
- What have I learned from the sessions and experiences during the training?
- What do I intend to do to continue improving on the skills and knowledge that I have acquired through this training?
- What will I do differently as a result of this training?
- What help do I need to perform the skills and to apply the knowledge I acquired in the training at my worksite?
- Whom will I contact for this assistance?

How to Keep the Journal
Use a recording method of your choice, but it should be easy to find when needed.

When to Collect Information
Collect information as needed during the session, for instance, when discussing learning insights, such as what you wish to do differently or what you plan to apply when you return to work.

When to Use the Information
- Any time throughout the training
- Toward the end of the training, including in the skills application plan (for your return to your worksite)
- After the training, at your worksite

Instructions
Collect and apply information from all sessions when giving feedback or comments to speaker (trainer or participant, client, community).
Daily Postabortion Care Training Evaluation Report

1. Which topic was most useful to you?

2. Which topic was least useful to you?

3. Which topic was repetitive for you?

4. What other topics do you suggest to improve this workshop?
Module 1: Postabortion Care
Module 1, Session 1: Issues Surrounding Miscarriage, Induced Abortion, and the Delivery of Postabortion Care

Summary

This introductory session is a brief orientation to postabortion care (PAC). It begins by describing the magnitude of maternal mortality and morbidity, factors that may cause a spontaneous abortion (also known as a miscarriage), reasons why clients may choose to have an induced abortion, and why clients may delay seeking PAC. This is followed by a brief review of national legislation and service delivery guidelines related to the provision of PAC.

Learning Objectives

At the end of this session, participants will be able to:

1. Define the term “abortion.”
2. Discuss the magnitude of maternal mortality worldwide and nationally (if known).
3. Explain possible reasons for a spontaneous abortion or miscarriage.
4. Explain possible reasons a client may choose to have an induced abortion.
5. Describe national abortion laws and regulations and discuss how they impact PAC.
6. Describe facility policies for PAC (at their place of employment) and how they impact service delivery.

Questions to Consider

- What happens to a client who visits your facility seeking PAC?
- Where does the client present?
- Who sees the client first?
- Is the client admitted or not?
- Who provides the emergency treatment and where is it provided?
- Who provides family planning (FP) counseling and where is it provided?
- Are a range of contraceptive commodities available to guarantee voluntary, informed method choice?
- Are there policies for providing PAC to youth?
- What is the cost of PAC to clients?
Brainstorming Exercise: Factors Affecting Access to and Provision of PAC

Identify factors that contribute to the ability to provide PAC or provide access to PAC and explain how and why each factor may help or hinder a client seeking PAC, whether the factor is avoidable, and approaches to mitigating the factor.

<table>
<thead>
<tr>
<th>Contributing factor</th>
<th>Will the identified factor facilitate or hinder provision of PAC?</th>
<th>Is the factor avoidable?</th>
<th>What can be done to avoid or promote the contributing factor (as appropriate)?</th>
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Module 1, Session 2: The Postabortion Care Model

Summary

PAC is a package of services provided to a client who has experienced an induced or spontaneous abortion. PAC comprises three core components that should be implemented systematically. This session will focus on defining PAC, explaining the rationale for PAC programs, introducing the core components of the PAC model established by the United States Agency for International Development (USAID) (see Reference Manual), and introducing the benefits of postabortion FP counseling and services.

Learning Objectives

At the end of this session, participants will be able to:
1. Define the term “postabortion care.”
2. Explain why counseling should be integrated throughout all components of PAC.
3. Outline the three components of the USAID PAC model and the main elements of each.
4. Explain the difference between emergency obstetric care and PAC.
5. Explain three benefits associated with PAC.
Case Study Exercise

Mrs. Joko has been married for the last two years. She has been trying hard to have a child but every time the pregnancy ends at two or three months. She does not know why this happens and she has been extremely sad lately, often crying at night alone. The neighbors have noticed her sadness and have wondered why she has not given birth after more than two years of marriage. Last night she started bleeding again. Her husband looked for transport and eventually took her to the health center.

The midwife, who is a PAC provider-in-training, is at the health center when Mrs. Joko arrives. She is also the in-charge at the facility during the current shift. While taking her history, the midwife learns that this is Mrs. Joko’s fourth pregnancy that has ended in a miscarriage. Mrs. Joko says she feels fine but is worried that she is losing another pregnancy. Her physical exam reveals an incomplete abortion.

The midwife counsels Mrs. Joko and her husband regarding her diagnosis and proposed treatment. Together, they discuss the frequent miscarriages and the emotional strain they have been experiencing. Mrs. Joko cries throughout the session but is eager to know how to prevent another miscarriage. As with the previous losses, she wishes to become pregnant again immediately.

While preparing the client for the evacuation procedure, the midwife encourages Mr. and Mrs. Joko to wait at least six months before trying to become pregnant again. She introduces the idea of contraception to help space the next pregnancy. Though Mr. Joko was reluctant at first, he agreed to continue the discussion about contraception after the procedure.

The procedure goes well and Mrs. Joko is recovering and will be discharged in a few hours. The midwife returns with teaching aids to discuss various available contraceptive methods with the couple. After a long discussion with many questions, Mr. Joko decides that his wife should use oral contraceptives. The midwife makes sure that they understand the instructions and provides the method. The midwife asks Mrs. Joko to return in two weeks for a follow-up visit.
Module 1, Session 3: Values and Attitudes

*Note: The content contained within this module is adapted from Counseling the Postabortion Client: A Training Curriculum.*

**Summary**

This session will discuss values and attitudes and their importance in delivering PAC. While many providers come from similar backgrounds, they may have vastly different experiences leading to different assumptions that affect their daily work interactions or how they address common issues. Awareness of one’s values and attitudes can help healthcare professionals offer care in a respectful and nonjudgmental manner, regardless of a client’s personal situation, social status, or values.

**Learning Objectives**

At the end of this session, participants will be able to:

1. Define the terms “value” and “attitude.”
2. Explain the importance of being aware of our own values and attitudes.
3. Explain the importance of unconditional respect and protecting and fulfilling the human rights of all clients, regardless of their values, social status, or personal situations.
4. Demonstrate respect during counseling sessions and/or classroom activities.

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Group Exercise: Images and Perceptions

*Ambiguous Figure* (left)


*The Dynamic Ebbinghaus* (left)

**Question:** Look at the center dots on both the left and right. Which dot is bigger?

**Sara Nader** (below)

**Question:** Do you see a woman or a musician?
**Source:** Shepard, R. 1990. “Sara Nader.”

**My Wife and My Mother-in-Law** (below)

**Question:** Do you see a young or old woman?
**Source:** Anonymous. 1888. “My Wife and My Mother-in-Law.”

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**Schachibretoge**

(left)

**Question:** Are the lines straight or are they curved?
**Source:** Muristerberg, H. 1897. “Schachibretoge” Z. Phycol 5, 184–86.
Forever and Always (below)

Question: What do you see? How many people do you see?

Source: Octavio Ocampo. 1930. "Forever and Always."
Spirit Calling (below)

Question: What do you see?

Role Play Exercise: Counseling Session

This role play will take place in the emergency ward and demonstrate the interaction between a postabortion client and the nurse who is the client's first contact upon admittance. There are two different scenarios, with two different clients and two different providers. The clients for each scenario will have different social characteristics and they will complete a role play with two different providers. The first provider will counsel the client without empathy, for approximately five minutes; then, the second provider will counsel the client using empathy.

**Scenario 1 Client**
You are a married woman experiencing a miscarriage who has come to the emergency ward. You recently had malaria and now are bleeding heavily and in pain. This is your first pregnancy. You are frightened about your health and that of your baby, and nervous about how the healthcare provider will respond to your situation.

**Scenario 2 Client**
You are an unmarried teenager who recently had an unsafe abortion because your boyfriend convinced you not to use a contraceptive method. You have been bleeding heavily and are in pain when you enter the emergency ward. You are frightened about your health, and nervous about how the healthcare provider will respond to your situation.

**The Empathetic Provider**
This provider will show empathy toward the client by encouraging her to share her feelings; focusing on the client, rather than their own emotions; actively listening and paraphrasing the client's feelings; responding to the client's nonverbal communication; and asking about the client's emotional and psychological health, for example: “Tell me how you’re feeling. You look sad.” This provider should consider the following:
- How would I want to be treated if I were the client in this situation?
- How would I treat the client if she were a guest in my home?

**The Non-Empathetic Provider**
This provider will show a lack of empathy toward the client, for instance, by scolding, being impatient, and being disrespectful in verbal language and/or body language. This provider should think of and use comments that they may have heard or said to clients previously. This provider should consider:
- How would I not want to be treated if I were the client in this situation?

Aspects of Empathetic Counseling Include:
- Greeting the client respectfully
- Ensuring privacy and confidentiality
- Asking about the client’s feelings
- Listening attentively
- Exploring the client’s existing knowledge
- Giving credit for appropriate actions
- Avoiding blame and condemnation

Remember: Empathy is not simply feeling sorry for someone. It means placing yourself in the other person’s situation to understand how they might be feeling. Acting with empathy means showing understanding, concern, and a desire to help in a way that encourages open, honest, and sincere communication. It is normal for providers to experience emotions in the life-and-death encounters of an emergency ward. It is therefore important to be aware of your emotional responses to clients and to be aware of specific thoughts and actions that you can employ to convey empathy and encourage two-way communication.

**Case Studies Exercise**

**Case Study: Meena**
Meena is a 28-year-old nurse. She is single and lives in an upper-middle class neighborhood with her family. Meena became pregnant with Jai, a pharmaceutical sales representative who serves the private hospital where she works. Meena told Jai that she was pregnant and that she had decided to keep the baby, regardless of whether he would be involved in raising the child. At 10 weeks gestation, Meena had a spontaneous abortion and visited a local public hospital with heavy bleeding. When Meena requested oral contraceptives, the nurses told her to visit...
the FP clinic next door during its regular operating hours, but also warned Meena that the clinic did not routinely provide FP methods to unmarried women.

