Postabortion Care Curriculum

Trainer Guide

2024
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In 2010, the United States Agency for International Development (USAID) Postabortion Care (PAC) Working Group supported development of the first edition of the global PAC Curriculum under the leadership of Carolyn Curtis, a certified nurse midwife, American College of Nurse-Midwives fellow, and public health specialist with a master of science in nursing. Frances Ganges (consultant, Jhpiego) co-authored the first edition. Members of the PAC Working Group who served during the development of the 2010 curriculum include: Mary Vandenburgoucke, Sarah Harbison, Gary Cook, Lily Kak, Mary Ellen Stanton, Patricia Stephenson, Willa Pressman, Sandra Jordan, Marguerite Farrell, Lindsay Stewart, Maureen Horton, Shawn Malarcher, Lois Schaefer, Patricia MacDonald, Rushna Ravji, Beverly Johnston, Dana Vogel, Michal Avni, Erin Mielke, Margaret D'Adamo, Jewel Gausman, Jennifer Mason, Megan Matthews, Ishrat Husain, Chelsea Smart, Emily Roseman, and Jeff Spieler.

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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 3 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

Introduction

This is the Postabortion Care Curriculum Trainer Guide. This updated guide may be used by trainers, preceptors, and clinical instructors—including clinical mentors and supervisors conducting structured on-the-job training or clinical mentorship. This guide should be used with the updated Postabortion Care Participant Guide, PowerPoint slides, and Reference Manual. This guide provides step-by-step instructions to enable trainers to successfully conduct the course. For each of the curriculum sessions, this document provides guidance on the learning objectives, time allocations, necessary training materials, advance preparation required to ensure readiness for facilitation, and session plans with key activities—including case studies (with answer keys, as applicable), role play exercises, and instructions for demonstration and return demonstration. This guide also includes information about any independent reading or activities that the course participants should complete prior to the session. Finally, the guide provides evaluation tools with detailed instructions.

What’s New in this Revised Postabortion Care Curriculum

The technical content in this curriculum is updated to align with the most recent evidence. This curriculum includes: new technologies, such as use of medical emergency treatment for incomplete abortion; additional information on counseling clients, including youth, before, during, and after emergency treatment for incomplete or inevitable abortion and related complications; additional information on postabortion contraception and other reproductive health conditions, including sexually transmitted infection (STI) and HIV screening, management, and/or referral. The content on postabortion family planning (FP) includes newer contraceptive methods, such as emergency contraception, vaginal ring, patch, and combined hormonal injectable contraception, as well as provision of contraceptives with first dose of misoprostol even before complete expulsion of the products of conception (except for intrauterine device [IUD] and female sterilization). Information related to treating common STIs is also updated in accordance with recent World Health Organization (WHO) guidance.

This revised curriculum has removed outdated practices that are no longer supported by evidence, such as dilatation and curettage as well as use of paracervical anesthesia for pain management in clients diagnosed with incomplete abortion who do not require cervical dilation.

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.

The materials are designed for use by trainers who are formally trained in adult learning principles and participatory learning skills. These trainers should also be proficient in the postabortion care (PAC) skills related to the sessions they facilitate.

Reorganization of Services: A Note for Program Managers

Before healthcare providers can offer 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 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.

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

Appendix A: Addendum to Participant Invitation Letter, outlines what participants will need to bring to the training to be prepared for their clinical experience.

Ideally, administering a pre-course skills assessment would assist trainers in ensuring that participants have the requisite skills. However, this can be time-consuming. Instead, a questionnaire focusing on skills and experience may be used. An example of such a questionnaire is included in Appendix B.

When training nonphysicians, be sure the local service delivery guidelines allow these providers to deliver PAC, including the use of misoprostol as well as vacuum aspiration (VA) equipment. This training can be adapted for different cadres depending on the type of uterine evacuation locally available or in use.

Due to the limited duration of the course, additional clinical time may be needed after the initial training. Participants should be available for on-the-job clinical mentorship or other practice opportunities.

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.
Postabortion Care Curriculum: Trainer Guide

- 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, 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#.
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. Appendix C includes a form to track participants’ progress in completing practice sessions and Appendix D provides information on selecting clinical training sites.

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 the WHO guidance¹¹ include:

- Availability of care
- Accessibility of care, across four dimensions:
  - Economic access
  - Information access


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\textsuperscript{12}
  - Family Planning: A Global Handbook for Providers\textsuperscript{13}
  - Medical Eligibility Criteria for Contraceptive Use, Fifth Edition\textsuperscript{14}
- A Participant Guide containing a questionnaire and practice checklists, which divide skills and activities (such as VA procedures, use of misoprostol for PAC, and FP counseling provision) into essential steps
- This 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 (\textit{Note: These plans should be adapted as appropriate; specific details of the session plan—such as how to carry out a learning activity or methodology—are the responsibility of the trainer or training team.})
- 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 Nepal[15] 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

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 fptraing.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 Trainer Guide is designed for use with the following materials:

- Postabortion Care Curriculum package (2024), including:
  - Participant Guide and Reference Manual (adequate copies of each for all participants)
  - PowerPoint slides, with text from the Reference Manual (Note: Trainers should select the slides that best enhance the content that they will cover but should not use lecture as the only form of training methodology.)
  - 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
- 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

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Training Duration and Class Size

The training is organized into 13 sessions to be completed over a two-week (or 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” and “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>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Day 1</td>
<td>Day 2</td>
<td>Day 3</td>
<td>Day 4</td>
<td>Day 5</td>
</tr>
<tr>
<td></td>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
</tr>
<tr>
<td>8:00 to 8:30 AM</td>
<td>Registration and welcome</td>
<td>• Agenda</td>
<td>• Agenda</td>
<td>• Agenda</td>
<td>• Agenda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Warm-up</td>
<td>• Warm-up</td>
<td>• Warm-up</td>
<td>• Warm-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recap</td>
<td>• Recap</td>
<td>• Recap</td>
<td>• Recap</td>
</tr>
<tr>
<td>8:30 to 10:30 AM</td>
<td>Course Introduction:</td>
<td>Module 1, Session 2:</td>
<td>Module 2, Session 2:</td>
<td>Module 2, Session 6:</td>
<td>Module 2, Sessions 3,</td>
</tr>
<tr>
<td></td>
<td>• Introductions</td>
<td>The Postabortion Care Model</td>
<td>Uterine Evacuation Methods</td>
<td>Medical Treatment for Postabortion Care</td>
<td>4, 5, 6, and 7</td>
</tr>
<tr>
<td></td>
<td>• Expectations</td>
<td></td>
<td></td>
<td>Module 2, Session 7:</td>
<td>Module 3, Session 1</td>
</tr>
<tr>
<td></td>
<td>• Group norms</td>
<td></td>
<td></td>
<td>Postabortion Care Complications and Management</td>
<td>(continued)</td>
</tr>
<tr>
<td></td>
<td>• Logistics and administrative details</td>
<td></td>
<td></td>
<td></td>
<td>• Classroom</td>
</tr>
<tr>
<td></td>
<td>• Training goal, objectives, and schedule</td>
<td></td>
<td></td>
<td></td>
<td>Practice Sessions</td>
</tr>
<tr>
<td></td>
<td>• Training materials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evaluation system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pre-course knowledge assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30 to 10:45 AM</td>
<td>Break</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:45 AM to 1:00 PM</td>
<td>Course Introduction (continued)</td>
<td>Module 1, Session 3:</td>
<td>Module 2, Session 3:</td>
<td>Module 2, Session 7:</td>
<td>Module 2, Sessions 3,</td>
</tr>
<tr>
<td></td>
<td>• Pre-course skill assessment</td>
<td>Values and Attitudes</td>
<td>Pain Management</td>
<td>Postabortion Care Complications and Management</td>
<td>4, 5, 6, and 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Module 3, Session 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(continued)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Classroom</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Practice Sessions</td>
</tr>
<tr>
<td>1:00 to 2:00 PM</td>
<td>Lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Monday</strong></td>
<td><strong>Tuesday</strong></td>
<td><strong>Wednesday</strong></td>
<td><strong>Thursday</strong></td>
<td><strong>Friday</strong></td>
</tr>
<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 2, Sessions 3, 4, 5, 6, and 7 Module 3, Session 1 (continued)</td>
</tr>
<tr>
<td>3:00 to 3:15 PM</td>
<td>Reading Assignment(s) Module 1, Sessions 1, 2, and 3 Module 2, Session 1</td>
<td>Break</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: Sexually Transmitted Infections and HIV Service Provision Wrap-up</td>
<td></td>
</tr>
<tr>
<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 4: Uterine Evacuation via Dilatation and Evacuation</td>
<td>Module 3, Session 1 (continued) Wrap-up</td>
<td>Module 3, Session 2</td>
</tr>
</tbody>
</table>

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

**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. The answer key is included at the end of the questionnaire. An Individual and Group Assessment Matrix is also included and can be used to record participants’ scores. Using this form, the trainer and participants can quickly chart the number of correct answers for all 31 questions. By examining the data in the matrix, group members can easily determine their collective strengths and weaknesses and jointly plan with the trainer how to best use the available time to achieve the desired learning objectives.

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.  
   - Module 2, Session 1, Objective 3 and Module 2, Session 7, Objective 2

2. Obtaining a complete medical history is the first step in assessing a client with possible complications of an incomplete abortion.  
   - Module 2, Session 1, Objective 3

3. An abdominal examination is the best way to determine uterine size.  
   - Module 2, Session 1, Objective 3

4. A client presenting with vaginal bleeding and signs and symptoms of pregnancy may have an ectopic pregnancy.  
   - Module 2, Session 1, Objective 3

5. Foul-smelling discharge may indicate an infection due to an incomplete abortion.  
   - Module 2, Session 1, Objective 3 and Module 2, Session 7, Objective 2

### Infection Prevention

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilized by boiling in water for 20 minutes.  
   - Module 4, Session 1, Objective 9

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.  
   - Module 4, Session 1, Objective 9

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.  
   - Module 4, Session 1, Objective 9

9. Cannulae should be sterilized by autoclaving for 20 minutes at 121°C.  
   - Module 4, Session 1, Objective 9

10. The vacuum aspiration (VA) syringe must be high-level disinfected between clients.  
    - Module 4, Session 1, Objective 9
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. Module 3, Session 1, Objectives 1, 2, and 3

23. Describing adverse side effects is the most important part of postabortion family planning counseling. Module 3, Session 1, Objectives 1 and 2

24. The doctor is best qualified to choose a contraceptive method for a client in good health. Module 3, Session 1, Objective 3

25. An intrauterine device is not recommended for immediate use by postabortion VA clients. Module 3, Session 1, Objective 3

26. A client’s fertility usually returns only after their first menstrual period following an incomplete abortion. Module 3, Session 1, Objective 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. Module 1, Session 2, Objective 3

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. Module 1, Session 2, Objective 3

29. Involving men is not a priority when working with community groups for addressing delays at the community level. Module 1, Session 2, Objective 2

30. Facility-based staff responsible for postabortion care should not be involved in sexually transmitted infection (STI) and HIV counseling and testing. Module 1, Session 2, Objective 3 and Module 3, Session 2, Objective 2

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 3, Session 2, Objectives 3 and 4
Pre-Course Questionnaire: Answer Key

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.  
   - True  
   - Module 2, Session 1, Objective 3 and Module 2, Session 7, Objective 2

2. Obtaining a complete medical history is the first step in assessing a client with possible complications of an incomplete abortion.  
   - False  
   - Module 2, Session 1, Objective 3

3. An abdominal examination is the best way to determine uterine size.  
   - False  
   - Module 2, Session 1, Objective 3

4. A client presenting with vaginal bleeding and signs and symptoms of pregnancy may have an ectopic pregnancy.  
   - True  
   - Module 2, Session 1, Objective 3

5. Foul-smelling discharge may indicate an infection due to an incomplete abortion.  
   - True  
   - Module 2, Session 1, Objective 3 and Module 2, Session 7, Objective 2

Infection Prevention

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilized by boiling in water for 20 minutes.  
   - False  
   - Module 4, Session 1, Objective 9

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.  
   - False  
   - Module 4, Session 1, Objective 9

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.  
   - False  
   - Module 4, Session 1, Objective 9

9. Cannulae should be sterilized by autoclaving for 20 minutes at 121°C.  
   - False  
   - Module 4, Session 1, Objective 9

10. The vacuum aspiration (VA) syringe must be high-level disinfected between clients.  
    - False  
    - Module 4, Session 1, Objective 9
Medical Evacuation Methods

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

Vacuum Aspiration Provision

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

18. Pain management should be a part of care for all clients requiring uterine evacuation for treatment. **True** 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. **False** Module 2, Session 5, Objective 5

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

21. When performing VA procedures, the vacuum will be lost if the uterus is perforated. **True** 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. **True** Module 3, Session 1, Objectives 1, 2, and 3

23. Describing adverse side effects is the most important part of postabortion family planning counseling. **False** Module 3, Session 1, Objectives 1 and 2

24. The doctor is best qualified to choose a contraceptive method for a client in good health. **False** Module 3, Session 1, Objective 3

25. The intrauterine device is not recommended for immediate use by postabortion VA clients. **False** Module 3, Session 1, Objective 3

26. A client's fertility usually returns only after their first menstrual period following an incomplete abortion. **False** Module 3, Session 1, Objective 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. **True** Module 1, Session 2, Objective 3

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. **True** Module 1, Session 2, Objective 3

29. Involving men is not a priority when working with community groups for addressing delays at the community level. **False** Module 1, Session 2, Objective 2

30. Facility-based staff responsible for postabortion care should not be involved in sexually transmitted infection (STI) and HIV counseling and testing. **False** Module 3, Session 2, Objective 2 and Module 1, Session 2, Objective 3

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. **True** Module 3, Session 2, Objectives 3 and 4
## Postabortion Care Course: Individual and Group Assessment Matrix

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Correct Answers (Participants)</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</td>
<td>Initial Assessment</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Infection Prevention</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>Medical Evacuation Methods</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Vacuum Aspiration Provision</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
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### Postabortion Care Course: Individual and Group Assessment Matrix (continued)

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Correct Answers (Participants)</th>
<th>Categories</th>
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**Categories**
- Postabortion Family Planning
- Community Empowerment and Sexually Transmitted Infection and HIV Counseling and Referral
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.

Time Allocation
4 hours

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Videos
- Name tags
- Course schedule (with copies for all participants)
- Pre-course questionnaire, answer key, and individual and group assessment matrix
- Course materials for each participant (e.g., Participant Guide and Reference Manual)

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Prepare flip charts (for instance, one with a welcome and one for writing expectations and norms).
- Collect all necessary training equipment and supplies listed under Training Materials.
- Confirm with any invited guests (such as government officials) on the timing of their attendance, for instance, to officially open and/or close the training.
- Confirm that all co-trainers are available and prepared to facilitate the training.

Session Presentation and Delivery
Trainers should decide on the format of the opening session in advance. This session should include an overview of the topics that the training will cover and provide information regarding how the topics will be presented. If there will be a formal opening ceremony, include time for that activity within the schedule.

Pre-Course Questionnaire
Distribute the pre-course questionnaire and explain its purpose, which is to:
- Help trainers form participant teams for group work and identify training approaches for participants who need special assistance.
• Obtain information on participants’ knowledge, experiences, and prior training, which will assist trainers in tailoring the course to individual and group needs.

• Obtain baseline training-related data that will help supervisors and managers plan further capacity development activities. Trainers and program managers can also use baseline information to evaluate the training program.

**Evaluation Tools**

Guide participants through the course evaluation process, including post-training tasks expected of PAC providers. Evaluation tools for this training may include:

- Pre-course questionnaire
- Pre-course skills assessment
- Daily PAC training evaluation report (or similar evaluation material)
- Daily session trainer evaluation (completed by participants)
- Clinical evaluation of performance in classroom and clinical settings, scored on checklists
- Mid-course and/or post-training questionnaire
- Participants’ end-of-course evaluation
- Participant feedback report
### Session Plan: Day 1
**Introduction to the Postabortion Care Training Course**

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 minutes</td>
<td>Welcome and introduce participants and facilitators</td>
<td>Welcome participants and confirm everyone has arrived</td>
<td>Warm-up exercise or ice-breaker</td>
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<td>Introduce an exercise or icebreaker</td>
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<tr>
<td>15 minutes</td>
<td>Review training objectives and schedule</td>
<td>Read and distribute training objectives</td>
<td>Presentation</td>
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<td>Explain each objective, encouraging participants to ask questions</td>
<td>Group discussion</td>
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<td>Present the training course schedule</td>
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<td>10 minutes</td>
<td>Share individual expectations for the training</td>
<td>Establish participant and facilitator expectations</td>
<td>Small group discussion</td>
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<td>After small group discussion, ask participants to share expectations and record</td>
<td>Group discussion</td>
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<td>responses on a flip chart</td>
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<td>Compare expectations with training goals and objectives</td>
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<td>10 minutes</td>
<td>Establish group norms</td>
<td>Agree on the norms set by participants and facilitators</td>
<td>Brainstorming</td>
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<td>Group discussion</td>
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<tr>
<td>30 minutes</td>
<td>Identify participant strengths and limitations based on the pre-course questionnaire</td>
<td>Facilitate the pre-course knowledge questionnaire and complete scoring</td>
<td>Written knowledge assessment and scoring</td>
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<td><em>Note: Trainers should use the break to record scores in the matrix; review can take place anytime thereafter on the first day.</em></td>
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<td>20 minutes</td>
<td>Review pre-course questionnaire analysis and daily evaluation report</td>
<td>Review the pre-course knowledge questionnaire scores and assure participants that</td>
<td>Review</td>
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<td>the training will enable them to answer all questions correctly during mid-point</td>
<td>Group discussion</td>
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<td>and final assessments</td>
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<td>2 hours, 15</td>
<td>Assess participants' skills in:</td>
<td>Assess participants' individual skills, including: counseling skills (using role</td>
<td>Pre-course skill assessment</td>
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<tr>
<td>minutes</td>
<td>• Counseling</td>
<td>plays) and clinical skills (using pelvic models)</td>
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<td>• Performing a pelvic exam</td>
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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, 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.

Time Allocation

2 hours 40 minutes

Training Materials

- Projector, laptop, and PowerPoint slides
- Videos, such as “Caring Completely” and/or “Why Did Mrs. X Die?” (optional, if available)
- Flip chart stands, paper, and markers
- Brainstorming exercises
- Handouts
- National policy guidelines, protocols, and norms and standards for managing abortion-related complications as well as facility guidance documents on abortion

Advance Preparation

- Review (and update, as needed) all training materials for the session.
- Print adequate copies of handouts and prepare flip charts.
- Obtain and review copies of national abortion regulations and laws applicable to your participants as well as examples of local facility policies and regulations for PAC. Consider printing or saving electronic copies of these materials to distribute to participants.
- Consider including in the participant invitation letter a request to share copies of local statistics and policies on PAC, including facility policies, if appropriate. Use this information to emphasize the magnitude of maternal mortality in the local context.
- Prepare an exercise to compare national policies with facility policies and practices as well as evidence from the Reference Manual. For instance, a role play exercise in which a couple seeking PAC asks questions; alternatively, assign small groups different policies to review and present.
Session Presentation

- Due to the importance of this topic, allow ample time for discussion. It is essential that participants understand their scope of practice regarding PAC, the flow of clients through a facility, and clients’ rights within the context of local laws. This discussion may continue throughout activities for objectives 4, 5, and 6 and/or as an introduction to the topic of how laws and policies affect PAC.

- Following the discussion of national policies, facilitate a discussion around what happens when clients visit participants’ facilities for PAC. Outline where services begin, who provides emergency treatment services, where misoprostol is dispensed to outpatient clients, who provides family planning (FP) counseling, and where FP services for PAC clients occur. Provide handouts with this information, if possible.

- The review of PAC standards should cover the following: who delivers which aspects of PAC; who is eligible for PAC, who are the priority PAC service groups (for example, youth), which health departments need to coordinate with PAC providers, how often and under what conditions is PAC provided, and how is PAC managed and supervised to ensure quality.

Questions to Prompt Discussion

- 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 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?
Resources
Examples of national policy and service delivery guidelines, such as those listed below, may be useful in discussions about how policy impacts PAC at the facility level.

### Examples of National Postabortion Care Policies and Guidelines

<table>
<thead>
<tr>
<th>Country</th>
<th>Policies/ Guidelines</th>
</tr>
</thead>
</table>
| **Bolivia**  | • Supreme Decree #25265 (1998): Addresses basic healthcare that promotes preventive and curative services to reduce maternal and infant morbidity and mortality  
• Ministerial Resolution #0133 (1999): Sets the scope of the government’s obligation to protect the health and well-being of the Bolivian population  
• Law #1788, Article 11 of the Bolivia Health Code: Details the norms, supervision, and evaluation of the national health system for improving service quality in line with the government’s Strategic Health Plan  
• Supreme Decree #26874 (2002): Describes the universal maternal and infant health insurance scheme  
• Law #2426 (2002): Details planning, acquisition, and maintenance of equipment in sufficient quantities for clients seeking treatment for a hemorrhage during the first half of pregnancy |
| **Kenya**    | • National Guidelines for Quality Obstetrics and Perinatal Care (n.d.): Ministry of Public Health and Population Standards, Chapter 14, with guidance related to postabortion contraception |
| **Nepal**    | • National Medical Standard for Reproductive Health, Volume 1, Contraceptive Services (2020): Ministry of Health and Population standards, Chapter 14, including PAC guidance |
| **Philippines** | • Administrative Order No. 2016–0041, National Policy on Prevention and Management of Abortion Complications (2016): Department of Health guidelines, including the scope of PAC, PAC procedures and responsibilities at each level of the healthcare system, and a general statement on quality assurance |
| **Tanzania (Zanzibar)** | • Guideline for Post Abortion Care Service Delivery (2019): Zanzibar Ministry of Health guidelines |
| **Uganda**   | • Clinical Guidelines, National Guidelines for Management of Common Conditions (2016): Ministry of Health guidelines, including PAC and contraception |
# Session Plan: Module 1, Session 1

**Issues Surrounding Miscarriage, Induced Abortion, and the Delivery of Postabortion Care**

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
</table>
| 5 minutes| **Introduce the session**  
Review learning objectives                        | Select an activity to set the stage for learning  
Display and discuss learning objectives | Warm-up exercise or icebreaker  
Presentation  
Group discussion                              |
| 30 minutes| **Watch a video (optional)**                                                         | Present video and discuss maternal mortality (or other video topic)               | Video presentation  
Group discussion                                                          |
| 10 minutes| **Define the term “abortion” (Objective 1)**                                         | Review the definition (write the definition on a flip chart or slide for display) | Group discussion                                                     |
| 10 minutes| **Discuss the magnitude of maternal mortality worldwide and nationally (if known) (Objective 2)** | Discuss the magnitude of maternal mortality, mortality from unsafe abortion, and local maternal health statistics | Interactive presentation  
Brainstorming  
Group discussion (may overlap with Objectives 5 and 6)                        |
| 15 minutes| **Explain possible reasons for spontaneous abortion or miscarriage (Objective 3)**    | Review the handout entitled “Spontaneous Loss of Pregnancy” and discuss factors contributing to spontaneous abortion | Interactive presentation  
Brainstorming  
Group discussion                                                             |
| 15 minutes| **Explain possible reasons a client may choose to have an induced abortion (Objective 4)** | Review the handout entitled “Why Clients Seek Abortion Services”                  | Interactive presentation  
Brainstorming  
Group discussion                                                             |
| 15 minutes| **Describe national abortion laws and regulations and how they impact PAC (Objective 5)** | Link local policy and legislation with PAC delivery, including how one impacts the other | Brainstorming  
Group discussion                                                             |
| 10 minutes| **Explain the rationale for this training and the overall training goal**              | Review the training goal and rationale, including how it relates to participants’ work | Presentation  
Group discussion                                                             |
### Session Plan: Module 1, Session 1
**Issues Surrounding Miscarriage, Induced Abortion, and the Delivery of Postabortion Care**

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
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</thead>
</table>
| 15 minutes| Describe facility policies for PAC and how they impact service delivery (Objective 6)  | Discuss how facility policies and practices can facilitate or hinder PAC and review the flow of PAC clients at the facility  
Facilitate an exercise to compare national policies with facility policies and practices as well as evidence from the reference manual  
*Note: See Advance Preparation for ideas.*                                      | Brainstorming  
Group discussion  
Group exercise                                                  |
| 35 minutes| Discuss contributing factors to spontaneous and induced abortion                       | Discuss contributing factors to spontaneous and induced abortion                                                                                                                                             | Brainstorming  
Group discussion                                                  |
Brainstorming Exercise: Factors Contributing to Spontaneous and Induced Abortions
1. While one trainer documents responses on a flip chart, ask participants: “What factors contribute to spontaneous and induced abortion?”
2. After participants have responded, review the list on the flip chart and briefly discuss each factor as a group.
3. Use prepared slides and/or handouts to summarize the contributing factors.