**Discussion Questions**

- What happens in your facility when unmarried clients present with signs of abortion?
- What happens when unmarried clients seek FP services? What are the protocols in your facility for providing contraceptives to unmarried clients?
- What happens in your facility when an adolescent or young person presents with signs of abortion?
- What happens when an adolescent or young person presents at a FP clinic? What are the protocols in your facility for providing contraceptives to adolescents and youth?
- Where are FP services provided at your facility? Can a client seeking PAC receive FP counseling and services before being discharged? *Note: There is strong evidence that FP uptake is higher when contraceptive counseling and services are provided in the same location as emergency postabortion treatment.*

**Case Study: Maskara**

Maskara is a 43-year-old mother of six. She lives in a lower-middle class rural area. In addition to being a wife and mother, she works to maintain the family farm. Maskara has had eight pregnancies, including one miscarriage and one stillbirth. She does not wish to have any more children, but she has never used a FP method. Maskara became pregnant for the ninth time and consulted her husband for advice. He recommended that she obtain an abortion from a traditional birth attendant in their community. Maskara visited the traditional birth attendant and received a vigorous massage intended to terminate the pregnancy. When she began to bleed heavily, Maskara returned to the traditional birth attendant for help who instructed her to visit the hospital. At the hospital, the providers refused to treat her until she confessed to inducing an abortion. No one at the hospital spoke to her about how to avoid becoming pregnant again in the future.

**Discussion Questions**

- In your facility, what are the protocols and standards for providing FP counseling and methods to clients who have experienced abortions (induced or spontaneous)?
- What is the relationship between unmet need for FP and clients seeking PAC?
- How do provider attitudes affect PAC clients (for instance, ignoring the need to address FP concerns, multiparity, and clients experiencing heavy bleeding, regardless of reason)?

**Role Play Exercise: Responding to Clients' Feelings**

- *Scenario 1:* A 15-year-old who attempted to terminate a pregnancy by inserting a foreign object into her vagina. She had never been to a hospital or seen a doctor before today. She arrived at the hospital alone and is afraid to return home to her family because they do not know that she has come here.
- *Scenario 2:* A 22-year-old who has come to the facility with her husband and mother-in-law. She is worried because she has been pregnant three times in the past year but has not yet had a child. All of her pregnancies have ended in a spontaneous abortion.
- *Scenario 3:* A 29-year-old unmarried woman who has come to the facility with a friend. She is anxious to see a doctor and leave as quickly as possible.
- *Scenario 4:* A 35-year-old married woman whose sister brought her to the hospital. The trip home will take 10 hours and she has children waiting. She appears to be very sick.
Module 2: Emergency Treatment
Module 2, Session 1: Preparation and Client Assessment

Summary
Preparations for healthcare provision start long before the client arrives at the facility. First, facilities must organize health services to ensure readiness to provide the highest quality of care. This includes not only restructuring the environment but also ensuring that providers are trained in all PAC components and that a range of contraceptive methods are available at the service site, when possible. Paired with a supportive policy environment for PAC, reorganizing services can improve provider attitudes and skills and increase access to contraceptive methods and services. Then, when the client presents for care, the provider can assess their clinical condition in an environment that increases quality of care and client satisfaction. A thorough assessment is the first step in providing the most appropriate care and treatment. This session is an introduction to the emergency treatment component of PAC, and includes a brief discussion about rearranging service areas to enhance client privacy, followed by guidance on gathering information about the client’s history and conducting a physical examination.

Learning Objectives
At the end of this session, participants will be able to:
2. Describe how to rearrange service areas to ensure confidentiality, privacy, and the ability to counsel a client with a spouse or companion (as appropriate).
3. Perform a client assessment and examination according to standards, including:
   » Conducting a rapid assessment to rule out life-threatening conditions and to facilitate immediate management, as needed
   » Obtaining a complete history
   » Completing a physical examination, including abdominal and pelvic examinations
   » Determining and obtaining appropriate laboratory tests
4. Explain the different types of miscarriage and abortion, including major signs and symptoms.
5. Demonstrate the ability to integrate appropriate counseling in emergency treatment as indicated.
### Client 1 Symptoms Description

A 30-year-old woman who lives far away from the clinic. Her symptoms are not severe, but her sister persuaded her to seek treatment. She does not think she is pregnant. Her symptoms and experiences include:

- Moderate bleeding for three days
- Last menstrual period ended about seven weeks ago
- Some cramping, but not severe
- Two previous births
- One previous miscarriage
- Using contraceptive injectables; last injection was seven months ago

### Client 2 Symptoms Description

A 15-year-old girl who is alone, in considerable pain, and extremely anxious that her family not know about her condition. Her symptoms and experiences include:

- Moderate vaginal bleeding for seven days
- Last menstrual period began about 11 weeks ago
- Severe cramping
- No previous pregnancies
- Warm to touch (no thermometer available)
- Sweats and chills
- Significant vaginal discharge that is:
  - Brown in color
  - Foul-smelling
- Using condoms regularly
Role Play Exercise: Rearranging Client Service Areas

Scenario 1: Crescent Health Center
At Crescent Health Center, there are two providers each shift: one is a midwife or medical assistant, the other is a junior nurse (enrolled nurse or auxiliary nurse). All senior providers are trained in PAC, but the junior staff are not. There is a waiting room with several benches and two tables near the front where staff take client histories and blood pressure on outpatient clinic days. There are two exam rooms: one labor and delivery room and one small ward with two inpatient beds. The providers use the exam rooms for all outpatient activities. The exam rooms are identical in equipment and set-up and each has a window facing the main road. Clinic administrators arranged the room with the feet of the exam tables facing the door.

Scenario 2: Triangle Maternity Home
The Triangle Maternity Home is owned and operated by Sarah, a midwife with many years of experience. Sarah has a reliable worker who completed training as a nurse’s assistant. This assistant collects most of the client intake information in the waiting area, including history, blood pressure, height, and weight. A nurse from the government hospital nearby also works at the maternity home a few days each month. Sarah completed a training in manual vacuum aspiration along with other private midwives approximately five years ago. She provides PAC about twice each month. The nurse gives FP counseling and supplies to PAC clients at the government hospital where she works. The maternity home has one exam room, which is also the counseling room, and one client care room with two beds for labor and delivery clients as well as PAC clients. The beds are separated by a curtain and face away from the door. A general waiting area is separated from the care room by a curtain and there are curtains in the doorway of the exam room because the door hinges are broken.

Scenario 3: Diamond District Teaching Hospital
Diamond District Teaching Hospital has many PAC providers—primarily doctors as well as a few midwives. Other hospital staff have not undertaken PAC training. Currently, PAC clients must visit the gynecology clinic during outpatient hours. Those seeking care outside of those clinic hours are directed to the gynecology or postpartum ward, wherever a PAC-trained provider is working during that shift. However, all vacuum aspiration procedures are completed in the operating theater, and PAC clients must undergo preoperative procedures (history, physical exam, blood work, etc.) like any other surgical client. Only then is a PAC client assigned to a bed on the ward to wait with other surgical clients until a provider and room is available for the procedure. During weekdays, the FP nurse counsels PAC clients about contraceptive options. Clients presenting at night or over the weekend receive referrals to the FP clinic for next available day. Most beds lack curtains but there are some movable screens available. For this reason, men and boys are not permitted in the wards.
Module 2, Session 2: Uterine Evacuation Methods

Summary

Because most complications result from products of conception being retained in the uterus, removal of the contents of the uterus (uterine evacuation), is one of the primary components of emergency treatment. There are several methods of uterine evacuation; the method chosen is based on national policies, facility type, available equipment, trained staff, and local conditions. Methods of uterine evacuation are broadly divided into three categories: surgical methods; medical methods; and the expectant method. The two most common methods of surgical evacuation are vacuum aspiration (VA) and dilatation and evacuation (D&E). The WHO recommends medication abortion over surgical approaches. Misoprostol is one medical method for evacuation of the uterus and is currently recommended for emergency treatment of an incomplete abortion occurring in the first or second trimester. There are, however, other medication combinations available for emergency treatment. Another medication commonly used in the second trimester is oxytocin; however, oxytocin is losing popularity compared to misoprostol. This session introduces and describes each method; subsequent sessions will detail techniques associated with each method.

Learning Objectives

At the end of this session, participants will be able to:
1. Describe how each method of uterine evacuation works.
2. List key advantages and disadvantages of each method.
3. Identify the instruments (or parts) used for each method, as relevant.
4. Describe indications, contraindications, and precautions applicable to each method.
5. Describe counseling appropriate for any uterine evacuation procedure.
Module 2, Session 3: Pain Management

Summary
While most health facilities have a general protocol for pain management, the service provider must recognize and respond to the individual needs of each client. Pain management for PAC includes not only appropriate medication, but also supportive interactions and gentle performance of procedures. In addition to pain management, other medications or related interventions may be necessary during emergency treatment including, for example, provision of antibiotics, intravenous fluids, and oxytocics. This session focuses on various types of pain management for PAC and information needed to appropriately select and administer each type.

Learning Objectives
At the end of this session, participants will be able to:
1. Describe the goal of pain management in emergency treatment for PAC clients.
2. Describe key information to share when counseling clients on pain management.
3. Describe the types of pain clients may experience from incomplete abortions and from different uterine evacuation procedures, including post-procedure pain.
4. List the types of pain management and available methods for each type.
6. Demonstrate counseling related to pain management and integrated with care, as appropriate.
Role Play Exercise: Pain Management Counseling

Scenario 1: Sarah
Sarah is a 19-year-old university student who has presented with signs of a miscarriage. Her last menstrual period was about six weeks ago. Sarah appears nervous and shy and the midwife heard her say that she was scared. She is accompanied by her sister, an accountant at the district hospital. They are seated in the examination room when the provider arrives. Sarah is holding her lower abdomen and is slouched forward in her seat.

Scenario 2: Miriam
Miriam is married with three young daughters. She recently experienced a pregnancy loss at nearly 12 weeks since her last menstrual period and opted for misoprostol for an incomplete abortion. Miriam is obviously in pain and is accompanied by her husband, who seems anxious. Her husband told the doctor that he does not want his wife to suffer, that he does not understand why she lost the pregnancy, and that he was hoping for a son. Miriam delivered her last baby about a year ago. The husband is pacing around the waiting room.

Scenario 3: Mrs. P.
You are preparing Mrs. P. for treatment and her physical exam revealed retained products of conception and signs of infection. She has agreed to the D&E but says she does not want to be awake for the procedure. There are no providers trained in VA available at this facility. She is allergic to ibuprofen and has said several times, “I can’t let this happen again.” Mrs. P. is a gravida 8, para 7, and has come to the hospital alone.