Brainstorming Exercise: Factors Affecting Access to and Provision of Postabortion Care
1. Identify three factors from each of the following areas that contribute to the ability to provide PAC or provide access to PAC:
   » Individual (e.g., age or marital status)
   » Community
   » Health services
2. 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.
3. Record responses on flip chart paper (see below for how to prepare the flip chart).

Factors That Hinder or Facilitate the Access to and Provision of Postabortion Care

<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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Trainer Notes:
This exercise may be more useful at the end of the training, prior to an action plan activity.
Handout: Spontaneous Loss Of Pregnancy

The World Health Organization defines spontaneous abortion (or miscarriage) as the spontaneous loss of a clinical pregnancy before 20 completed weeks of gestation or, if gestational age is unknown, a weight of 500 grams or less. As of 2019, the World Health Organization estimates that, worldwide, up to 39 abortions (spontaneous and induced) occur each year per 1,000 women ages 15 to 49 years. Most reported abortions are induced; however, an estimated 23 million spontaneous abortions occur each year, translating to 44 pregnancies lost every minute. Most miscarriages occur between the 6th and 12th weeks of pregnancy and can result in complete or incomplete expulsion of the products of conception. Caring for clients experiencing a miscarriage may require specific counseling and support, particularly for those grieving the loss of a pregnancy and/or experiencing anxiety concerning future fertility. The exact cause of a spontaneous abortion in many cases may not be clear, even after a thorough history and physical examination. However, clients who experience multiple miscarriages should undergo further evaluation. Some known factors that contribute to miscarriages include:

- Genetic factors
- Hormonal factors, including:
  - Hypothyroidism
  - Polycystic ovarian syndrome
  - Poorly controlled diabetes (as well as other blood sugar metabolism disorders)
- Infections, including:
  - Bacterial, fungal, parasitic, and viral infections
  - Malaria (there is a strong association between malaria during pregnancy and an increased risk of spontaneous abortion)
  - Sexually transmitted infections (prompt treatment of sexually transmitted infections during pregnancy can reduce the risk of spontaneous abortion)
- Gender-based violence (physical violence during pregnancy is linked with higher rates of miscarriage)
- Other contributing factors:
  - Medications
  - Environment
  - Other medical illnesses
  - Placental abnormalities
  - Smoking

Note: HIV status in the era of combination antiretroviral therapy does not demonstrate a risk for miscarriage.
Handout: Induced Abortion—Why Clients Seek Abortion Services

There are multiple reasons why clients seek abortion services when experiencing unplanned pregnancies. Some may have become pregnant due to a lack of power to negotiate sexual activity and/or use of contraception. The cultural and social environment in which a client lives, the dominant religion, and their personal beliefs all can contribute to the decisions they make about an unintended pregnancy and the services they seek.

In addition, providers may indirectly influence whether clients seek care. For example, the sociocultural perspectives and religious beliefs of health workers affect their attitudes toward clients seeking abortion services. If these attitudes are negative, clients may be reluctant to access care in a timely manner.

It is important to remember that every client’s situation is different and the factors that lead a client to seek abortion care vary widely. Knowing the reason for a client’s decision can assist providers in individualizing counseling, care, and referrals. Possible reasons why clients seek abortion are listed below.

- Economic problems, such as:
  - Inadequate income to care for a baby
  - Lack of employment

- Social and cultural problems, such as:
  - A pregnancy outside of marriage
  - Cultural and religious stigma
  - Preference for a male child (if the fetus is a female)
  - Pressure or coercion to have an abortion

- Medical problems, such as:
  - A history of medical problems during pregnancy
  - A history of obstetric complications
  - Knowledge that the child will be born with serious health problems

- Unintended pregnancy, due to:
  - Lack of access to contraception
  - Contraceptive method failure
  - Rape or incest

- Other reasons, such as:
  - Desire to delay pregnancy for personal circumstances
  - Desire to limit or space pregnancies
  - School enrollment status
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.

Time Allocation
2 hours

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Case study
- Small group exercise
- National clinical guidelines and protocols related to emergency treatment of different types of abortion and abortion-related complications
- Global statements on PAC, including: Postabortion Family Planning: A Critical Component of Postabortion Care

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Inform participants of required reading assignments.

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<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
</table>
| 5 minutes | Introduce the session  
Review learning objectives  
Allow participants to ask questions and respond, as needed | Select an activity to set the stage for learning  
Display and discuss learning objectives | Warm-up or icebreaker  
Presentation (consider involving participants in reading objectives) |
| 15 minutes | Define the term “postabortion care” (Objective 1) | Display and discuss the definition and components of PAC  
Introduce the case study and divide participants into small groups | Interactive presentation  
Group discussions and presentation |
| 20 minutes | Explain why counseling should be integrated throughout all components of PAC (Objective 2) | Discuss the importance of integrating counseling throughout all components of PAC  
Discuss examples of counseling for each component, emphasizing that timing varies depending on topic  
Have participants share examples of counseling topics that may cross components; for example, ask participants when clients with bleeding early in pregnancy should be counseled, while one of the trainers records responses on a flip chart  
*Note: Responses should include during and immediately after the assessment, during emergency treatment, post-procedure or after emergency treatment, and at discharge.* | Interactive presentation  
Group discussion  
Brainstorming |
| 40 minutes | Outline the three components of the USAID PAC model and the main elements of each (Objective 3) | Display the PAC model and discuss each of the three components, including what each component includes for each level of care | Interactive presentation  
Small group exercise  
*Note: This may include an optional activity.* |
### Session Plan: Module 1, Session 2
The Postabortion Care Model

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
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</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Explain the difference between emergency obstetric care and PAC (Objective 4)</td>
<td>Discuss the difference between emergency obstetric care and PAC, emphasizing that without FP counseling and services, PAC is incomplete</td>
<td>Group discussion</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Explain three benefits associated with PAC (Objective 5)</td>
<td>Explore the benefits of PAC, including increased contraceptive acceptance rates, increased access to FP, reduced repeat abortions</td>
<td>Group discussion</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Role play, video, or discussion</td>
<td>Optional activity, as time permits (examples provided)</td>
<td>Optional activity</td>
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</table>
Case Study Exercise

Instructions
Inform participants that the following exercise will help them to understand the concept of PAC. They are not expected to know the clinical aspects at this time, only the PAC components as outlined in the reference manual. Let participants know that they can use an observation checklist as a guide and make notes as they listen to the story. Ask participants to listen for aspects of the following in the story:

- Community awareness and mobilization
- Treatment of an incomplete abortion
- Contraceptive counseling and services

After reading the story, lead a group discussion about which PAC components were included, missing, and/or incomplete.

Case Study
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.

Discussion Questions
The following are some sample questions to help guide the discussion; they can be modified or adapted, as needed, including if different stories are used for the case study.

- What would you say to Mrs. Joko during your first encounter with her?
- What problems can you identify with this story?
• What are possible solutions for the identified problems?
• What would you say to Mrs. Joko to address her needs and fears?
• How was Mr. Joko involved in this discussion?
• How could the community support this family?
• Based on this situation, how can the community become more aware of problems associated with bleeding during pregnancy?

Small Group Exercise
Divide the group into three small groups and assign one PAC component to each group. Ask each group to discuss and present back to the larger group the following question: “How should we attend to a client presenting with an incomplete abortion?” Themes that should ideally emerge from these discussions are included below.

**Group 1**
Client assessment and evaluation, stabilization, pain management, counseling, and emergency treatment

**Group 2**
Provision of contraceptive counseling and method of choice; assessment of risk for sexually transmitted infections (STIs), including HIV; referral for STI management and/or HIV counseling and testing

**Group 3**
Community empowerment about the benefits of PAC; community understanding of problems related to bleeding in early pregnancy; development of strategies for facilitating access to PAC; facilitation of availability of resources required for accessing and providing care; establishment of functional referral systems; establishment of linkages between the community and various levels of care in the health system; facilitation of access to and efficient provision of PAC
Module 1, Session 3: Values and Attitudes

Note: The content contained within this module is adapted from Counseling the Postabortion Client: A Training Curriculum.29

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.

Time Allocation
2 hours, 15 minutes

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Group exercises
- Brainstorming exercise
- Role plays
- Case studies
- Handout
- Video, such as, Put Yourself in Her Shoes: Family Planning Counseling to Prevent Repeat Abortion30 (optional, if available or other, as appropriate)

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Print adequate copies of handouts and prepare flip charts.
- Review the exercises and role plays in this session and decide which are appropriate for your setting. Prepare and/or review scripts and instructions for the client, provider, and observers for the role play exercise. Practice the role play exercise with co-trainers and revise scripts, as needed. Adapt the session plan, including timing, as needed.
- Ask participants to read the relevant sections of the resource manual.

Trainer Notes
This session may be followed by sessions on FP counseling and service provision instead of emergency treatment and complications. This sequence may be helpful if participants need time for an FP update. This may also help to reinforce the information and the importance of FP counseling before, during, and after emergency treatment.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session</td>
<td>Select an activity to set the stage for learning</td>
<td>Warm-up or icebreaker Presentation (consider involving participants in reading objectives)</td>
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<tr>
<td></td>
<td>Review learning objectives</td>
<td>Display and discuss learning objectives</td>
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<td>Ask if there are any questions and clarify as needed</td>
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<tr>
<td>15 minutes</td>
<td>Discuss how people have different perceptions, using images</td>
<td>Display images on slides or distribute handouts with images and ask participants to share their perceptions Note: See Images and Perceptions.</td>
<td>Interactive presentation Group discussion</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Define the terms &quot;value&quot; and &quot;attitude&quot; (Objective 1)</td>
<td>Define the terms &quot;value&quot; and “attitude” and ask participants to explain these terms in their own words</td>
<td>Interactive presentation Brainstorming</td>
</tr>
<tr>
<td>1 hour, 5 minutes</td>
<td>Explain the importance of being aware of our own values and attitudes (Objective 2)</td>
<td>Facilitate a discussion on values and attitudes as well as empathetic and non-empathetic providers Conduct the values clarification exercise; explore provider attitudes through group discussion after the exercise</td>
<td>Interactive presentation Group exercise Role play exercise Case studies</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Explain the importance of unconditional respect and protecting and fulfilling the human rights of all clients (Objective 3)</td>
<td>Explore clients’ perspectives through group discussion and a learning activity Note: Depending on time, the activity could be watching the Putting Yourself in Her Shoes video, or other relevant film, and discussing in small groups.</td>
<td>Group discussion Video (optional)</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Demonstrate respect during counseling sessions or classroom activity (Objective 4)</td>
<td>Demonstrate respect for PAC clients during counseling through role play exercises Note: Additional practice counseling PAC clients is included in sessions on emergency care and postabortion FP.</td>
<td>Role play exercises Case studies Group discussion</td>
</tr>
<tr>
<td>5 minutes</td>
<td>Summarize the session</td>
<td>Confirm that all learning objectives have been accomplished</td>
<td>Interactive presentation</td>
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Group Exercise: Images and Perceptions

Instructions

- Divide participants into teams of two. Distribute handouts or display slides with first image (use another example, if this one is familiar).
- Ask participants to review the images and share what they see with their partner. Then, ask for volunteers to share their thoughts with the larger group.
- If a participant describes an elderly woman, ask others who saw the same to raise their hands. Do the same for those that describe a young woman.
- Discuss this exercise by asking the following questions:
  - Did you and your partner immediately agree on what you saw?
  - How do you explain how people in the group saw two different images in the same picture?
  - How do you think this applies to counseling PAC clients?
- Repeat this exercise for other images, as time allows.

Images for Discussion

Ambiguous Figure (left)

**The Dynamic Ebbinghaus**

*Question:* Look at the center dots on both the left and right. Which dot is bigger?
*Answer:* They are both the same size.

**Sara Nader** (below)

*Question:* Do you see a woman or a musician?

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

*Question:* Do you see a young or old woman?
Schachibretoge (below)

**Question:** Are the lines straight or are they curved?

**Answer:** All the lines are straight—measure against the straight edge of a piece of paper or ruler.

**Source:** Muristerberg, H. 1897. “Schachibretoge” Z. Phycol 5, 184–86.

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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?

Brainstorming Exercise: Defining “Value” and “Attitude”

- Ask participants to define the terms “value” and “attitude” in their own words.
- Responses should include:
  - A value is a belief that is important to an individual. Values are also moral principles or accepted standards of a person or group. Values can be influenced by educational, cultural, or religious factors, as well as by personal experiences. A value judgment is a subjective assessment based on one’s beliefs or one’s experience and social characteristics.
  - An attitude is a feeling, opinion, or view that is formed by values or beliefs.
- After discussing the definitions individually, highlight the substantial overlap between the two terms.
- Ask participants to give a few examples of their own personal values and attitudes based on their beliefs.
- Discuss how some of their values and attitudes may be different from those of their clients and how to manage those differences in a counseling context.

Group Exercise: Values Clarification Activity

Instructions

- Place signs reading “Agree,” “Disagree,” and “Unsure” at different locations in the room.
- Explain that participants will now explore their own attitudes and values about PAC and postabortion clients through a group exercise.
- Explain the activity by saying: “I will read several statements aloud. When I read each statement, move to the sign that best reflects your opinion—meaning, whether you agree, disagree, or are unsure.”
- Read as many statements as time allows from the list of Sample Value Statements. After participants move according to their opinion, ask one or two participants from each group to explain their positions.

Sample Value Statements

Note: The statements included here draw from the Counseling the Postabortion Client: A Training Curriculum31 as well as contributions from reviewers of this updated curriculum.

- Doctors have a responsibility to terminate unplanned pregnancies that result from contraceptive failure.
- A woman’s role is to bear children.
- A woman should have an abortion if her husband wants her to, even if she wants to continue the pregnancy.
- It is okay for an unmarried man to engage in sexual activity.

• It is okay for an unmarried woman to engage in sexual activity.
• Healthcare providers should promote abstinence as the best family planning method for unmarried women.
• An unmarried schoolgirl who becomes pregnant does not deserve to be expelled from school.
• A woman who has multiple abortions should be sterilized.
• If a woman consistently has miscarriages, she must be doing something wrong.
• Parents have a right to know if their daughter has an abortion (either induced or spontaneous).
• It is in a man’s nature to be a polygamist (to be with many women).
• If a woman deliberately induces an abortion, she is committing murder.
• Women who induce abortions deserve to suffer and should expect to feel pain during PAC procedures.
• If abortion is legal, people will be more promiscuous and less responsible about sex.
• In a couple, the woman should be responsible for contraception.
• If a postabortion client has many children, she should be encouraged to undergo sterilization.
• Contraceptive methods should be available to adolescents and unmarried adults.
• Spacing between pregnancies should be decided by God and not interfered with by contraception.
• Providers who disagree with abortion should not provide PAC.
• A woman who is physically abused during pregnancy did something to deserve the abuse.
• Men who use condoms are promiscuous.
• Women who have induced abortions should feel guilty.
• Young women who present with abortion complications have probably induced their abortions.
• Women who induce abortions should be required to pay for otherwise free medical services.
• Women who have spontaneous abortions deserve more compassion than those who seek induced abortions.
• A married, multiparous woman who terminates a pregnancy does not want to have any more children.

Discussion Questions
After completing the exercise, debrief by asking the group questions, such as:
• Which statements caused the most disagreement? What could explain these differences?
• Were any of the results of the exercise surprising to you? Which ones? Why do you think this is so?
• How might we express these attitudes to clients? How might these attitudes make clients feel?

Activity Summary
Remind participants that while they may come from similar backgrounds, they had different responses to the statements. A couple of reasons why this is important include:
• Different experiences lead people (providers and clients) to different conclusions.
• Being aware of our own attitude helps ensure that we do not impose our values on our clients.

Tell participants that the next activity will demonstrate the difficulty of keeping personal values and attitudes separate from professional responsibilities, and how this can affect client care.

Trainer Notes
Do not distribute these statements as a handout, because participants (or others who may see these materials), may misunderstand the intent of the exercise and think that these statements reflect the beliefs of the trainers.
Role Play Exercise: Counseling Session

Instructions

Explain that this exercise is a role play focused on counseling PAC clients and that a few participants will role play the parts of empathetic and non-empathetic providers with clients while the rest of the group observes. The exercise will help participants understand how empathy influences the effectiveness of a counseling session.

Ask for volunteers to participate in the role-play exercise in front of the group—two volunteers for each scenario, one to be a provider, the other a client. Give the volunteers instructions separately from the group.

Trainer Notes

Depending on the time available, determine if it is possible to complete one or both scenarios (or more). Choose from either of the situations included or adapt one, as needed, for the local context. We do not recommend having participants split into groups to practice and observe the different scenarios.

Scenarios and Roles: Guidance for Volunteers

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. Explain to the volunteers that 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
Activity Summary
After completing both role plays (or one role play, with empathetic and non-empathetic providers, if time is a constraint), have each provider and client comment on how they felt during the role play. Then, ask the group to discuss what they observed. Prompt this discussion by asking how provider empathy affects the client and the interaction and how participants would describe or define empathy. Record the responses on a flip chart.

Remind participants: 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 raise participants' awareness of their emotional responses to clients and to help them to become aware of specific thoughts and actions that they can employ to convey empathy and encourage two-way communication.

Ask participants to individually generate a list of emotions that they or their colleagues experience during their daily interactions with clients. After a few minutes, ask participants to form pairs and share their lists and to discuss how their emotions affect how they act toward clients. Ask for volunteers to share one or two responses with the larger group to wrap up the activity.

Case Studies Exercise
Use these case studies to guide additional discussions. Consider adapting case studies to local languages and local issues to make them more relevant for participants. Choose as many as appropriate for the participants' learning needs; this includes creating additional case studies, if needed. Allow approximately 10 to 15 minutes for each case study. There is no answer key for this exercise as the responses to questions will depend on the local setting.

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**

**Instructions**
- Explain that this exercise will help participants understand client’s feelings and experiences.
- Create a flip chart with three columns labeled with: “Emotions,” “Reasons,” and “Responses.”
- Explain to the group that their assignment is to think about how they would feel if they were the clients described in the following scenarios, why they might have such feelings, and how healthcare providers can respond to help resolve the situation.
- Divide participants into four small groups and assign each group one of the following scenarios to role play. Read each scene aloud before each role play.
  - **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.
- Potential questions “providers” can ask “clients” during this exercise to explore their fertility intentions include:
  - How many children do you have?
  - How many more children do you want?
  - When would you like to have your next child?
  - What contraceptive method or methods do you use now?
  - What contraceptive methods do you know about or have you heard about?
- After each role play, ask participants to share the emotions they associated with the client, while a trainer records responses on the prepared flip chart (refer to the illustrative answers on the next page to help prompt the discussion, if necessary). Consider creating and completing a new chart for each scenario.
## Illustrative Answers

This chart shows examples of potential responses; however, there are no incorrect answers in this exercise and there may be other appropriate answers. For instance, other feelings may include: anger, anxiety, embarrassment, fear, grief, pain, relief, sadness, shyness, and worry.

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Reasons</th>
<th>Responses</th>
</tr>
</thead>
</table>
| Fear    | • Fear of legal prosecution or criticism from health workers and/or family for illegally inducing abortion  
         • Fear of dying or becoming disabled  
         • Fear of the unknown (including what will happen at hospital)  
         • Fear of being ostracized by peers, especially for young people  
         • Anxiety about their future ability to have children | • Listen to the client’s concerns.  
• Reassure the client.  
• Tell the client what will happen before, during, and after the procedure.  
• Say, “I see you are uncomfortable. Please don’t hesitate to ask me any questions.”  
• Arrange for FP counseling, services, and/or referrals and let the client know that these are available.  
• Be aware of your own negative bias or appearing to “punish” the client. |
| Grief   | • Sadness at losing pregnancy | • Be respectful of the client’s feelings.  
• Do not assume the abortion was induced.  
• Tell the client that feeling sad is common. |
| Loneliness | • Hospital protocols do not allow family members to accompany clients  
              • Transportation costs prohibit family or friends from accompanying clients  
              • The client was afraid to tell anyone about the abortion or ask anyone to accompany them  
              • The client does not have any emotional support | • Establish a waiting area for family and friends accompanying clients.  
• Counsel and reassure client that:  
  » Treatment is confidential.  
  » Treatment will help them get better.  
  » They will not get in trouble.  
• Tell the client that you are there to help and ask if they need anything. |
| Pain    | • Abdominal cramping  
         • Pain from an infection or other complications  
         • Pain that intensified during transportation  
         • Emotional pain, mourning loss of pregnancy | • Assess the client’s need for pain relief and offer medication, as appropriate.  
• Provide a comfortable area for client to rest before and after procedure.  
• Streamline processes to allow the client to be treated as soon as possible.  
• Help the client understand the value of avoiding pregnancy for at least six months and evaluate any repeated pregnancy loss. |
Handout: Values and Attitudes about Postabortion Care

Note: The content contained within this handout is adapted from Counseling the Postabortion Client: A Training Curriculum.32

A value is a belief that is important to an individual. Values and beliefs can be influenced by culture, education, religion, and various personal experiences. Our values are often so ingrained that we may be unaware of them until we are confronted with a situation that challenges them. Our values shape our attitudes, or the way that we think about and act toward various people and ideas.

How we communicate our attitudes and values (verbally and nonverbally) is an important part of our interactions with clients. Every interaction between a client and healthcare provider, from the time the client enters the healthcare system until discharge, affects the client’s satisfaction with care, their recovery time, and how well they care for themselves after leaving the facility. Our attitudes, biases, feelings, and values affect how we treat clients. For example, our feelings about a client’s age, appearance, culture, economic status, marital status, parity, religion, and/or other social characteristic can affect the gentleness or harshness with which we perform procedures, the delay that we impose on clients, and whether we respond to the full range of healthcare needs of the client. For instance, this may result in biased treatment of clients presenting with a spontaneous or induced abortion as well as unequal treatment of young and unmarried adolescent clients presenting with an induced abortion versus married adolescent clients presenting with a miscarriage.

In some settings, provider attitudes regarding clients presenting with abortion-related complications may be influenced by community and social norms outside the health system. For example, providers may fear community and/or legal repercussions for treating postabortion clients despite explicit laws and policies that allow for the provision of PAC.

Being self-aware helps ensure that we do not impose our beliefs on clients. It is not always easy to keep our personal attitudes and values separate from our professional responsibilities, but it is our duty to do so.

Remember: Two people from similar experiences and backgrounds may see things differently. What do you see in the image below, a woman or a musician?

Sara Nader


Trainer Notes: Summarizing the Session

When wrapping up this session, be sure to highlight how effective communication between the client and provider is built on the provider's ability to understand the feelings and experiences of the client.

Explain that a client seeking treatment of an incomplete abortion will likely have more complicated circumstances than a client seeking other types of care.

A client may view their abortion as a crisis and people in crisis often have difficulty discussing their situations, even with those who are trying to help. Healthcare workers are not obligated to resolve clients’ feelings, but it is often helpful to let clients know that we understand their feelings. Counselors who work with clients in crisis situations use the concept of “focusing with empathy.” The ability to feel and express empathy for clients can increase understanding and confidence. An empathetic approach makes it easier to engage in an open dialogue. Empathy is expressed via nonverbal communication and active listening as well as verbal communication. A counselor who demonstrates empathy during PAC can understand a client’s situation regardless of age, cultural background, or socioeconomic status.

Providers should consider the following circumstances when treating postabortion clients:

• It is possible that the client may be having a miscarriage due to malaria.

• It is possible that the client may have experienced physical violence and may be experiencing a miscarriage related to such violence. Approximately one-third of abortion clients have been abused at some time during their lives.*

• The client may have been forced or coerced to have an abortion and may be experiencing guilt and regret.

Technical expertise is not the only factor that affects how clients rate quality of care. Clients respond more favorably to providers who expresses genuine interest and concern. Note that even in challenging circumstances—for instance with an anxious, unmarried client—it is possible for healthcare providers and FP counselors to foster confidence and offer emotional support. Some providers are naturally able to make clients feel comfortable and this is not a skill necessarily developed in standard professional training programs.

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.