Scenario 4: Thandi
Thandi is a teacher at a local secondary school. This is her second miscarriage. The first time she miscarried (six years ago), she received misoprostol at the community health center but did not receive analgesia. Thandi now has many questions about pain medication, as she fears a repeat of the pain she experienced last time. Her husband is also a teacher and they have two children. Thandi does not want her mother-in-law, who is in the waiting area, to participate in the counseling session.

Scenario 5: Wati
Wati has agreed to VA treatment for an incomplete abortion. She asked the midwife to hurry because she must be home in time to prepare dinner for her family. When approached about pain medication, Wati said, “The women in my culture are strong. We don't need Western medicines. I want to go home as soon as it is over. You said this was a simple procedure, is it not?”

Scenario 6: Multiple Clients
For the following scenarios, practice using the pain assessment scale.

- **Scenario 6-A:** Mrs. B. traveled across the border to your facility with signs of an incomplete abortion. You do not speak her language well, but can tell she is in pain. Assess her pain using the appropriate method.
- **Scenario 6-B:** Mr. M. has accompanied his wife to the hospital. He says she is about three months pregnant but has been bleeding for the past two hours. Mr. M. and his wife are teachers at the local school. Try to assess the level of Mrs. M.’s pain.
- **Scenario 6-C:** Ms. T. was brought to the operating theater to have a D&E due to excessive bleeding after a miscarriage. You need to discuss pain management with her prior to the procedure. Ms. T. is 17 and this was her first pregnancy.
- **Scenario 6-D:** Mrs. G. is undergoing treatment for a septic abortion. She told the midwife that she does not hurt much, but she is moaning and constantly rubbing her lower abdomen. You need to discuss pain management with her urgently before treatment, but she seems very shy.
- **Scenario 6-E:** Ms. R. received her first dosage of misoprostol for emergency treatment of an incomplete abortion procedure 15 minutes ago. Her vital signs are stable and she will not be admitted. You need to explain how she should take pain medication and discuss danger signs with her before discharge.
Module 2, Session 4: Uterine Evacuation via Dilatation and Evacuation

Summary
This session presents an overview and description of the dilatation and evacuation (D&E) procedure for uterine evacuation. Each step of the procedure is outlined in detail. Always follow local guidelines or protocols for the procedure, including anesthesia or related care.

Learning Objectives
At the end of this session, participants will be able to:
1. Identify the instruments used for D&E.
2. Explain and demonstrate the procedure for D&E using a model.
3. Describe post-procedure care.

Participant Notes
Many low-resource countries still rely on sharp curettage for treating incomplete abortion. However, the World Health Organization (WHO) no longer recommends sharp curettage for treating incomplete abortions, and instead recommends use of D&E, specifically VA for first and second trimester abortions. This is because sharp curettage under general anesthesia is associated with cervical trauma, increased blood loss, and other problems, whereas D&E can be performed safely with systemic analgesia, rather than general anesthesia.

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23 Ibid.
Role Play Exercise: Post-Procedure Counseling

Scenario 1: Mrs. P
Mrs. P. is recovering after a D&E procedure three hours ago. Her husband is with her but is concerned about caring for her at home. They have a young son and want to try for another pregnancy as soon as possible. Mrs. P. is upset about the miscarriage but is anxious to go home today. Her recovery has been uneventful and she is not experiencing any signs of complications or problems. The midwife has arrived for her shift and is preparing to counsel the couple.

Scenario 2: Olivia
Olivia is a first-year university student who received treatment for an incomplete abortion a few hours ago. She asked the midwife not to give her more pain medication and she wants to know when the bleeding will stop. She told the midwife she does not want to use pills or any other contraceptive method that can be seen or discovered by her parents. Olivia is ready to be discharged but wishes to wait until sunset so that "no one will see her."

Scenario 3: Yosef
Yosef accompanied his wife for treatment of an incomplete abortion. He was in the waiting room during the procedure but has now joined his wife in the recovery area. Yosef tells the doctor that he feels guilty about causing the miscarriage, saying, "I should not have had sex with her so early in the pregnancy." They have five children at home.
Module 2, Session 5: Uterine Evacuation via Vacuum Aspiration

Summary

This session focuses on various vacuum aspiration (VA) equipment and procedures (electric, foot pump, and manual). Participants will learn how to perform the procedure through a step-by-step process and then discuss how to recognize and solve problems that may arise during the procedure.

Learning Objectives

At the end of this session, participants will be able to:

1. Identify the parts of manual vacuum aspiration (MVA) equipment and select the correct size syringe and cannula.
2. If locally applicable, for electric vacuum aspirator (EVA) and/or foot pump suction evacuation (FSE):
   » Identify the parts of the EVA and/or FSE equipment.
   » Select the correct size cannula.
3. Demonstrate the ability to assemble, test, and prepare MVA, EVA, or FSE equipment.
4. Perform the VA procedure using MVA, EVA, or FSE, according to the steps outlined.
5. Demonstrate appropriate counseling before, during, and after the procedure.
6. Recognize and solve technical and/or procedural problems.
7. Record complete, accurate case information in client charts, logbooks, and other forms, as needed.
Module 2, Session 6: Medical Treatment for Postabortion Care

Summary
This session covers use of misoprostol for medical treatment of abortion-related complications, particularly incomplete and inevitable abortions in the first and second trimester. This session aims to equip participants with the skills required to provide medical treatment for PAC using misoprostol. The session will begin with key information about misoprostol then explain the recommended steps for providing medical treatment and related components of PAC.

Learning Objectives
At the end of this session, participants will be able to:
1. List the key steps of medical treatment for abortion-related complications according to standards.
2. Describe indications and contraindications for using misoprostol to manage abortion-related complications.
3. Demonstrate competencies in counseling and providing medical treatment for abortion-related complications using misoprostol.
4. Demonstrate competencies in providing other postabortion services to clients who choose misoprostol to treat abortion-related complications.
Role Play Exercise: Counseling for and Provision of Misoprostol

Scenario 1: Ms. A.
Ms. A., who is 21, presented at the facility with vaginal bleeding and lower abdominal pain. She has not had her menses for the last three months and has not been using any contraceptives. She has a three-year-old child and wants to delay her next pregnancy for another two years.

Scenario 2: Mrs. B.
Mrs. B. is a 30-year-old housewife with three children. Her last birth was two years ago. Her last menses was four months ago. She was using injectables but her last injection was a year ago. She is currently receiving treatment for hypertension. She has not attended an antenatal clinic. She presented with severe vaginal bleeding, lower abdominal pain, headache, high fever, and vomiting.

Scenario 3: Ms. C.
Ms. C. is a 19-year-old college student. She presented at the facility with vaginal bleeding, lower abdominal pain, fever, and dizziness. Her last period was three months ago. Her mother accompanied her to the facility.

Scenario 4: Mrs. D.
Mrs. D. is a 25-year-old woman, para 2+1. Her last birth was two years ago. She has not had her period for the last three months. She presented with lower abdominal pain and has been experiencing vaginal bleeding for the past two weeks. She is in stable condition. She is interested in FP, particularly in obtaining an intrauterine device (IUD). She is in a monogamous relationship and does not have a history of sexually transmitted infections (STIs).

Scenario 5: Mrs. E.
Mrs. E. is 29 and para 4+0. Her last birth was one year ago. Her last menstrual period was four months ago. A week ago she started bleeding and experiencing lower abdominal pain. She visited the facility and received medication and guidance to take bed rest. The bleeding has progressed and now she is presenting with a foul-smelling vaginal discharge. She complains of fever, general malaise, sweating, and palpitations.

Scenario 6: Ms. F.
Ms. F. is 22 years old, para 2+0. Her last birth was eight months ago and her last menstrual period was two months ago. She has never used FP. She reports severe lower abdominal pain, dizziness, thirstiness, and slight vaginal bleeding.

Scenario 7: Ms. G.
Ms. G. is 24, para 3+0, and presented at the facility with signs of an incomplete abortion. She selected misoprostol for emergency treatment and received a single dose of misoprostol four days ago. She has come back to the facility complaining of slight vaginal bleeding. She believes she expelled some products of conception two days ago, but she did not see it as it happened in a pit latrine.

Scenario 8: Ms. H.
Ms. H. is 33, para 5+0, and came to the facility six days ago with vaginal bleeding and lower abdominal pain. She received a single dose of misoprostol as treatment for an incomplete abortion. She had not used a contraceptive method before; however, after being counseled, she opted for the injectable, which she also received during that consultation. Ms. H. has returned to the facility complaining of the same symptoms (lower abdominal pain and vaginal bleeding). She did not call the facility using the phone number she received during her last consultation because she did not have airtime.
Module 2, Session 7: Postabortion Complications and Management

Summary
A client with an incomplete abortion may experience life-threatening complications. Healthcare providers must recognize these complications and initiate immediate treatment to save lives. This session provides an overview of the major postabortion complications—shock, severe vaginal bleeding, intra-abdominal injury, infection, sepsis, and uterine perforation—and then provides details for managing each.

Learning Objectives
At the end of this session, participants will be able to:
1. Identify potential postabortion complications and their signs and symptoms.
2. Describe rapid assessment, treatment, and other measures for:
   » Shock
   » Severe vaginal bleeding
   » Infection and sepsis
   » Intra-abdominal injury
   » Uterine perforation
3. Explain elements of emergency resuscitation and preparation for referral and transport to a tertiary care facility.
Case Study Exercise: Postabortion Complications

Case Study 1
Mrs. P. comes to the facility with vaginal bleeding. Her sister says Mrs. P. has been agitated and confused for the past hour. A quick observation reveals that Mrs. P. is breathing rapidly and perspiring. According to her sister, Mrs. P. married about three months ago and she suspects she was pregnant. Mrs. P. is not sure when the bleeding started, but thinks it was at least four hours ago after she walked three km home from the market. Vital signs reveal the following: blood pressure 80/50; pulse 120; respiration 40. The amount of blood observed appears less than 500 ml.

- What other information will you gather to assist in your assessment?
- Based on this rapid assessment, what is your initial diagnosis?
- What initial actions will you take to address the immediate situation?
- What other steps will you take to manage her problems?

Case Study 2
Ms. B. was admitted three hours ago with a diagnosis of incomplete abortion and is scheduled for a D&E when the doctor arrives. She calls for the midwife to say that she is bleeding “down there.” Ms. B. says she fell asleep 30 minutes ago after the nurse took her vital signs and does not know when the bleeding started. She complains of dry lips and feeling light-headed. You inspect her vaginal area and discover blood-soaked pads with several clots. Vital signs reveal the following: blood pressure 100/60; pulse 100; respiration 24. The lab technician reports a hemoglobin of 7 gm/dl.