Time Allocation
2 hours, 25 minutes

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Role plays
- Group exercise

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Collect samples of current client charts and referral slips; consider preparing copies to distribute.
## Session Plan: Module 2, Session 1
### Preparation and Client Assessment

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session Review the learning objectives Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning Display and discuss learning objectives</td>
<td>Warm-up or icebreaker Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Describe emergency treatment, including providing an overview of the main aspects (Objective 1)</td>
<td>Introduce emergency treatment by asking participants: “What is emergency treatment?” and allowing for a few responses before explaining using the slides Review emergency treatment care provided at facility and staff levels Refer participants to the PAC model, as appropriate</td>
<td>Interactive presentation</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Describe how to rearrange service areas to ensure confidentiality, privacy, and the ability to counsel a client with a partner (Objective 2)</td>
<td>Review definitions of confidentiality, dignity, and privacy, and explain how providers can ensure these, including by arranging (or rearranging) service areas Note: Participants can share ideas from their respective facilities.</td>
<td>Brainstorm Group discussion</td>
</tr>
<tr>
<td>55 minutes</td>
<td>Perform a client assessment and examination according to standards (Objective 3), including: Rapid assessment to rule out life-threatening conditions, with immediate management as needed Complete history Abdominal exam Pelvic exam Laboratory tests</td>
<td>Review the goal and components of a client assessment and examination, including: Rapid initial assessment General management Identification of signs and symptoms Record of history Physical exam Laboratory testing Determination of uterine size Identification of vaginal bleeding in early pregnancy Understanding client feelings and ensuring confidentiality and privacy Referrals</td>
<td>Interactive presentation Demonstration and return demonstration (may occur now or in later sessions) Group discussion Brainstorming Role play exercises Classroom practice</td>
</tr>
</tbody>
</table>
### Session Plan: Module 2, Session 1
#### Preparation and Client Assessment

<table>
<thead>
<tr>
<th>Time</th>
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<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
</table>
| 10 minutes | Explain the different types of miscarriage and abortion, including major signs and symptoms (Objective 4) | Outline different categories of abortion and miscarriage, including major signs and symptoms | Interactive presentation  
Group discussion                                                             |
| 10 minutes | Demonstrate the ability to integrate appropriate counseling in emergency treatment (Objective 5) | Provide examples of integrated counseling through demonstration, to be followed by participant practice | Group discussion  
Demonstration and return demonstration                                           |
| 25 minutes | Review symptom identification and reorganization of services                             | Facilitate role play exercises focused on symptom identification and reorganization of services | Role play exercise                                                      |
| 5 minutes | Summarize the session                                                                    | Summarize major content from the session and ensure objectives are addressed     | Group discussion                                                        |
Trainer Notes

Consider introducing the session by asking participants, “What is the goal of a client assessment?” Possible responses include:

- To make an accurate diagnosis, including to identify or confirm:
  - Pregnancy
  - Gestation (weeks since last menstrual period)
  - Type of abortion (e.g., inevitable, incomplete)
  - Complications

- To determine appropriate treatment, including:
  - Uterine evacuation, medical management, or other treatment
  - Antibiotic therapy

- To identify treatment constraints or contraindications, including:
  - Bleeding disorders
  - Chronic illness
  - Allergies to various medications

Other possible introductory questions may include:

- What is meant by the term “emergency”?
- How do you prepare for service provision at your facility?
- Who makes decisions about the organization of services? **Note:** After this topic is presented, providers can discuss what they can do. The role plays may be a good start for this discussion.
- What happens when a client presents for care in your facility? **Note:** Focus on the triage system. This can be discussed more fully after individual treatment topics are presented.

This discussion should be brief, to prompt participant discussions about emergency treatment, and can be made more interactive by providing a reading assignment in advance and posing questions at the start of the session or using an exercise.
Role Play Exercise: Obtaining Client Histories and Identifying Symptoms

Instructions

Use the two client symptom cards below, with either course participants or “local clients” (local or community volunteers portraying clients). For each role play, share the symptom card with the “client” (and “observers,” if you wish) but not with the “midwife.” The “client” and “midwife” should role play an assessment interview, with the “midwife” working to obtain thorough information from the “client” while demonstrating respect and compassion. After the exercise, ask the “observers” to provide constructive feedback on the interviewing techniques of the “midwife.”

Roles

**Client:** One participant will act as the client, using the symptom description card provided and making up any additional information required to respond to the midwife’s questions.

**Provider:** One participant will act as a midwife or service provider obtaining a client’s history.

**Observers:** The remaining participants will observe the role play, noting the interviewing skills of the provider.

---

### 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

**Possible diagnosis: Incomplete abortion**

### 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

**Possible diagnosis: Infection or sepsis**
Role Play Exercise: Rearranging Client Service Areas

Instructions
Divide participants into three groups and give each group one of the following scenarios to discuss, brainstorm, and present solutions for in the form of a role play.

Scenarios

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.
**Group Exercise: Addressing Postabortion Client Fears**

Use the table below to prompt a summary discussion about how providers can respond to postabortion client fears.

<table>
<thead>
<tr>
<th>Client Fears</th>
<th>Provider Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling pain during the procedure</td>
<td>Ask about and listen to the client’s concerns; reassure the client.</td>
</tr>
<tr>
<td>Experiencing complications from the procedure</td>
<td>Be aware of one’s own feelings toward the client and do not be judgmental.</td>
</tr>
<tr>
<td>Being pressured to accept a long-acting or permanent FP method</td>
<td>Explain what to expect during the procedure and what pain control medication is available (if any).</td>
</tr>
<tr>
<td>Dying</td>
<td>Explain the risk of complications.</td>
</tr>
<tr>
<td>Becoming infertile or disabled</td>
<td>Tell the client they have the right to choose whether to receive a FP method, and which method they want.</td>
</tr>
<tr>
<td>Being prosecuted</td>
<td>Some methods can be provided with the selected emergency treatment option for the abortion or immediately after the procedure. Provide or arrange for FP counseling and services, including referrals, as needed.</td>
</tr>
<tr>
<td>Not knowing what will happen while they are at the facility</td>
<td></td>
</tr>
<tr>
<td>Not receiving treatment due to inability to pay</td>
<td></td>
</tr>
</tbody>
</table>
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.

Time Allocation
2 hours

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Pelvic model
- Equipment locally used for uterine evacuation (Note: The VA type used locally, whether electric, foot pump, or manual is essential to this session. For manual vacuum aspiration (MVA), this includes different types of syringes and equipment used locally. Other materials required include metal cannulae and different types of dilators.)
- Samples of medication(s) used locally for uterine evacuation

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Obtain, assemble (as needed), and test (as needed) all equipment and sample medications.
- Set up demonstration and participant workstations.
**Trainer Notes**

This session is an introduction to the various methods for uterine evacuation but should prioritize the method(s) available locally and/or that will be used by the participants. The three main methods of uterine evacuation are: (1) surgical methods, including VA and D&E; (2) medical emergency treatment, including misoprostol or oxytocin; and (3) expectant management. Currently, misoprostol is the preferred method.

All participants should have the opportunity to observe and perform relevant uterine evacuation skills using models or through role play exercises for misoprostol. However, it is important to emphasize that uterine evacuation is only one component of the PAC model and all learners must actively participate in learning and practicing contraceptive counseling and service delivery for the comprehensive delivery of PAC services.
## Session Plan: Module 2, Session 2
### Uterine Evacuation Methods

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session&lt;br&gt;Review learning objectives&lt;br&gt;Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning&lt;br&gt;Display and discuss learning objectives</td>
<td>Warm-up or icebreaker&lt;br&gt;Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>55 minutes</td>
<td>Describe how each method of uterine evacuation works (Objective 1)&lt;br&gt;List key advantages and disadvantages of each method (Objective 2)&lt;br&gt;Identify the instruments (or parts) used in each method (Objective 3)&lt;br&gt;Describe indications, contraindications, and precautions applicable to each method (Objective 4)</td>
<td>Display and review the definition of VA; describe and compare different VA methods, including electric, foot pump, and manual; discuss:&lt;br&gt;• Equipment used&lt;br&gt;• Advantages and disadvantages&lt;br&gt;• Indications, contraindications, and precautions&lt;br&gt;• Client satisfaction&lt;br&gt;Describe D&amp;E, including indications, contraindications, and precautions; compare with VA&lt;br&gt;Describe misoprostol use, including indications, contraindications, and precautions; compare with oxytocin use&lt;br&gt;Describe expectant management, including indications, contraindications, and precautions&lt;br&gt;Discuss risks and side effects of all uterine evacuation methods</td>
<td>Interactive presentation&lt;br&gt;Group discussion (consider asking participants to suggest when and how different counseling topics should be introduced and when and how to engage the client’s partner, if appropriate)</td>
</tr>
<tr>
<td>1 hour</td>
<td>Describe counseling appropriate for any uterine evacuation procedure (Objective 5)</td>
<td>Demonstrate counseling before, during, and after uterine evacuation, emphasizing the importance of integrating counseling throughout PAC and including information on counseling young clients</td>
<td>Counseling demonstration&lt;br&gt;Counseling practice</td>
</tr>
</tbody>
</table>
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.

Time Allocation
2 hours, 15 minutes (Note: Time for the different activities will vary based on allowances for skill practice, role plays, and any optional discussions or activities.)

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Demonstrations
- Role plays
- Handout
- Pelvic model
- Pain assessment scale
- Pain management tools, including 22-gauge needle, needle extender, syringe, and lidocaine solution

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Print adequate copies of the handout.
- Set up demonstration and participant workstations.
- Arrange or ensure arrangement of clinical practice sessions.
- Review and, as necessary, revise content about local anesthesia to ensure alignment with local protocols, as guidance for types, dosages, strength, etc. may vary. Note: Some protocols require all PAC clients to receive a paracervical block to provide pain relief; however, current evidence shows that a paracervical block is only useful in cases in which cervical dilatation is necessary. This protocol aims to mitigate provider bias and maltreatment against clients perceived as having induced abortion. This practice, by supporting PAC client pain relief, has proven to increase client willingness to seek care.
<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session</td>
<td>Select an activity to set the stage for learning</td>
<td>Warm-up or icebreaker</td>
</tr>
<tr>
<td></td>
<td>Review learning objectives</td>
<td>Display and discuss objectives</td>
<td>Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td></td>
<td>Allow participants to ask questions and respond, as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 minutes</td>
<td>Describe the goal of pain management in emergency treatment for PAC clients (Objective 1)</td>
<td>Introduce the goal of pain management during uterine evacuation and describe the tools used to measure pain experienced during emergency treatment</td>
<td>Interactive presentation</td>
</tr>
<tr>
<td></td>
<td>Review tools for objectively measuring and documenting client’s level of pain</td>
<td></td>
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</tr>
<tr>
<td>35 minutes</td>
<td>Describe key information to share when counseling clients on pain management (Objective 2)</td>
<td>Ask participants to brainstorm components of pain management and elements of a supportive environment</td>
<td>Interactive presentation Brainstorming Group discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review the Counseling and Pain Management handout</td>
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<td>Discuss informed consent</td>
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</tr>
<tr>
<td>45 minutes</td>
<td>Describe the types of pain clients may experience from incomplete abortions and from different uterine evacuation procedures (Objective 3)</td>
<td>Review the following through presentation and demonstration:</td>
<td>Interactive presentation Demonstration and return demonstration (practice can begin during this session and continue later, as needed and as time allows)</td>
</tr>
<tr>
<td></td>
<td>List the types of pain management and available methods for each type (Objective 4)</td>
<td>• Types and origins of pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Describe symptoms of local anesthesia complications and treatment (Objective 5)</td>
<td>• Pain transmission pathways</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Types of pain management medication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of analgesia</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Use of anesthesia</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Paracervical block</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allow participants to practice various procedures</td>
<td></td>
</tr>
<tr>
<td>45 minutes</td>
<td>Demonstrate counseling related to pain management and integrated with care (Objective 6)</td>
<td>Review the handout</td>
<td>Group discussion Role play exercise</td>
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<td></td>
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<td>Divide participants into groups and assign role play exercises</td>
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<td>Debrief the session</td>
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</table>
Trainer Notes
As an optional activity, consider posing one or more of the following questions for discussion:

• What are the advantages of using analgesics only, or local anesthesia and light sedation, versus heavy sedation for VA?
  » What are the advantages for clients (e.g., shorter recovery time)?
  » What are the advantages for health workers (e.g., more responsive clients)?
  » What are the advantages for the health system (e.g., use of fewer facility resources)?
• What are the disadvantages of relying on verbal reassurance for pain management and how might the client and community perceive such a pain management approach?

Demonstration: Pain Management Techniques with Model
Demonstrate injection techniques using a model; then, give participants the opportunity to simulate administration of injections. As applicable to the participants, and depending on the type of anatomical model available, include demonstration and practice of placement of the paracervical block for D&E. Note: Paracervical block has not been proven effective in procedures that do not require cervical dilatation.

Closely supervise practice of these techniques to ensure that participants:
• Know the correct dosages and maximum allowable dose.
• Place injections around (not in) the cervix at 3, 5, 7, and 9 o'clock.
• Withdraw the plunger slightly before each injection to prevent intravenous injection.
• Place anesthetic just under the epithelium, not deeper than 2 or 3 mm.
• Demonstrate competence on the model before practicing with live client.

Trainer Notes
It may be necessary to repeat demonstrations several times to ensure all participants can adequately view and fully understand the techniques.