- What information will help you determine the severity of her blood loss?
- Based on these findings, what is your initial diagnosis?
- What initial actions will you take to address the situation?

Case Study 3
Amina is a 21-year-old university student. Last night, she awoke with a fever and chills and she presents today complaining of a foul-smelling vaginal discharge. Only she and her boyfriend know that she had a miscarriage three days ago and she begs the midwife not to reveal her recent pregnancy to her parents. Vital signs reveal the following: temperature 39° Celsius (102.2° Fahrenheit); blood pressure 130/80; pulse 100; respiration 30.

- What are the main signs of infection or sepsis in a postabortion client?
- What initial actions will you take to address the situation?
- Coagulopathy is a bleeding disorder that is sometimes seen with severe cases of sepsis. What are the main signs of coagulopathy?

Case Study 4
Mrs. Y. presents with signs of an incomplete abortion. The PAC-trained medical assistant performed an MVA but noticed continued bleeding after the uterus was empty. The medical assistant monitored her vital signs for the next 30 minutes. Though she denied it at first, Mrs. Y. admitted that she attempted to terminate the pregnancy earlier that day with a traditional healer. Vital signs reveal the following: temperature 38° Celsius (100.4° Fahrenheit); blood pressure 160/80; respiration 28; pulse 100; decreased bowel sounds.

- Based on this information, what is the likely diagnosis?
- What initial actions will you take to address this situation?
- The medical assistant recognized an important sign of perforation. During the MVA procedure, what other signs might indicate a perforation?
Module 3: Family Planning Counseling and Service Provision, Sexually Transmitted Infection Evaluation and Treatment, and HIV Counseling and Testing
Module 3, Session 1: Family Planning Counseling and Service Provision

Summary

Fertility can resume almost immediately following an abortion or miscarriage—the average time to ovulation postabortion is three to four weeks, but it can occur in as few as eight days. Postabortion clients therefore should carefully consider whether they want to become pregnant again and, if so, when. Some clients may wish to conceive again soon; others may not wish to conceive again soon or at all. In either case, every PAC client (and their partner, if the client desires), should receive counseling and information about the return of fertility and available contraceptive options. It is important to emphasize healthy timing and spacing of pregnancy during counseling, as delaying pregnancy for at least six months after an abortion or miscarriage can reduce adverse outcomes, including the chances of low birth weight, maternal anemia, and preterm birth.\(^{25}\) \textbf{Note: A systematic review and meta-analysis primarily comprising studies from high-income countries suggests that an interval of less than six months following miscarriage is not associated with adverse outcomes.}\(^{26}\)

As emphasized throughout this training; PAC is incomplete without family planning (FP) counseling and services. This session focuses on aspects of FP most relevant to PAC.

Learning Objectives

At the end of this session, participants will be able to:

1. State the essential FP information that all PAC clients should receive before discharge.
2. Explain the importance of informed choice for effective FP services.
3. Describe the personal and clinical factors that should be discussed during FP counseling.
4. Demonstrate appropriate FP counseling during different phases of care.
5. State one point of consensus from the International Federation of Gynecology and Obstetrics (FIGO); International Confederation of Midwives (ICM); International Council of Nurses (ICN); United States Agency for International Development (USAID); White Ribbon Alliance (WRA); United Kingdom Foreign, Commonwealth & Development Office (FCDO) (formerly Department for International Development, DFID); and Bill & Melinda Gates Foundation joint statement on postabortion FP.\(^{27}\)


Additional Resources

Comprehensive contraceptive methods and counseling information is not included in this module; however, resources with current, evidence-based information are readily available. Recommended materials are listed in the table below.

### Comprehensive Contraceptive Guidance

- Contraceptive Technology (2023): Available to order
- Selected Practice Recommendations for Contraceptive Use (2016): Available from the WHO

### Counseling Frameworks

- Counseling the Postabortion Client: A Training Curriculum (2003): Available from EngenderHealth

### Job Aids

- Family Planning Wall Chart: Also known as "the wall chart" or "the Tiahrt Chart," available to order
- Medical Eligibility Criteria for Contraceptive Use (2015): Available in print or as an app from the WHO

### Other Relevant Articles and Similar

- Post Abortion Family Planning: A Key Component of Post Abortion Care (2013): Available from USAID
- Saving Women's Lives through Emergency Obstetric Care and Voluntary Family Planning (2019): Available from Global Health Sciences and Practice
Case Study Exercise: Contraceptive Method Choice

Case Study 1
A 17-year-old client treated for an incomplete abortion will be released later today. You check her chart and find that she was treated with MVA and there were no complications. Her uterus size was approximately eight weeks before treatment and her overall health status is good. The client says that she does not want to become pregnant again and would like to talk about FP. She says that she does not want anyone, even her boyfriend, to know that she is using FP.

Case Study 2
A 30-year-old client treated for an incomplete abortion is in recovery. Her chart indicates that fragments of plastic were found in her vagina during her pelvic examination. When asked, she says that she did nothing to provoke an abortion. She also says that she does not want more children for a few years and she has been using progestin-only pills since her last child was born one year ago. She is interested in “the injection” because she heard that it is a good method.

Case Study 3
A 20-year-old client treated for an incomplete abortion is interested in FP. She says she has two living children and that she does not want to be pregnant again until her youngest child starts school in two years. She says that she wants an IUD because her sister has one and likes it. The client has no signs of infection but may be slightly anemic, as she bled for five days before coming for treatment. When you asked about the incomplete abortion, she shrugged, looked at the floor, and said it was a shame.

Case Study 4
A 28-year-old client treated for an incomplete abortion with MVA underwent surgery to repair damage to her uterus and bowel discovered during the procedure. She was hospitalized for several days but is now recovering and is interested in “the pill.” You check her chart and find that her blood pressure has been slightly elevated throughout her stay. While obtaining her medical history, you find out her father had a heart attack when he was young and one sister is currently taking anti-hypertensive medication. Her blood pressure today is 140/86.

Case Study 5
A 30-year-old client treated for an incomplete abortion two weeks ago returned to the FP clinic. She has two children and is in a hurry, concerned about getting home in time to complete her chores. You find out that her family does not know where she is and that her mother-in-law and husband want her to have many more children. She wants more children too, but not for another year or two. Her medical history is unremarkable except for iron deficiency anemia.

Case Study 6
A 19-year-old client is treated for an incomplete abortion with no complications, but reports receiving treatment for chlamydia a year ago. While she has not said so, you suspect that she is a sex worker. She says she is interested in an IUD because she does not trust hormonal methods. She declines counseling and testing for HIV.

Case Study 7
A 40-year-old client with seven children tells you that she and her husband have decided not to have any more children and that she would like to be sterilized. When you review her medical chart, you see that she was treated for an incomplete abortion with a uterine size of 12 weeks, but there is no signed consent form in her file. You tell her that you cannot do the operation today because of the government’s requirement to obtain consent 30 days
before the procedure. She begins crying and says she lives far from the hospital and does not know when she will be able to return.

Case Study 9
A 27-year-old client treated for an incomplete abortion says that this is the third time she has lost a pregnancy in the last five years. She asks you how to make sure that her next pregnancy is not lost. She does not have any living children. Other than occasional migraines, she reports an unremarkable medical history.

Case Study 10
A 26-year-old client is treated for an incomplete abortion without complications. She reports taking injections before becoming pregnant but had stopped because it took so long to walk to the nearest clinic for the injections and because the clinic did not always have the supplies available. Additionally, it is difficult for her and her husband to afford the shots. She does not want more children right now because of the eclampsia she experienced after her first baby.

Role Play Exercise: The Counseling Process
Consider the following in developing the role plays:

- Determining which contraceptive methods are appropriate to the client’s situation, needs, and reproductive intentions and desires
- Demonstrating emotional support, empathy, and respect
- Involving the client’s partner, as appropriate and with the client’s permission
- Explaining the return to fertility following an abortion or miscarriage
- Offering contraceptive services at the same place as emergency treatment

Scenario 1: Ngozi
My name is Ngozi. I am 28, happily married, and a mother of three children. I am self-employed and have a small tailoring shop in the center of town, a municipality of 500,000 inhabitants.

My husband and I talked, and he would like us to complete our family; I also want one more child, but after resting for a couple of years. Since my last delivery, 18 months ago, I have been trying to practice what my friends call “child spacing” by using oral contraceptives, according to the maternal and child health nurse’s advice. I like the pills and have not had any of the side effects. Sometimes I forget to take the pill, but when that happens, I take two as soon as I remember, according to what I was taught by the nursing sister. My husband supports me using FP, but I am afraid of the neighbors seeing and possibly telling my mother-in-law.

I received my initial pills from the clinic when I took my baby for a check-up and immunization, but since then I have been buying them from the nearby chemist that belongs to my friend’s husband. Due to the poor economy, the chemist cannot always maintain a continuous supply of pills and three months ago, after I used my last pills, the chemist did not have any in stock, and it took me a week to find another source. I guess this was too long of a break because I soon learned that I was pregnant. We were happy with the pregnancy and looking forward to having the baby to complete our family, though it came much sooner than we had planned.

Last week, I began to bleed heavily and had terrible pains in my tummy. My husband desperately looked for a taxi to take me to the hospital without success. Fortunately, a neighbor with a car returned home then and kindly rushed me to the hospital. At the hospital, they told me that I had lost my baby.

Scenario 2: Mrs. Perez
My name is Mrs. Perez. I am 33 and a mother of six children. My husband works as a truck driver and is away most of the time, only returning home every three months or so for a few days. I live in a small village many kilometers from the nearest market town. I support our family by growing yams to sell by the roadside; however, times are hard, and my family barely has enough to eat.
My husband is very proud of the number of children he has. The last time he was home, he left me pregnant. I felt weak and tired, and could not imagine having another baby, but my husband did not seem to notice or be bothered. My children have gone hungry because I could not fetch and prepare food for them. I was afraid of terminating this pregnancy but I cannot support another child.

One week ago, I felt sick and began to bleed. I was brought to the hospital two days ago and the doctor cleaned my womb. I feel much better now, though I am still bleeding a little, still have some pain, and still feel extremely weak. I do not understand much of what is happening here—the hospital is so large and the doctors talk too fast—however, I know they are talking about me and that they think I intentionally terminated my pregnancy. Secretly, I do not believe that I could have survived through the pregnancy and I have no means of taking care of a newborn; I do not want any more children ever.