Demonstration: Pain Management Techniques with Clients
As allowable by caseload, demonstrate an assessment of client needs for pain management, proper techniques for pain management approaches, indications for administering a paracervical block, and monitoring for complications. Under direct supervision, allow participants to practice these skills with clients until they demonstrate competence.
Role Play Exercise: Pain Management Counseling

Instructions
Select two or more role play scenarios. Divide participants into small groups (four to six participants, per group). Assign each group a different scenario and instruct them to develop a role play based on the scenario. Explain to participants that they should assume that the provider has already performed a rapid initial assessment for urgent care and that the role play should focus on pain assessment and/or management and counseling. Tell participants that they may use the handout on counseling and pain management to guide the exercise. Remind them to include information on the timing and location for introducing different aspects of counseling, including emotional support, FP counseling (as appropriate), and inclusion of a spouse, family member, or friend, if the client requests. After each role play is performed, facilitate a plenary discussion of observations, including the strengths and areas of improvement for each, to summarize the activity.

Scenarios

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, participants should practice using the pain assessment scale. Involve up to six participants, with one participant acting as the provider and the others playing the part of the different clients:
- 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.
Handout: Counseling and Pain Management Tasks

- Arrange the setting to facilitate a confidential discussion.
- Ask the client if there is anyone else that they would like to join the discussion (e.g., a partner or spouse, family member, or friend).
- Be sure the client understands what level of pain and discomfort to expect for the procedure.
- Acknowledge that feeling confused, scared, or worried are common for most people in the client’s situation.
- Explain pain management options using simple terms and explanations. Include information about pre- and post-procedure pain management, benefits, and possible side effects.
- Be sure that the client understands everything by asking them to repeat or summarize the information in their own words.
- Follow local or facility protocols for documenting informed consent for the procedure and pain management, as appropriate.
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.

Time Allocation
1 hour, 40 minutes

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Role plays
- Pelvic model
- Equipment used locally for D&E, including dilators, cannulae, and relevant VA equipment
- National policies and protocols for D&E

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Obtain, assemble (as needed), and test (as needed) all equipment.
- Set up demonstration and participant workstations.
- Arrange or ensure arrangement of clinical practice sessions.
- Obtain and review copies of local protocols or policies for D&E. Consider creating a handout illustrating the steps of the procedure, according to local protocols, for the participants to reference during the discussion and demonstration.

Trainer 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.

35 Ibid.
<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
</table>
| 5 minutes | Introduce the session  
Review learning objectives  
Allow participants to ask questions and respond, as needed | Select an activity to set the stage for learning  
Display and discuss learning objectives | Warm-up or icebreaker  
Presentation (consider involving participants in reading objectives) |
| 20 minutes | Identify the instruments used for D&E (Objective 1)                                     | Present the instruments and equipment used for D&E, allowing participants to handle the instruments (pass them around the room) | Group discussion  
Interactive presentation                                      |
| 45 minutes | Explain and demonstrate the procedure for D&E using a model (Objective 2)             | Describe all the steps for D&E, demonstrating on the pelvic model, noting any indications, contraindications, risks, and side effects  
Allow participants to practice D&E using pelvic models | Interactive presentation  
Demonstration and return demonstration                               |
| 30 minutes | Describe post-procedure care (Objective 3)                                             | Discuss post-procedure care, emphasizing comfort, pain management, and FP counseling | Interactive presentation  
Group discussion  
Role play exercise                                                  |
Role Play Exercise: Post-Procedure Counseling

Instructions
The following role play scenarios focus on post-procedure counseling. Choose at least one scenario and ask for volunteers. Instruct those acting in the role play to think creatively and to include and exclude various key components of counseling to stimulate the subsequent discussion. Instruct participants observing the role play to take note of the content covered in counseling. After the role play, facilitate a discussion of the strengths and areas of improvement, using the list of key components included below.

Key Components of Post-Procedure Counseling
- Assurance of confidentiality and privacy
- Provision of emotional support
- Counseling on danger signs
- Counseling on return to fertility
- Counseling on healthy timing and spacing of pregnancy
- FP counseling that includes the client’s partner, if desired
- Provision of FP services at the emergency treatment site or referral for services not available
- STI and HIV risk assessment, counseling, testing, and treatment or referral
- Gender-based violence screening, care, and/or referral as needed
- Follow-up care

Before concluding this activity, remind participants that regardless of evacuation method, PAC comprises emergency treatment plus FP counseling and services plus STI and HIV counseling and services plus community empowerment.

Repeat this activity with more than one scenario, time permitting, as needed. These role plays can be used during any session on emergency treatment by changing the procedure outlined in the scenario.

Scenarios

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.

Time Allocation
3 hours, 45 minutes

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Pelvic models
- Equipment and supplies used locally for VA, including containers with water for demonstrating use of MVA syringe
- Videos, demonstrating the procedure or related practices, such as infection prevention, as available
- Other materials, as appropriate (see Advance Preparation)

Advance Preparation
Before this session:
- Review (and update, as needed) all training materials for the session.
- Obtain and review copies of national protocols and job aids for VA.
- Obtain and review samples of client records and registers from local PAC procedure facilities.
- Set up demonstration and participant workstations.
- Arrange or ensure arrangement of clinical practice sessions.
- Consider sourcing or creating additional handouts, for instance equipment and supplies lists, VA procedure checklists, and counseling job aids.
# Session Plan: Module 2, Session 5
## Uterine Evacuation via Vacuum Aspiration

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session&lt;br&gt;Review learning objectives&lt;br&gt;Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning&lt;br&gt;Display and discuss learning objectives</td>
<td>Warm-up or icebreaker&lt;br&gt;Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Identify the parts of MVA equipment and select the correct size syringe and cannula (Objective 1)</td>
<td>Review basic principles, parts, and labels of MVA equipment, including cannula and syringe (MVA Plus®)&lt;br&gt;Present the different MVA instruments and parts of the MVA syringe (pass them around the room) and demonstrate how to use the syringe</td>
<td>Interactive presentation&lt;br&gt;Demonstration and return demonstration (practice can begin during this session and continue later, as time allows)</td>
</tr>
<tr>
<td>15 minutes</td>
<td>For EVA and/or FSE (Objective 2):&lt;br&gt;• Identify the parts of the equipment&lt;br&gt;• Select the correct size cannula</td>
<td>Review basic principles, parts, and labels of EVA and/or FSE equipment, including cannula</td>
<td>Interactive presentation&lt;br&gt;Demonstration (if locally applicable)</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Demonstrate the ability to assemble, test, and prepare MVA, EVA, or FSE equipment (Objective 3)</td>
<td>Demonstrate assembly, testing, and preparation of instruments</td>
<td>Interactive presentation&lt;br&gt;Demonstration and return demonstration (practice can begin during this session and continue later, as time allows)</td>
</tr>
<tr>
<td>1 hour, 30 minutes</td>
<td>Perform the VA procedure (MVA, EVA, or FSE) according to the steps outlined (Objective 4)</td>
<td>Demonstrate how to perform the VA procedure</td>
<td>Interactive presentation&lt;br&gt;Demonstration and return demonstration (practice can begin during this session and continue later, as time allows)</td>
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</table>
### Session Plan: Module 2, Session 5
#### Uterine Evacuation via Vacuum Aspiration

<table>
<thead>
<tr>
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<th>Objectives &amp; Activities</th>
<th>Training Content</th>
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</tr>
</thead>
<tbody>
<tr>
<td>30 minutes</td>
<td>Demonstrate appropriate counseling before, during, and after VA (Objective 5)</td>
<td>Review the importance of integrating counseling throughout PAC, including with VA</td>
<td>Role play exercise</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Recognize and solve technical and/or procedural problems (Objective 6)</td>
<td>Discuss and demonstrate how to identify and manage technical and procedural problems during VA</td>
<td>Interactive presentation Group discussion Demonstration and return demonstration (practice can begin during this session and continue later, as time allows)</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Record complete, accurate case information in client charts, logbooks, and other forms (Objective 7)</td>
<td>Demonstrate and practice recording information</td>
<td>Demonstration and return demonstration (practice can begin during this session and continue later, as time allows)</td>
</tr>
</tbody>
</table>

#### Trainer Notes

**Preparing Instruments:** Divide trainees into pairs and distribute an MVA kit to each pair. Instruct participants to practice preparing instruments, while wearing gloves. If you have more than one type of MVA syringe (single valve, double valve, or MVA Plus®) allow participants to practice with each type of syringe. Answer any questions that arise.

**Performing MVA:** Present slides, as well as video (if available) on the MVA procedure. Encourage participants to ask questions or clarify information during this review.

**MVA Practice with Models:** Prepare the pelvic model for practice and demonstrate the procedure on the model, following all 12 steps and using the “no-touch” technique. Allow each participant to practice as much as they need to demonstrate competence with the model. Some participants may need more practice than others to become competent; it is important to allow as much practice as each participant requires. Participants must be competent using the model before starting clinical practice.

**MVA Practice with Clients:** Arrange clinical practice as permitted by the clinic schedule and client caseload. Review guidelines for clinical practice, as needed. Supervise participants’ practice sessions with clients closely and be prepared to intervene if the procedure becomes complicated, the client suffers undue discomfort, or the participant does not appear to be able to complete the procedure without error. Trainers should also demonstrate examination of aspirated tissues and allow participants to practice the skill.
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.

Time Allocation
3 hours

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Role play
- Expired misoprostol tablets
- National clinical guidelines, protocols, and job aids for managing vaginal bleeding in early pregnancy
- Samples of client charts, registers, and information and education materials with instructions for FP and misoprostol use

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Collect expired misoprostol tablets.
- Obtain and review copies of national clinical guidelines, protocols, and job aids for managing vaginal bleeding in early pregnancy. Consider printing or saving electronic copies of these materials to distribute to participants.
- Obtain local samples of client charts, registers, and information and education materials with instructions for FP and misoprostol use.
- Set up demonstration and participant workstations.
- Arrange or ensure arrangement of clinical practice sessions.
## Session Plan: Module 2, Session 6
### Medical Treatment for Postabortion Care

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session&lt;br&gt;Review learning objectives&lt;br&gt;Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning&lt;br&gt;Display and discuss learning objectives</td>
<td>Warm-up or icebreaker&lt;br&gt;Display and present objectives (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>15 minutes</td>
<td>List key steps of medical treatment for abortion-related complications according to standards (Objective 1)</td>
<td>Introduce medical treatment for abortion-related complications using misoprostol</td>
<td>Interactive presentation</td>
</tr>
<tr>
<td>10 minutes</td>
<td>Describe indications and contraindications for using misoprostol to manage abortion-related complications (Objective 2)</td>
<td>Discuss indications and contraindications for using misoprostol</td>
<td>Interactive presentation&lt;br&gt;Group discussion</td>
</tr>
<tr>
<td>1 hour, 45 minutes</td>
<td>Demonstrate competency in counseling and providing medical treatment for abortion-related complications using misoprostol (Objective 3)</td>
<td>Explain and practice the steps for managing an incomplete abortion with misoprostol</td>
<td>Interactive presentation&lt;br&gt;Group discussion&lt;br&gt;Role play exercise&lt;br&gt;Coaching and mentoring (role play exercise and coaching and mentoring can begin during this session and continue later, as time allows)</td>
</tr>
<tr>
<td>45 minutes</td>
<td>Demonstrate competency in providing other postabortion services to clients who choose misoprostol to treat abortion-related complications (Objective 4)</td>
<td>Demonstrate and practice provision of misoprostol</td>
<td>Clinical demonstration and return demonstration&lt;br&gt;Coaching and mentorship&lt;br&gt;Group discussion</td>
</tr>
</tbody>
</table>
Role Play Exercise: Counseling for and Provision of Misoprostol

Instructions
Review the scenarios provided and select or modify as appropriate for the local context. Divide participants into groups of three or four and assign each group at least three scenarios. Instruct participants to take turns playing the roles of client, provider, and observer(s). Note that the participant playing the provider may refer to the Learning Guide for Postabortion Care Using Misoprostol to inform the client-provider interaction. Ensure everyone has the opportunity to act as the provider at least once to allow all participants to practice counseling and receiving feedback for improvement.

Explain that observers should focus on the following aspects of the client-provider interaction:

- Client assessment and determination of eligibility for medical treatment
- Counseling for use of misoprostol
- Counseling on warning signs
- FP counseling and method provision or referral, as appropriate
- Screening and referral for gender-based violence
- STI screening and treatment or referral and HIV counseling and referral
- Evaluation and care of clients with treatment-related problems and those seeking FP services

Instruct observers to share feedback after each role play, identifying strengths and areas for improvement.

Scenarios

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 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.

Time Allocation
3 hours

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Case studies
- Clinical guidelines, treatment protocols, and job aids for PAC
- Local samples of referral forms

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Obtain and review copies of national clinical guidelines, protocols, and job aids.
- Obtain local samples of referral forms.