Scenario 3: Rani
My name is Rani. I am a 15-year-old student at a girls’ secondary boarding school in the capital. I am the oldest in a family of five children, and my parents, who live in the village with my younger brothers and sisters, expect me to perform well in school and help them with my siblings. Living in the city without my family has been difficult because everything happens so fast and makes me nervous, but I am managing well so far.

Two months ago, I was a virgin, before going out with a man for the first time. I was afraid of having sex because some of my friends had been expelled from school after becoming pregnant. However, I trusted this man because he is much older than me, has been with many women, and said he knew how to prevent making me pregnant, especially my first time. He assured me that it was my safe period, but my trust was not worth it.

When I discovered I was pregnant, this man, who is rich, took me to a doctor he knew who could end the pregnancy confidentially so I could continue with my education. The procedure was expensive but this man did not have a problem paying, as long as I did not tell anyone. The doctor told me that what he was doing would make me bleed and that I should go to the hospital immediately after the procedure. However, what he did was extremely painful and made me scream. My womb felt hot and I am still bleeding now. The doctor in this hospital told me that I had an infection and gave me pills for the pain.

I am glad that the doctor assured me that I will be able to have children in the future, but I am not ready to be pregnant now. I have heard about pills that can protect people from pregnancy, but I am afraid to use them. I cannot consult the school nurse because I fear being expelled from school and then what would my father say? People will have bad ideas about me if they knew I was using such pills. However, I urgently want to learn more about preventing pregnancy...I wonder whom I can ask?

Scenario 4: Ajay
My name is Ajay. I came to the hospital to get my wife, who was treated for something called “incomplete abortion.” I am very worried about her and do not want her to be pregnant again until she is better, but I do not know what to do. My mother tells me to be careful with these modern birth control methods as they can cause infertility or prevent conception of a male child. I think I will take my wife to the traditional healer next week as he has much success in treating hard cases.
Module 3, Session 2: Sexually Transmitted Infection and HIV Service Provision

Summary

This session provides an overview of sexually transmitted infection (STI) evaluation and treatment using the syndromic approach and referral. The section on HIV and AIDS focuses on information for counseling and referrals to appropriate services for provider-initiated counseling, testing, care, and treatment.

Learning Objectives

At the end of this session, participants will be able to:

1. Describe the symptoms and complications of common STIs as well as HIV and AIDS.
2. List the essential STI information that all PAC clients should receive before discharge.
3. Explain how to evaluate, treat, and follow up with PAC clients with STIs using the syndromic approach.
4. Provide counseling within the context of STIs and HIV risk.
Module 4: Infection Prevention
Module 4, Session 1: Infection Prevention

Summary

Infection prevention is critical to minimizing risks to clients, healthcare workers, and the community during the provision of health services. This session introduces infection prevention procedures, including standard precautions, aseptic techniques (including hand hygiene), the no-touch technique, preparation of the surgical area, use of antiseptics, use of barriers, maintenance of the procedure area, waste management, and processing of medical devices and other items for reuse.

Learning Objectives

At the end of this session, participants will be able to:

1. Explain the principles of infection prevention, including standard precautions.
2. Demonstrate effective hand hygiene procedures.
3. Describe the appropriate use of antiseptics and the no-touch technique.
4. Demonstrate appropriate gloving practices.
5. Demonstrate correct use of personal protective equipment.
6. Demonstrate safe handling of sharps.
7. Demonstrate safe disposal of contaminated waste.
8. Describe recommended housekeeping practices.
9. Demonstrate how to process reusable equipment and other items used in PAC provision.
Case Study Exercise: Infection Prevention

Case Study 1: Marie and Nathalie

When sisters Marie and Nathalie were hired to clean a local maternity hospital, they were told to clean the floors of the hospital, including PAC procedure areas and rooms as well as the operating theaters, daily. Every day they sweep the floors of the wards with straw brooms and then dust and sweep the PAC procedure areas, including the surgical theaters. If the PAC procedure area or operating theater was not used the day before, they do not clean it again. No one said anything about their cleaning habits, so they thought they were doing a good job. Are the sisters practicing appropriate cleaning methods? Why?

Case Study 2: Ms. P.

Ms. P. is a nurse-midwife at the Ponce Clinic, a small but busy maternal and child health clinic. She recently attended an infection prevention training and realized that she did not know where medical waste was disposed of at her clinic. Upon returning to the clinic, she discovers that the area designated for waste disposal is a shallow pit in the trees behind the clinic. She notices that there are many plungers for the syringes but not the barrels. She questions the doctors, midwives, and housekeeping staff, but no one knows what happens to the syringe barrels. The providers say that after using the syringes and needles, they remove the needles, place them in empty bottles, and throw the syringes in the trash can. Ms. P. then asks the man who collects and disposes the medical waste about the barrels. He tells her that he once saw some teenage girls who lived near the clinic collecting syringe barrels to use as rollers for their hair, which he thought was clever. What are the waste disposal issues here? Who is at risk of infection or injury, and why? What should be done about this situation?

Case Study 3: Dr. T.

Dr. T. is the director of the Mosi Clinic, which is holding a community health fair. During the opening session, many more community members arrive than the space can accommodate and they spill out into the bushy areas. During the opening speech, a painful wail is heard from the crowd—a man has stepped on a needle and syringe, which is now sticking out of his foot. Upon inspection of the area where the man was standing, Dr. T. finds a pile of fresh medical waste at the base of a tree. He is angry and confused—the clinic has an incinerator, so he does not understand why the medical waste was dumped there. He discusses the issue with the staff responsible for waste disposal, who tell him that they often receive more waste than the incinerator can handle and sometimes have to dump waste in the trees. What are the waste disposal issues here? What can be done about this situation?

Case Study 4: Mrs. D.

Each morning, Mrs. D., a provider in the female ward and PAC procedure room of a district hospital, prepares the 0.5% chlorine solution for the ward and the PAC procedure area. This morning, however, she decides to prepare only enough solution for use in the ward because no PAC procedures were performed yesterday, and the chlorine solution that she prepared yesterday morning for the procedure room remained unused. She figures that the solution from yesterday can be used today. Is she correct? Why or why not?

Case Study 5: Ms. A.

Ms. A., a support staff person, assists the nurses and clinicians in the outpatient department of a busy district hospital and is responsible for cleaning the PAC instruments and other items used during MVA procedures in the PAC room. To make sure that she is always available to assist the team, Ms. A. cleans the instruments and other items used during the prior surgery in the PAC procedure area while the next MVA procedure is performed. The new head nurse responsible for the outpatient department asks her to discontinue this practice. Why would the new head nurse ask Ms. A. to discontinue this practice? What should Ms. A. do instead?

Case Study 6: Dr. C.

Dr. C. has drawn blood from a client, and as she is placing the used needle and syringe in the sharps box, she sticks herself on a needle that is protruding from the sharps box, which is very full. What should Dr. C. do? How can she prevent this from happening again?
Learning Guides and Practice Checklists for Postabortion Care Clinical Skills and Family Planning Counseling Skills

Introduction to the Learning Guides and Practice Checklists

These learning guides and practice checklists aim to help you learn the steps or tasks involved in:

- Screening a client for serious complications and further evaluating the client if medical problems are identified
- Talking with a client before and during a uterine evacuation procedure
- Treating complications of incomplete abortion
- Counseling a client about postabortion family planning (FP)

The practice checklists included in this guide are the same as the ones that the trainer will use to evaluate your performance at the end of the course.

Do not expect to be able to perform all the steps or tasks correctly the first time. Instead, use the learning guides to:

- Assist you in learning the correct steps and the sequence in which the steps should be performed (skill acquisition).
- Measure progressive learning incrementally as you gain confidence and achieve skill competency through the following process:
  - The trainer demonstrates the required skills and client interactions several times using a pelvic model and appropriate audiovisual aids (e.g., video).
  - With supervision from the trainer, participants practice the required skills and client interactions using a pelvic model and actual instruments in a simulated setting that is as similar as possible to the real situation. Participants practice until they achieve skill competency and feel confident performing the procedure.
  - After participants demonstrate skill competency with models they may begin practicing with clients.

Used consistently, the learning guides and practice checklists will enable you to chart your progress and to identify areas for improvement.

The learning guides are designed to increase the ease and efficiency of communication (coaching and feedback) between the participant and trainer. When using the learning guides, it is important that participants and trainers work together as a team. For example, before you attempt the skill or activity for the first time, a trainer (or person evaluating participants, if not the trainer) should briefly review the steps involved and discuss the expected outcome. Then, immediately after you have completed the skill or activity, the trainer (or evaluator) should debrief with you. The purpose of the debrief is to provide positive feedback regarding learning progress and to define the areas (knowledge, attitude, or practice) where improvement is needed, which will help inform subsequent practice sessions.

Because the learning guides are used to assist in developing skills, it is important that the evaluator scores each participant as carefully and as objectively as possible. Your performance of each step will be rated using a three-point scale:

1. **Needs improvement**: Step or task is performed incorrectly, out of sequence, or is omitted
2. **Competently performed**: Step or task performed correctly and in proper sequence, but participant does not progress from step to step efficiently
3. **Proficiently performed**: Step or task is performed efficiently and precisely and in the proper sequence
Using the Learning Guides

Start using the learning guides to follow the steps as the trainer demonstrates the procedure or skill, for instance by using a pelvic model or through role plays. Subsequently, during the classroom practice sessions, the learning guides serve as step-by-step manuals for you as you perform the skill or activity using the pelvic model or, for client counseling, with a peer or volunteer playing the role of a client. During this practice, you will work in teams, with one participant serving as the service provider performing the skill or activity while another participant serves as the evaluator and uses the learning guide to rate the performance or prompt the “service provider,” as necessary. Then, you will trade roles, so everyone has the opportunity to practice demonstrating the skill and providing feedback. During this initial learning phase, trainers will circulate to each group of participants to check how the learning is progressing and to ensure participants are following the steps outlined in the learning guides.

Using the Practice Checklists

The practice checklists include key steps for the procedure, and are more condensed than the full learning guides. As you progress through the course and gain experience, your dependence on the detailed learning guides should decrease. When this occurs, you should shift to using the practice checklists. Further, once all participants feel confident performing a procedure, you will use the practice checklist to rate each other’s performance. These classroom practice sessions can also help facilitate discussion during a clinical conference before you begin practicing serving clients in the clinical setting.