Trainer Notes
Participants may best learn Objective 2 by reviewing and discussing case studies for each complication. Consider allowing participants to discuss case studies in small groups or plenary. Consider selecting and modifying case studies included to best meet the needs of participants.
# Session Plan: Module 2, Session 7
## Postabortion Complications and Management

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<thead>
<tr>
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<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session Review learning objectives Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning Display and discuss learning objectives</td>
<td>Warm-up or icebreaker Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Identify potential postabortion complications and their signs and symptoms (Objective 1)</td>
<td>Introduce common postabortion complications</td>
<td>Interactive presentation Group discussion</td>
</tr>
<tr>
<td>1 hour, 30 minutes</td>
<td>Describe rapid assessment, treatment, and other measures for: Shock Severe vaginal bleeding Infection and sepsis Intra-abdominal injury Uterine perforation (Objective 2)</td>
<td>Describe signs and symptoms as well as initial treatment and other measures for complications (including shock, severe vaginal bleeding, infection, sepsis, intra-abdominal injuries, and uterine perforation) Facilitate small group discussions of case studies</td>
<td>Interactive presentation Case studies Group discussion</td>
</tr>
<tr>
<td>25 minutes</td>
<td>Explain elements of emergency resuscitation and preparation for referral and transport to a tertiary care facility (Objective 3)</td>
<td>Discuss preparing clients for referral, transport, and care during transport Review referral protocols and guidelines, including feedback mechanisms Discuss participant experiences</td>
<td>Interactive presentation Group discussion</td>
</tr>
<tr>
<td>45 minutes</td>
<td>Using case studies, describe treatment and other measures for each complication</td>
<td>Facilitate small group discussions of case studies</td>
<td>Case studies</td>
</tr>
</tbody>
</table>
Case Study Exercise: Postabortion Complications

**Trainer Notes**

The following case studies are illustrative. Consider revising or adapting them based on the local context. Encourage participants to share examples from their experience and clinical settings, but to ensure respect for client confidentiality and privacy. Review the answer key that follows for illustrative answers, but remember that other responses or information provided by learners may be equally acceptable.

**Case Study 1: Shock**

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: Severe Vaginal Bleeding**

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: Infection and Sepsis**

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°C (102.2°F); 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: Intra-Abdominal Injury**

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°C Celsius (100.4°F Fahrenheit); blood pressure 160/80; respiration 28; pulse 100; decreased bowel sounds.
Case Study Exercise: Postabortion Complications—Answer Key

Case Study 1: Shock

- What other information will you gather to assist in your rapid assessment?
  - Vital signs
  - Color, for instance pallor or redness
  - History (ask the client’s sister if the client is not alert), including:
    - History of bleeding
    - Obstetric history
    - Overall medical history
  - Bleeding quantity, color, and presence of clots and products of conception (assess through physical examination)
- Based on this rapid assessment, what is your initial diagnosis?
  - Shock
  - Bleeding in early pregnancy; possible threatened or spontaneous abortion
- What initial actions will you take to address this situation?
  - Call for assistance, as you will need others to help you urgently manage the client’s care
  - Monitor the client’s vital signs (temperature, blood pressure, pulse, respiration) every 15 minutes
  - Turn the client onto her side to minimize the risk of aspiration if she vomits
  - Ensure the client’s airway is open
  - Administer oxygen at six to eight liters per minute (via mask or nasal cannula)
  - Keep the client warm (but do not overheat)
  - Elevate the client’s legs to increase blood flow to her heart, either by placing blankets or pillows under her feet or raising the bed using a block under the foot of the bed
- What other steps will you take to manage the client’s problems?
  - Administer fluids intravenously (normal saline or Ringer’s lactate), one liter over the course of 15 to 20 minutes using a large-bore needle or catheter (16 to 18 gauge); do not give fluids orally
  - Monitor the client’s vital signs, intravenous fluids, and urine output
  - Collect blood for hemoglobin or hematocrit testing (Note: A hemoglobin of 5 g / 100 ml or less or hematocrit of 15 or less is life-threatening and requires blood transfusion.)
  - Immediately cross-match the client’s blood if your facility has a blood bank
  - Remove any visible products of conception, being careful to maintain aseptic technique; do not perform a complete pelvic exam at this time
  - If heavy bleeding is suspected as the cause:
    - Empty the client’s uterine cavity of any retained products of conception
    - Perform a transfusion as soon as possible
    - Reassess the client’s condition for improvement
» If infection is suspected as the cause:
  − Collect appropriate blood and other samples before beginning antibiotics
  − Give the client antibiotics according to protocol
» If trauma is suspected as the cause, prepare the client for surgical intervention
» Refer and transfer the client to a higher-level of care if unable to manage the client despite resuscitation

**Case Study 2: Severe Vaginal Bleeding**

- What information will help you determine the severity of her blood loss?
  - Blood pressure, pulse rate, hematocrit or hemoglobin testing, and urine output (primary measures)
  - Number of pads soaked and amount of blood on clothing, sheets, and/or mattress (secondary measures)
- Based on this rapid assessment, what is your initial diagnosis?
  - Severe vaginal bleeding
- What initial actions will you take to address this situation?
  - Elevate the client’s legs to increase blood flow to her heart, either by placing blankets or pillows under her feet or raising the bed using a block under the foot of the bed
  - Ensure the client’s airway is open
  - Administer oxygen at six to eight liters per minute (via mask or nasal cannula)
  - Administer fluids intravenously (normal saline or Ringer’s lactate), one liter over the course of 15 to 20 minutes (up to two liters in the first hour), using a large-bore needle (16 to 18 gauge)
  - Continue to monitor blood loss, vital signs, intravenous fluids, and urine output
  - Collect blood for hemoglobin or hematocrit testing *(Note: A hemoglobin of 5 g/100 ml or less or hematocrit of 15 or less is life-threatening and requires blood transfusion.)*
  - Immediately cross-match the client’s blood if your facility has a blood bank
  - Obtain blood cultures if there is any sign of infection or sepsis (fever or foul-smelling vaginal discharge) and then start broad-spectrum intravenous or intramuscular antibiotics; do not give oral antibiotics
  - Administer intravenous or intramuscular analgesia for pain management, according to local protocols
  - Evacuate the client’s uterus as soon she is stable

**Case Study 3: Infection and Sepsis**

- What are the main signs of infection or sepsis in a postabortion client?
  - Abdominal distension
  - Abdominal pain and/or tenderness, with or without rebound tenderness
  - Bleeding that is prolonged (more than eight days)
  - Chills, fever, sweating, general malaise (flu-like symptoms)
  - Dilated cervix and/or cervical motion tenderness or pain
  - Foul-smelling vaginal discharge
  - Mucopurulent discharge from the cervix
  - Previous (particularly recent) miscarriage or a history of attempting to end the pregnancy
- What initial actions will you take to address this situation?
  - Ensure the client’s airway is open
  - Administer oxygen at six to eight liters per minute (via mask or nasal cannula), if the client is unstable
» Obtain blood cultures and then start broad-spectrum intravenous antibiotics immediately
» Administer tetanus toxoid if you suspect the client has had an unsafe abortion or has been exposed to tetanus and her vaccination history is uncertain
» Administer fluids intravenously (normal saline or Ringer’s lactate), one liter over the course of 15 to 20 minutes or faster, as the client may require rapid administration of several liters to restore fluid balance
» Collect blood for hemoglobin or hematocrit testing, if the client has lost a lot of blood or appears anemic (*Note: A hemoglobin of 5 g/100 ml or less or hematocrit of 15 or less is life-threatening and requires blood transfusion.*)

» Immediately cross-match her blood if your facility has a blood bank
» Monitor the client’s vital signs, intravenous fluids, and urine output
» Obtain abdominal x-rays (*Note: Flat or horizontal x-rays will help identify air or fluid levels in the bowel; in the case of clostridia infection, gas can be seen in the tissue. Upright x-rays will help identify air under the diaphragm if there is a uterine or bowel perforation.*)

- Coagulopathy is a bleeding disorder that is sometimes seen with severe cases of sepsis. What are the main signs of coagulopathy?
  » Bleeding from the bladder, injection site, mouth, or venipuncture site
  » Blood in the urine
  » Failure of the blood to clot (*Note: If there is no lab available, look where the blood has pooled, such as on the bed or floor, to assess clotting.*)
  » Decreased platelet count

*Note: Treating underlying sepsis is key to managing coagulopathy and disseminated intravascular coagulation. Giving blood products, such as fresh whole blood or fresh frozen plasma, can help control bleeding while treating the infection. A referral to a higher-level (tertiary) facility is usually required.*

**Case Study 4: Intra-Abdominal Injury**

- Based on this information, what is the likely diagnosis?
  » Perforated uterus (or intra-abdominal injury)
- What initial actions will you take to address this situation?
  » Treat the perforation, if the evacuation is complete
  » Prepare the client for immediate referral, as she may need a higher level of care; transfer as soon as possible, if needed (i.e., if bleeding continues)
  » Administer broad-spectrum intravenous antibiotics
  » Administer 0.2 to 0.5 mg of ergometrine intramuscularly; repeat as needed (up to three doses)
    - If the client stabilizes and bleeding slows, administer additional ergometrine (same dosage) and continue to observe overnight
    - If the client’s condition worsens, administer oxytocin or additional doses of ergometrine
  » Consider recommending a laparoscopy or minilaparotomy if bleeding continues
- The medical assistant recognized an important sign of perforation. During the MVA procedure, what other signs might indicate a perforation?
  » Penetration of a cannula or dilator beyond the expected size of the uterus
  » Decrease of syringe vacuum when the cannula is inside the uterus
  » Excessive bleeding after the uterus is empty
  » Fat or bowel in aspirated tissue found during or after the procedure
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.\(^{37}\) 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.\(^{38}\) As emphasized throughout this training: PAC is incomplete without family planning (FP) counseling and services. Comprehensive contraceptive methods and counseling information is not included in this training; however, resources with current, evidence-based information are readily available (see Training Materials and Advance Preparation for suggested resources). 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.\(^{39}\)

Time Allocation

6 hours, 50 minutes

Training Materials

- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Case studies
- Role plays
- Handouts
- Video(s)
- Other materials, as appropriate (see Advance Preparation)

Trainer Notes

This session is designed for providers with experience in FP counseling and service delivery; however, the FP background and experience of participants may vary. Any participants who have not completed basic FP training, should arrange to separately complete such training according to local, regional, or national practices and standards.


Advance Preparation

- Review (and update, as needed) all training materials for the session.
- Print adequate copies of handouts.
- Review and select (or modify, as appropriate) case studies and role play scenarios.
- Identify videos, as appropriate (e.g., a video on contraceptive counseling).
- Set up demonstration and participant workstations.
- Arrange or ensure arrangement of clinical practice sessions.
- Obtain and review copies of national or local FP policies, guidelines, statistics, and resources applicable to your participants, including contraceptive prevalence data, method mix data, FP service delivery policies and guidelines (for instance, those detailing which cadre may offer which methods, and current job aids) (see Resources). Consider printing handouts or saving electronic copies of relevant materials to distribute to participants. Alternatively, consider asking participants to bring these materials (those they are already using) to this session for discussion.

Resources

Recommended resource materials are included in the table below.

### Comprehensive Contraceptive Guidance

- Contraceptive Technology (2023): Available to [order](#).
- Selected Practice Recommendations for Contraceptive Use (2016): Available from [WHO](#).

### Counseling Frameworks

- Counseling the Postabortion Client: A Training Curriculum (2003): Available from [EngenderHealth](#).
- REDI Counseling Framework (2018): 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](#).