For the clinic practice sessions, you will again work in pairs, with one participant performing the procedure while the other observes and uses the practice checklist to remind the “service provider” of any missed steps. During this phase, the trainer will also be present in the clinic to supervise initial client encounters for each participant. Thereafter, depending on the circumstances, trainers may circulate among the groups of participants to ensure there are no problems and to provide continued coaching to help strengthen the participants’ skills and confidence.

Remember: The goal of this training is that every participant performs every task or activity correctly with clients by the end of the course.
Learning Guide for Postabortion Care Using Manual Vacuum Aspiration: Clinical Skills

Rate the performance of each step or task observed using the following rating scale:
1. **Needs improvement**: Step or task is performed incorrectly, out of sequence, or is omitted
2. **Competently performed**: Step or task performed correctly and in proper sequence, but participant does not progress from step to step efficiently
3. **Proficiently performed**: Step or task is performed efficiently and precisely and in the proper sequence

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
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<tbody>
<tr>
<td><strong>Initial Assessment</strong></td>
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<tr>
<td>1. Assess the client for shock and other life-threatening conditions.</td>
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<tr>
<td>2. If any complications present, stabilize and, if necessary, transfer the client. Confirm that the client is stable before progressing with detailed medical evaluation.</td>
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<tr>
<td><strong>Medical Evaluation</strong></td>
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<tr>
<td>3. Obtain the client’s medical history, including reproductive health history.</td>
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<tr>
<td>4. Perform a physical examination of the client, including pelvic examination.</td>
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<td>5. Perform indicated laboratory tests.</td>
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<tr>
<td>6. Rule out any contraindications to the manual vacuum aspiration (MVA) procedure (first trimester and uterine size up to 14 weeks, incomplete abortion, etc.).</td>
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<tr>
<td>7. Explain findings to the client in an empathetic and respectful manner; counsel the client on the treatment options. Support the client to make a free and informed decision. If the client opts for MVA, explain what will happen before, during, and after the procedure, and explain the pain management regimen.</td>
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<td>8. Obtain written consent for the MVA procedure from the client.</td>
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<tr>
<td>9. Discuss the client’s reproductive intentions, as appropriate.</td>
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<tr>
<td>10. Counsel client on FP and allow them to make a free and informed decision:</td>
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<tr>
<td>» Explain that short-acting methods (such as oral contraceptives and injectables) and implants can be provided immediately after the MVA procedure.</td>
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<tr>
<td>» If the client is considering an intrauterine device (IUD) or sterilization, provide comprehensive counseling on the method and obtain consent for procedure. Explain that the decision to insert an IUD or perform sterilization following the MVA procedure will depend on the clinical situation.</td>
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### Steps and Tasks

<table>
<thead>
<tr>
<th>Getting Ready</th>
<th>Cases</th>
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<tbody>
<tr>
<td>11. Tell the client what is going to happen and encourage them to ask questions.</td>
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<tr>
<td>12. Tell the client that they may feel some discomfort during some of the steps of the procedure and that you will tell them in advance about these steps.</td>
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<tr>
<td>13. Ask the client about any allergies to antiseptics, medications for pain management, and anesthetics.</td>
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<tr>
<td>14. Confirm that the following are available in the procedure room:</td>
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<tr>
<td>» Sterile instruments and supplies used for MVA (speculum and retractor, galipot, sponge holding forceps, tenaculum or vulsellum, MVA kit, receptacle and strainer, antiseptic solution)</td>
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<tr>
<td>» FP methods and sterile kits for long-acting reversible contraceptives (including IUD and implant insertion kits), as required</td>
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<tr>
<td>15. Confirm that emergency medications and equipment are available.</td>
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<tr>
<td>16. Confirm that the appropriate size cannulae and adapters are available.</td>
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<tr>
<td>17. Check the MVA syringe and charge it (establish vacuum).</td>
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<tr>
<td>18. Check that the client has recently emptied their bladder.</td>
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<tr>
<td>19. Check that the client has thoroughly washed and rinsed their perineal area.</td>
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<tr>
<td>20. Assist the client onto the couch or exam table and position them in lithotomy position with drape.</td>
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<tr>
<td>21. Orally administer medication for pain management, 30 to 60 minutes before the MVA procedure (nonsteroidal anti-inflammatory drugs and mild sedative).</td>
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<tr>
<td>22. Put on a clean plastic or rubber apron and other personal protective equipment, such as eye shields or googles. Wash hands thoroughly with soap and water and dry with a clean cloth or allow them to air dry.</td>
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<tr>
<td>23. Put new sterile surgical gloves on both hands.</td>
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<tr>
<td>24. Arrange sterile instruments on a sterile tray or trolley covered with a sterile drape.</td>
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<tr>
<td>25. Continue communicating with the client and providing emotional support throughout the procedure. Have an assistant provide this support, if possible.</td>
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## Steps and Tasks

### Pre-MVA Tasks

<table>
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<tr>
<th>Steps</th>
<th>Cases</th>
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<tbody>
<tr>
<td>26. Perform a bimanual pelvic examination, checking the size and position of the uterus and the degree of cervical dilatation.</td>
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<tr>
<td>27. Insert the speculum and remove blood or tissue from the vagina using sponge holding forceps and sterile gauze.</td>
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<tr>
<td>28. Remove any products of conception protruding from the cervical os with sponge holding forceps; check the cervix and vaginal walls for lacerations, tears, or other anomalies.</td>
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<tr>
<td>29. Apply antiseptic to the cervix and vagina twice, using gauze or a cotton sponge held with sponge holding forceps.</td>
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<tr>
<td>30. Put single-tooth tenaculum or vulsellum forceps on the anterior lip of the cervix.</td>
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### Administering Paracervical Block (administer only if you will perform cervical dilatation)

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<thead>
<tr>
<th>Steps</th>
<th>Cases</th>
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<tbody>
<tr>
<td>31. Fill a 10 ml syringe with local anesthetic (1% without epinephrine). If it is a 2% solution, withdraw 5 ml and dilute it with 5 ml of distilled water.</td>
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<tr>
<td>32. With tenaculum or vulsellum forceps on the cervix, use slight traction and movement to help identify the area between the smooth cervical epithelium and the vaginal tissue.</td>
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<tr>
<td>33. Insert the needle just under the epithelium and aspirate by drawing the plunger back slightly to make certain that the needle is not penetrating a blood vessel.</td>
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<tr>
<td>34. Inject approximately 2 ml of a 1% local anesthetic just under the epithelium, not deeper than 2 to 3 mm, at 3, 5, 7, and 9 o’clock.</td>
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<tr>
<td>35. Wait a minimum of two minutes for the anesthetic to have the maximum effect.</td>
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### MVA Procedure

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<th>Steps</th>
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<tr>
<td>36. Gently apply traction on the cervix to straighten the cervical canal and uterine cavity.</td>
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<tr>
<td>37. If necessary, dilate the cervix using progressively larger cannulae. Hold the cervix steady and gently perform the dilatation by rotating the cannulae (clockwise and anticlockwise) to avoid tearing the cervix with the tenaculum.</td>
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<tr>
<td>38. While holding the cervix steady and applying the no-touch technique, insert the selected cannula gently and slowly into the uterine cavity until it just touches the fundus (not more than 10 cm). Rotating the cannula with gentle pressure may help ease insertion. Note the depth of the uterine cavity with the dots on the cannula. Then withdraw the cannula slightly away from the fundus.</td>
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<tr>
<td>39. Attach the prepared syringe to the cannula by holding the cannula in one hand and the tenaculum and syringe in the other. Make sure the cannula does not move forward as the syringe is attached.</td>
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<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
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<tr>
<td>40. Release the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity.</td>
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<tr>
<td>41. Evacuate any remaining contents of the uterine cavity by rotating the cannula and syringe from 10 to 2 o’clock and moving the cannula gently and slowly back and forth within the uterus.</td>
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<tr>
<td>42. If the syringe becomes half full before the procedure is complete, detach the cannula from the syringe. Remove only the syringe, leaving the cannula in place. Note the volume of products of conception.</td>
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<tr>
<td>43. Gently push the plunger to empty the products of conception into the strainer.</td>
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<tr>
<td>44. Recharge the syringe, reattach it to the cannula, and release the pinch valve(s); proceed with the evacuation of the uterine cavity.</td>
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<tr>
<td>45. Check for signs of completion (red or pink foam, no more tissue in the cannula or a gritty sensation, increased cramping with the client complaining of pain, and the uterus contracting and gripping the cannula). Reassure the client and withdraw the cannula and MVA syringe gently.</td>
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<tr>
<td>46. Remove the cannula from the MVA syringe, noting the volume of the products of conception, and push the plunger to empty the contents into the strainer.</td>
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<tr>
<td>47. Rinse the tissue with water or saline.</td>
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<tr>
<td>48. Quickly inspect the tissue removed from the uterus to be sure the uterus is completely evacuated or determine if there is evidence of a molar pregnancy.</td>
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<tr>
<td>49. If no products of conception are seen, reassess the situation to be sure the client does not have an ectopic pregnancy.</td>
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<tr>
<td>50. Remove the forceps or tenaculum from the cervix and confirm there is no further bleeding from the cervical os or site held with tenaculum and no tears. If there are tears on the cervix, repair before removing the speculum.</td>
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<tr>
<td>51. Perform a bimanual examination to check the size and firmness of the uterus.</td>
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<tr>
<td>52. If the uterus is still soft or bleeding persists, repeat steps 38 to 51.</td>
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<tr>
<td>53. Inform the client that you have completed the emergency evacuation procedure. If the client selected an IUD and is eligible, inform them that you will now insert the IUD. If the client selected implants, offer the method now, but only complete the insertion after removing your soiled gloves, performing hand hygiene, and donning a new pair of sterile gloves.</td>
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<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
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<tr>
<td><strong>Post-MVA Tasks</strong></td>
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<tr>
<td>54. Before removing your gloves, dispose of all waste materials in a leak-proof container or plastic bag, ensuring appropriate waste segregation.</td>
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<tr>
<td>55. Place the speculum and metal instruments in a container filled with clean water.</td>
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<tr>
<td>56. Dispose of the needle and syringe in a puncture-proof container or safety box.</td>
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<tr>
<td>57. Place the used MVA syringe and cannula in a container filled with clean water.</td>
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<tr>
<td>58. Empty the products of conception into a utility sink, flushable toilet, latrine, or container with tight-fitting lid (according to national and/or institutional guidelines and protocols).</td>
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<tr>
<td>59. Thoroughly wash the instruments and the MVA kits before drying and processing for reuse.</td>
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<tr>
<td>60. Remove your gloves by turning them inside out and dispose of them by placing them in a leak-proof container or plastic bag.</td>
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<tr>
<td>61. Wash your hands thoroughly with soap and water; dry with a clean, dry cloth or air dry.</td>
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<tr>
<td>62. Give oxytocin, ergometrine, and/or misoprostol.</td>
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<tr>
<td>63. Allow the client to rest comfortably for at least 30 minutes in a place where they can be monitored. The client should rest for at least two hours at the facility.</td>
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<td>64. Use the pain scale to determine the client’s level of pain and/or discomfort.</td>
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<td>65. Monitor the client’s vital signs before assisting them to move from the couch or exam table to the recovery area.</td>
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<tr>
<td>66. Check for bleeding at least once and ensure that cramping has decreased before discharging the client.</td>
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<tr>
<td>67. Instruct the client regarding post-procedure care and warning signs. Provide information on when they may resume normal work and sexual activity, where they can obtain contraceptive supplies (as necessary), what warning signs they should watch for (e.g., prolonged bleeding, persistent cramping, foul-smelling vaginal discharge, fever, and/or fainting). Provide telephone contact information for the facility and the provider that the client can call if they have any questions or concerns.</td>
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<tr>
<td>68. Tell the client when to return if follow-up care is needed. Let the client know that they can return any time they have concerns.</td>
<td></td>
</tr>
<tr>
<td>69. If the client has not already accepted a contraceptive method, discuss their reproductive intentions and, as appropriate, provide a contraceptive method of choice.</td>
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</tr>
<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
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<tr>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>70. Provide counseling on sexually transmitted infections (STIs) and HIV using the syndromic approach or refer the client for HIV counseling and testing, as appropriate.</td>
<td></td>
</tr>
<tr>
<td>71. Encourage the client to eat, drink, and work as they wish.</td>
<td></td>
</tr>
<tr>
<td>72. Record findings and document the procedures performed.</td>
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</tr>
<tr>
<td>73. Discharge the client in line with institutional guidelines and protocols.</td>
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</tr>
</tbody>
</table>
Checklist for Postabortion Care Using Manual Vacuum Aspiration: Clinical Skills

This checklist should be used by participants during practice sessions and by the trainer to evaluate competency at the end of the course.

Place a “√” in the case box if the step or task was performed satisfactorily, an “X” if it was not performed satisfactorily, or an “N/O” if it was not observed.

- **Satisfactory:** Participant performed the step or task according to the standard procedure or guidelines
- **Unsatisfactory:** Participant unable to perform the step or task according to the standard procedure or guidelines
- **Not Observed:** The participant did not perform the step or task

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Getting Ready</strong></td>
<td></td>
</tr>
<tr>
<td>1. Complete a rapid assessment and ensure the client is stable.</td>
<td></td>
</tr>
<tr>
<td>2. Explain findings to the client in an empathetic, supportive, and respectful manner; explain treatment options.</td>
<td></td>
</tr>
<tr>
<td>3. Provide FP counseling.</td>
<td></td>
</tr>
<tr>
<td>4. Obtain informed consent for the MVA procedure and for FP, as appropriate.</td>
<td></td>
</tr>
<tr>
<td>5. Tell the client what is going to happen and encourage them to ask questions.</td>
<td></td>
</tr>
<tr>
<td>6. Tell the client that they may feel some discomfort during some of the steps of the procedure and that you will tell them in advance about these steps.</td>
<td></td>
</tr>
<tr>
<td>7. Check that client has thoroughly washed their perineal area and has recently emptied their bladder.</td>
<td></td>
</tr>
<tr>
<td>8. Orally administer medication for pain management, 30 to 60 minutes before the MVA procedure (nonsteroidal anti-inflammatory drugs and mild sedative).</td>
<td></td>
</tr>
<tr>
<td>9. Confirm that the required medications, equipment, and supplies are available.</td>
<td></td>
</tr>
<tr>
<td>10. Check the MVA syringe and charge it (establish vacuum).</td>
<td></td>
</tr>
<tr>
<td>11. Put on a clean apron and other personal protective equipment. Wash hands thoroughly with soap and water, and dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>12. Put new sterile gloves on both hands.</td>
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</tr>
<tr>
<td>13. Arrange sterile instruments on a sterile tray or trolley covered with a sterile drape.</td>
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</tbody>
</table>
### Pre-MVA Tasks and MVA Procedure

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>14.</strong> Explain each step of the procedure to the client prior to performing it.</td>
<td></td>
</tr>
<tr>
<td><strong>15.</strong> Perform a bimanual pelvic examination, checking the size and position of the uterus and the degree of cervical dilatation.</td>
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</tr>
<tr>
<td><strong>16.</strong> Check the vagina and cervix for any tissue fragments and remove them.</td>
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</tr>
<tr>
<td><strong>17.</strong> Apply antiseptic twice to the cervix and vagina.</td>
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</tr>
<tr>
<td><strong>18.</strong> Put the tenaculum or vulsellum forceps on the anterior lip of the cervix.</td>
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</tr>
<tr>
<td><strong>19.</strong> Correctly administer the paracervical block, if necessary.</td>
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</tr>
<tr>
<td><strong>20.</strong> Dilatate the cervix, if needed.</td>
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</tr>
<tr>
<td><strong>21.</strong> While holding the cervix steady, insert the cannula gently through the cervix and into the uterine cavity.</td>
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</tr>
<tr>
<td><strong>22.</strong> Attach the prepared syringe to the cannula by holding the cannula in one hand and the tenaculum and syringe in the other.</td>
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<tr>
<td><strong>23.</strong> Evacuate the contents of the uterus by rotating the cannula and syringe and moving the cannula gently and slowly back and forth within the uterus.</td>
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<tr>
<td><strong>24.</strong> Inspect the contents removed to ensure it contains the products of conception.</td>
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<tr>
<td><strong>25.</strong> After observing the signs of a complete procedure, withdraw the cannula and MVA syringe and remove forceps or tenaculum and speculum.</td>
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</tr>
<tr>
<td><strong>26.</strong> Perform a bimanual examination to check the size and firmness of the uterus.</td>
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</tr>
<tr>
<td><strong>27.</strong> Reinsert the speculum and check for bleeding.</td>
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</tr>
<tr>
<td><strong>28.</strong> If uterus is still soft or bleeding persists, repeat steps 21 to 27.</td>
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</tr>
</tbody>
</table>

### Post-MVA Tasks

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>29.</strong> Before removing your gloves, dispose of all waste materials and soak instruments and MVA equipment in clean water.</td>
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</tr>
<tr>
<td><strong>30.</strong> Remove your gloves by turning them inside out and dispose of them by placing them in a leak-proof container or plastic bag.</td>
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</tr>
<tr>
<td><strong>31.</strong> Wash your hands thoroughly with soap and water; dry with a clean, dry cloth or air dry.</td>
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</tr>
<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>32. Check for bleeding and ensure that cramping has decreased at least once before discharging the client.</td>
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<tr>
<td>33. Instruct the client regarding post-procedure care and warning signs.</td>
<td></td>
</tr>
<tr>
<td>34. If the client has not already accepted a contraceptive method, discuss their reproductive intentions and, as appropriate, provide a contraceptive method of choice.</td>
<td></td>
</tr>
</tbody>
</table>
Learning Guide for Postabortion Care Using Misoprostol

Rate the performance of each step or task observed using the following rating scale:

1. **Needs improvement**: Step or task is performed incorrectly, out of sequence, or is omitted

2. **Competently performed**: Step or task performed correctly and in proper sequence, but participant does not progress from step to step efficiently

3. **Proficiently performed**: Step or task is performed efficiently and precisely and in the proper sequence

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Greet the client respectfully and with kindness.</td>
<td></td>
</tr>
<tr>
<td>2. Ensure privacy and assure the client of confidentiality.</td>
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<tr>
<td>3. Inquire about the reason for the visit.</td>
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<tr>
<td>4. Obtain a complete client history.</td>
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<tr>
<td>5. Perform a physical examination, including a pelvic exam.</td>
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<tr>
<td>6. Inform the client of any laboratory examinations needed and perform the test(s).</td>
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</tr>
<tr>
<td>7. Establish a diagnosis: confirm an incomplete abortion, determine the uterine size (gestation less than or greater than 14 weeks), and identify any complications.</td>
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</tr>
<tr>
<td>8. Explain all findings to the client, demonstrating respect and empathy; provide emotional support, as appropriate.</td>
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</tr>
<tr>
<td>9. Counsel the client on options for emergency treatment of an incomplete abortion by explaining that the condition may be treated with medication or surgical treatment. Or, for those who do not want either treatment, through expectant management.</td>
<td></td>
</tr>
<tr>
<td>10. If the client opts for medical treatment with misoprostol, confirm that the client:</td>
<td></td>
</tr>
<tr>
<td>» Is in a stable condition</td>
<td></td>
</tr>
<tr>
<td>» Has no history of allergies to prostaglandins</td>
<td></td>
</tr>
<tr>
<td>» Is showing no evidence of sepsis</td>
<td></td>
</tr>
<tr>
<td>» Is not experiencing severe vaginal bleeding</td>
<td></td>
</tr>
<tr>
<td>» Has no intra-abdominal or genital injuries requiring surgical intervention</td>
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</tbody>
</table>

If the client will be treated as an outpatient, confirm that they will be able to reach the facility within one hour if they develop problems or complications.
11. If the client is eligible for misoprostol, provide additional information and instructions.

- Name of medication, dosage, and number of tablets
- Route of administration, explaining and demonstrating:
  - Sublingual: Place the tablet(s) (depending on prescribed dose) under the tongue for the medication to be absorbed by the body for 30 minutes; then swallow whatever remains.
  - Oral: Swallow the tablets with water.
- When and where to take the medication, either at the facility (for the first dose) or at home (*Note: At the facility is preferable.*)
- Timing for the medication to take effect (*Note: For most clients, complete expulsion of the products of conception will occur within the first 24 hours.*)
- Confirm the client understands the information and answer any questions

12. Explain the expected effects of the medication to the client, noting that the medication will cause rhythmic contractions of the uterine muscles to facilitate complete expulsion of the retained products of conception. Explain possible side effects associated with the treatment including:

- Cramping and lower abdominal pain
- Diarrhea
- Fever and chills
- Light to moderate vaginal bleeding with some clots followed by expulsion of any remaining products of conception
- Nausea and vomiting

13. Explain that most of the side effects are transient and will stop after a short period. Explain that you will provide oral analgesics to help with any lower abdominal pain and cramping. Emphasize the importance of resting and not working or doing chores while the medication takes effect.

14. Describe warning signs and signs of complications. Tell the client that if they experience any of these, to immediately return to the clinic or find emergency care:

- Cramping pain that does not stop with analgesics and is severe or persistent
- Feeling extremely sick
- Foul-smelling vaginal discharge
- Light-headedness, dizziness, or fainting
- Persistent fever
- Severe vaginal bleeding

Ask if the client has any questions and clarify as appropriate.
15. Tell the client that if they need more clarification or have more questions after they return home, to call the facility (provide a phone number), and to return to the facility if they develop any problems.

16. Provide contact information to the client in writing, including the telephone number for the facility and/or an emergency hotline number for the facility, so that they can call if a problem or emergency arises.

17. Explain that if the misoprostol use does not result in the complete expulsion of the retained products, the client may need a repeat dose of misoprostol or to return to the facility for an MVA procedure to remove the retained products.

18. Counsel the client (with their partner, if the client wishes) on contraception.

19. Discuss the need for STI and reproductive tract infection (RTI) prevention and treatment and voluntary HIV counseling and testing, as needed.

20. Provide misoprostol and analgesics to take at the facility and/or at home.

21. Provide the contraceptive method of choice the same day as the misoprostol, unless the client opts for an IUD or female sterilization, in which case, provide the client with condoms to use until returning for the procedure.

22. Provide follow-up care instructions—verbally and in writing, if possible—to the client:
   - If a complete expulsion of the products of conception occurs and they have received their FP method of choice, there is no need to return to the facility unless they experience problems.
   - Clients who choose IUD or female sterilization should return to the facility after one week to receive the FP method (following a health assessment).
   - Do not have sex until the bleeding stops, usually within five to seven days.
   - Do not insert anything in the vagina until the bleeding stops.
   - Do not resume chores until two or three days after a complete expulsion.
   - Return to the facility if they experience any problems or warning signs.
   Ensure the client understands the instructions by asking them to repeat the instructions and allowing them to ask any questions.

23. Complete the client record and relevant registers.

24. Provide the client with any referrals needed for other sexual or reproductive health needs (such as domestic violence or abuse, STI and RTI treatment, HIV testing), and explain where the client should go, if there are costs involved, and if so, how much it will cost. Give the client referral slips, as needed.
Checklist for Postabortion Care Using Misoprostol

**Note:** The content contained within this checklist is adapted from Clinical Monitoring and Coaching Toolkit. This checklist should be used by participants during practice sessions and by the trainer to evaluate competency at the end of the course.

Place a “√” in the case box if the step or task was performed satisfactorily, an “X” if it was not performed satisfactorily, or an “N/O” if it was not observed.

- **Satisfactory:** Participant performed the step or task according to the standard procedure or guidelines
- **Unsatisfactory:** Participant unable to perform the step or task according to the standard procedure or guidelines
- **Not Observed:** The participant did not perform the step or task

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<tbody>
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</tr>
<tr>
<td>2. Obtain a complete history and perform a physical examination, including a pelvic exam.</td>
<td></td>
</tr>
<tr>
<td>3. Establish a diagnosis: confirm an incomplete abortion, determine the uterine size, and identify any complications.</td>
<td></td>
</tr>
<tr>
<td>4. Explain all findings to the client demonstrating respect and empathy.</td>
<td></td>
</tr>
<tr>
<td>5. Confirm that the client is in stable condition and is eligible for misoprostol to treat incomplete abortion.</td>
<td></td>
</tr>
<tr>
<td>6. Counsel the client on options for emergency treatment of an incomplete abortion.</td>
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</tr>
<tr>
<td>7. If the client opts for medical treatment with misoprostol, provide additional information and instructions:</td>
<td></td>
</tr>
<tr>
<td>» Name and dosage of medication</td>
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</tr>
<tr>
<td>» Route of administration</td>
<td></td>
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<tr>
<td>» When and where to take the medication</td>
<td></td>
</tr>
<tr>
<td>» Timing for medication to take effect</td>
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<tr>
<td>8. Explain and ensure that the client understands expected effects and possible side effects of the medication, such as:</td>
<td></td>
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<tr>
<td>» Cramping and lower abdominal pain</td>
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<tr>
<td>» Diarrhea</td>
<td></td>
</tr>
<tr>
<td>» Fever and chills</td>
<td></td>
</tr>
<tr>
<td>» Light to moderate vaginal bleeding with some clots followed by expulsion of any remaining products of conception</td>
<td></td>
</tr>
<tr>
<td>» Nausea and vomiting</td>
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<table>
<thead>
<tr>
<th>Steps</th>
<th>Cases</th>
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<tbody>
<tr>
<td>9. Explain and ensure that the client understands signs of complications and the need to return to the clinic or seek emergency care in the event of:</td>
<td></td>
</tr>
<tr>
<td>» Cramping pain that does not stop with analgesics and is severe or persistent</td>
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</tr>
<tr>
<td>» Feeling extremely sick</td>
<td></td>
</tr>
<tr>
<td>» Foul-smelling vaginal discharge</td>
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<tr>
<td>» Severe vaginal bleeding</td>
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<tr>
<td>10. Tell the client that if they have questions after they return home to call the facility, and to return to the facility if they develop any problems.</td>
<td></td>
</tr>
<tr>
<td>11. Provide contact information so that they can call if a problem or emergency arises.</td>
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<tr>
<td>12. Explain that if the misoprostol does not result in the complete expulsion of the retained products, the client may need a repeat dose or to undergo an MVA procedure.</td>
<td></td>
</tr>
<tr>
<td>13. Counsel the client (with their partner, if the client wishes) on contraception.</td>
<td></td>
</tr>
<tr>
<td>14. Discuss the need for STI and RTI prevention and treatment and voluntary HIV counseling and testing, as needed.</td>
<td></td>
</tr>
<tr>
<td>15. Provide misoprostol and analgesics to take at the facility and/or at home.</td>
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<tr>
<td>16. Provide the contraceptive method of choice on the same day as the misoprostol, unless the client opts for an IUD or female sterilization.</td>
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</tr>
<tr>
<td>17. Provide follow-up care instructions to the client. Ensure the client understands the instructions by asking them to repeat the instructions and allowing them to ask any questions.</td>
<td></td>
</tr>
<tr>
<td>18. Complete the client record and relevant registers.</td>
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</tr>
<tr>
<td>19. Provide the client with any referrals and related information needed.</td>
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</tbody>
</table>
Checklist for Postabortion Family Planning Counseling Skills

This checklist should be used by participants during practice sessions and by the trainer to evaluate competency at the end of the course.

Place a “√” in the case box if the step or task was performed satisfactorily, an “X” if it was not performed satisfactorily, or an “N/O” if it was not observed.

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<tbody>
<tr>
<td><strong>Initial Interview</strong></td>
<td></td>
</tr>
<tr>
<td>1. Greet the client respectfully and with kindness.</td>
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</tr>
<tr>
<td>2. Assess whether contraceptive counseling is appropriate at this time; if not, arrange for counseling at another time.</td>
<td></td>
</tr>
<tr>
<td>3. Ensure privacy and assure the client of confidentiality.</td>
<td></td>
</tr>
<tr>
<td>4. Obtain biographic information from the client (name, address, etc.).</td>
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</tr>
<tr>
<td>5. Assess the client’s reproductive intentions.</td>
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<tr>
<td>6. Ask if client was using contraception before becoming pregnant. If so, find out if they:</td>
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</tr>
<tr>
<td>» Used the method correctly</td>
<td></td>
</tr>
<tr>
<td>» Discontinued use</td>
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</tr>
<tr>
<td>» Experienced any trouble using the method</td>
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</tr>
<tr>
<td>» Had any concerns about the method</td>
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<tr>
<td>7. Help the client to assess their STI and HIV risk status.</td>
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</tr>
<tr>
<td>8. Provide general information about FP.</td>
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</tr>
<tr>
<td>9. Explore with the client any attitudes, beliefs, or past experiences that may favor or rule out one or more methods.</td>
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</tbody>
</table>
10. Give the client information about their preferred contraceptive method, including:
   - Risks and benefits associated with the method
   - The effectiveness of the method
   - When and how to use the method
   - Common side effects and other health problems associated with the method
   - Where and how to obtain resupplies, if applicable

11. Discuss any needs, concerns, and fears the client expresses in a thorough and sympathetic manner.

12. Assist the client in making a free and informed decision about the most appropriate FP method for their situation.

### Client Screening

13. Screen the client carefully to ensure there is no medical condition that may pose a problem with using the preferred method (use a client screening checklist, if available).

14. Help the client implement their decision.

15. Provide the FP method.

16. Review with the client how to use the method correctly.

17. Discuss what to do if the client experiences any side effects or problems.

18. Provide instructions for a follow-up visit, as necessary.

19. Assure the client they can return to the facility at any time to receive additional advice or medical attention.

20. Ask the client to repeat the instructions to confirm understanding.

21. Provide written instructions for the client to take home.

22. Answer any questions the client may have and refer the client for any related reproductive health issues and concerns, as needed.
Postabortion Care Course Evaluation

This evaluation should be used by participants at the end of the postabortion care (PAC) course.

Instructions: Please indicate your opinion of the course components using the rating scale below.

5 – Strongly Agree  4 – Agree  3 – No Opinion  2 – Disagree  1 – Strongly Disagree

1. The Pre-Course Questionnaire helped me to study more effectively.
2. The role play exercises on communication and counseling skills were helpful.
3. There was sufficient time scheduled for practicing communication skills and counseling through role play exercises.
4. The curriculum materials helped me better understand uterine evacuation procedures for treating incomplete abortions prior to practicing with the pelvic model.
5. The practice sessions with the pelvic model made it easier for me to provide PAC to clients.
6. There was sufficient time scheduled for practicing PAC with clients with incomplete abortions.
7. I feel confident providing PAC.
8. I feel confident using the infection prevention practices recommended for PAC.
9. The interactive training approach used in this course made it easier for me to learn how to provide PAC.
10. Ten days were adequate for learning how to provide PAC.

Additional Comments (use reverse side, if needed)

1. What topics (if any) should be added (and why) to improve the course?

2. What topics (if any) should be deleted (and why) to improve the course?