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**Trainer Notes**

Either print the Medical Eligibility Criteria for Contraceptive Use Wheel or ask participants to download the app version in advance. Some countries have developed their own version of the wheel; if that is the case in your setting, use the local version.
## Session Plan: Module 3, Session 1
### Family Planning Counseling and Service Provision

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session</td>
<td>Select an activity to set the stage for learning</td>
<td>Warm-up or icebreaker</td>
</tr>
<tr>
<td></td>
<td>Review learning objectives</td>
<td>Display and discuss learning objectives</td>
<td>Presentation (consider involving participants in reading objectives)</td>
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<td></td>
<td>Allow participants to ask questions and respond, as needed</td>
<td>Review some of the resource materials for FP services</td>
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<tr>
<td>30 minutes</td>
<td>Watch the video(s)</td>
<td>Present video(s) and discuss FP counseling and/or services</td>
<td>Video presentation</td>
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<td>Group discussion</td>
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<tr>
<td>40 minutes</td>
<td>State the essential FP information that all PAC clients should receive before discharge (Objective 1)</td>
<td>Introduce postabortion FP</td>
<td>Interactive presentation</td>
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<td>Group discussion</td>
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<tr>
<td>30 minutes</td>
<td>Explain the importance of informed choice for effective FP services (Objective 2)</td>
<td>Present and discuss the importance and components of informed choice</td>
<td>Interactive presentation</td>
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<td>Group discussion</td>
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<tr>
<td>30 minutes</td>
<td>Describe the personal and clinical factors that should be discussed during FP counseling (Objective 3)</td>
<td>Present and discuss personal and clinical factors that affect method selection</td>
<td>Interactive presentation</td>
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<td>Group discussion</td>
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<tr>
<td>30 minutes</td>
<td>Demonstrate appropriate FP counseling during different phases of care (Objective 4)</td>
<td>Demonstrate and discuss key aspects of FP counseling, including the special needs of adolescents</td>
<td>Interactive presentation</td>
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<td>Demonstration (practice can begin during this session and continue later, as time allows)</td>
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<tr>
<td>15 minutes</td>
<td>State one point of consensus from the FIGO, ICM, ICN, USAID, WRA, FCDO, and Bill &amp; Melinda Gates Foundation joint statement on postabortion FP (Objective 5)</td>
<td>Review and discuss the consensus statement</td>
<td>Group discussion</td>
</tr>
<tr>
<td>Time</td>
<td>Objectives &amp; Activities</td>
<td>Training Content</td>
<td>Learning Activities &amp; Methodologies</td>
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| 1 hour, 5 minutes | Identify appropriate methods and solutions to dilemmas for various case studies        | Demonstrate FP counseling approaches (including use of the Medical Eligibility Criteria Wheel) and service provision through case studies and role plays | Case studies  
Role play exercise  
(case studies and role play exercise can begin during this session and continue later, as time allows) |
|                 | Demonstrate communication skills and counseling techniques (including active listening, showing empathy, ensuring free and informed choice, respecting client rights) through role plays |                                                                                   |                                                                                                      |
| 2 hours         | Demonstrate FP counseling skills in clinical setting                                     | Apply different counseling approaches (in accordance with national guidelines)      | Clinical demonstration and return demonstration                                                       |
| 45 minutes      | Review of clinical practice                                                             | Provide feedback on and discuss experience from the clinical practice              | Clinical conference                                                                                   |

**Trainer Notes**

There will likely be times when there are no clients available for learners to practice providing PAC in a clinical setting. During these periods, consider using the time instead for observation and practice of FP counseling and service delivery. For instance, if appropriate, learners can practice method provision, such as IUD insertion.
Case Study Exercise: Contraceptive Method Choice

**Trainer Notes**
Reviewing case studies is important for reinforcing the information introduced in this session and helping participants practice counseling clients on a range of FP methods. Sample case studies are included below; however, consider adapting or developing additional cases to respond to the local setting or to participant knowledge and skill gaps. For example, consider using real client case studies from local facilities, but be sure to uphold confidentiality and privacy by removing any personally identifying information.

**Instructions**
Divide participants into small groups or teams and assign each group a list of the cases, ensuring all cases will be covered. Instruct groups to discuss the clinical, personal, and resource issues associated with selecting a contraceptive method for each of the assigned cases, including identifying which methods are appropriate and not appropriate and proposing solutions to any dilemmas presented. Let participants know that they can refer to course materials and resources to complete the exercise, but only after they have tried solving the cases on their own. Instruct each group to appoint a recorder to take notes and a reporter to present their work to the larger group.

Allow at least 30 minutes for the groups to work independently. Bring participants back together and then allow time for each group to share their cases and responses. Remind participants that the reports should focus on the clinical, personal, and resource issues associated with each case. After each case is presented, allow participants to comment.

**Case Studies**

**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 31-year-old client was diagnosed with and treated for a miscarriage this afternoon. She is eager to become pregnant again “as soon as possible.” She has three daughters but says she “must have a male child.” She is diabetic and weighs 73 kg. This is the first time she has experienced a spontaneous abortion.

Case Study 7
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 8
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

Instructions
Divide participants into four groups and assign each group one of the scenarios to role play for the class. Ask participants to consider the following in developing the role plays:

- Determining which contraceptive methods are appropriate to the client’s situation, needs, and reproductive intentions
- 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

Instruct the groups to use the handouts to guide preparations for these role plays, as well as in the future. Note that the Simple Answers handout may be particularly useful for counseling clients who come with specific method requests or concerns. Ask at least one group to omit a few important components of comprehensive counseling to stimulate feedback and discussion after their presentation.
Scenarios

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.
Handout: Simple Answers to Clients’ Questions about Postabortion Family Planning

When can I resume sexual activity?
After your bleeding has stopped, which should be in approximately five to seven days.

How soon can I become pregnant again?
Almost immediately—even before your next period. It is possible to become pregnant again less than two weeks after this treatment.

How can I avoid becoming pregnant again?
Start using a modern contraceptive method immediately.

Which method can I use?
You can discuss all available methods with your provider (and include your partner or spouse, if you wish) to decide what may be right for you. If you are otherwise healthy and free of infection, there are many contraceptive methods that are safe to start immediately after incomplete abortion, including:40
- Condoms (Note: Abstinence and condoms are the only methods that provide protection against sexually transmitted infections [STIs] and HIV. Therefore, it is advisable to use condoms with all other methods—dual method use—to protect against both pregnancy and STIs.)
- Oral contraceptives, also known as “the pill” and “birth control pills”
- Injectable contraceptives, or “injectables”
- Contraceptive patch, also known as “the patch” and “birth control patch”
- Contraceptive implants
- Vaginal ring
- Cervical cap
- Contraceptive diaphragm
- Intrauterine device, or IUD*
- Emergency contraception
- Voluntary surgical contraception or sterilization, including tubal ligation* and vasectomy

* Clients without other health problems who choose misoprostol to treat an incomplete abortion, can receive any contraceptive method with the first dose of misoprostol except IUD or female sterilization, which may only be administered, with the client’s consent, after the complete expulsion of the products of conception from the uterus.

I had a miscarriage and want to become pregnant again soon—which methods are right for me?
To give your body the rest it needs and to make sure the next pregnancy is healthy, it is strongly recommended that you wait until your body has healed. Waiting six months before becoming pregnant again can help reduce the risk of low birth weight, premature birth, and maternal anemia. 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.41 You can use any short- or long-acting method to space your pregnancies, which can help reduce the risk of another miscarriage. However, you may wish to consider that there may be a delay in the return of fertility with some methods after you stop using them—your provider can explain which methods have this delay. Short-acting methods that you can use include barrier methods (such as condoms), oral contraceptives, and injectables. Long-acting reversible methods that you can use include implants and IUDs.

Handout: Family Planning Counseling Approaches

**Trainer Notes**

Abbreviations often do not translate, so it is important to determine what abbreviation or tool will best help participants remember the information in their language. The GATHER tool is available in French and Spanish, for instance. The REDI framework may also be used depending on the approach recommended in the national guidelines, protocols, checklists, and other supervision tools.

The most important thing to remember about any counseling model is that the client is more important than the framework. Frameworks are helpful in giving providers a structure for counseling clients so that they do not omit critical steps. Too often, though, the provider may focus more on following the steps than on responding to what the client says. Remember: The purpose of counseling is to determine what the client needs and then to help them meet those needs.

There are several approaches to providing family planning (FP) counseling. The GATHER and REDI approaches, which are summarized here, are two examples. These (and other) approaches take the client through the four stages of counseling as summarized in the figure below.

Refer to the Reference Manual for a detailed description of these steps.

**The GATHER Method of Counseling**

*Note: The content contained within this section is adapted from the GATHER Guide to Counseling.*

Providing counseling about FP and other reproductive health matters often includes six elements or steps and it may be helpful to remember these elements using the English word GATHER (or another word in the participants' language), as each letter in the word GATHER represents one of these elements. However, effective counseling is more than the GATHER elements. Providers must not only ensure confidentiality and privacy, they must understand and address any pain or discomfort clients may be experiencing. Skilled counselors also understand their clients' feelings and needs and use this understanding to adapt counseling to best support each client. Postabortion care (PAC) counseling should be tailored to each client's unique needs. For instance, not all clients need to be counseled according to all six GATHER elements or in the order presented here, and some clients may need an element repeated.

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Postabortion Care Curriculum: Trainer Guide

G: Greet (Greet the client)
- Greet the client, introduce yourself, and offer the client a seat (as applicable).
- Be polite, friendly, and respectful, including by giving the client your full attention.
- Conduct counseling in a private space and reassure the client that your conversation will be kept confidential.
- Determine if the client is ready for counseling.
- If there is a partner, spouse, or other companion present, ask the client if they would like this person to participate in the conversation.
- Explain what will happen during the client’s visit.

A: Ask (Ask the client about themselves)
- Ask the client about their reason(s) for coming and how you can help.
- Ask the client about their concerns, doubts, feelings, needs, and wants and allow them to ask questions.
- Ask the client about their experience with the reproductive health matter that concerns them.
- Ask the client for any information needed to complete client records.
- Ask the client what they want to do and help them understand their choices and options.
- Actively listen to the client and allow them to lead the discussion.
- Keep questions brief, open, and simple.
- Demonstrate your interest in and understanding of the client by expressing empathy; avoid showing any bias or judgment.

T: Tell (Tell the client about their options)
- Present information respectfully, including by looking at the client as you speak.
- Help the client understand their options.
- Tailor and personalize information, focusing on what is important and relevant to the client’s situation.
- If the client is choosing an FP method:
  » Ask the client which methods interest them and explain that you will help them obtain their preferred method, assuming it is available and there is no medical reason that they should not use that method.
  » Ask the client what they know about the method already. If the client has important information wrong, gently correct them.
  » Briefly describe the client’s preferred method, being sure to address: (1) effectiveness of the method; (2) how to use the method; (3) other characteristics, including possible side effects and complications; and (4) danger or warning signs. Use samples and other audiovisual materials, if possible.
  » Mention any other available method(s) that the client might wish to consider using, now or later.
  » Explain that condoms are the only method that offers reliable protection against sexually transmitted infections (STIs).

H: Help (Help the client choose)
- Tell the client that the decision is theirs.
- Offer advice but avoid deciding for the client.
- To help the client make the decision, ask them to think about:
  » Their plans and family situation
  » The implications of each possible choice
  » What their partner might want
• Ask if the client understands the options and if they have any questions. Repeat and reword information, as needed.
• Explain that some FP methods may not be safe for clients with certain medical conditions. Once a client makes a choice, ask about these conditions or perform a clinical exam, if necessary, and discuss results with the client. If a method would not be safe, clearly explain why, and then help them choose another method.
• Check whether the client has made a decision by asking, “What have you decided to do?” and then wait for the client to answer.

E: Explain (Explain what to do)
After the client has made a choice:
• Provide the client with their chosen method, as appropriate. If the method or services cannot be given at this time, tell the client how, when, and where they can access the service or method.
• For voluntary sterilization, ask the client to voluntarily sign a consent form that confirms that the client has chosen the method, has received information about the method, and understands that information. Help the client understand the consent form before they sign.
• Provide instructions on how to use the method and, if possible, demonstrate how to use the method and have the client return the demonstration to confirm understanding.
• Describe possible side effects and explain what the client should do if they occur.
• Tell the client when to return for routine follow-up care or for resupply, as needed.
• Tell the client to come back whenever they wish, and particularly if they develop any side effects, experience any danger signs, or if there are medical reasons to return (explain potential medical reasons).
• Ask the client to repeat instructions and make sure they remember and understand the instructions.
• Give the client printed instructions to take home, if possible.

R: Return (Return for follow-up care)
During a follow-up visit:
• Check if the client is using the method correctly.
• Ask if the client has any questions or concerns. Answer any questions and treat all concerns seriously.
• Ask the client if they have experienced any problems. Help address any problems.
• Ask if the client is satisfied with the current method. If the client is not satisfied, ask if they want to try a different method. If so, help the client choose another method and explain how to use it. Remember and explain to the client: changing methods is normal; no one can determine if a method works well for them without trying it. Also, a person’s situation can change, making a different method a better choice.
• Ask if the client has experienced any health problems since the last visit. Discuss if another method may be better, based on such problems, and provide referrals for additional care, as needed.
• If a client wants an intrauterine device (IUD) or implant removed, arrange for the removal. If the client plans to become pregnant, provide information for prenatal care as well as voluntary counseling and testing to prevent possible mother-to-child transmission of HIV, as appropriate.
• Check whether the client might need STI protection and/or voluntary counseling and testing for HIV.
The REDI Model of Counseling

Note: The content contained within this section is adapted from REDI: A Client-Centered Counseling Framework.43

The REDI framework, designed with a client-centered approach, aims to ensure provision of comprehensive FP counseling as part of integrated health services. REDI is an acronym for the four components of the framework:

- Rapport-building with the client
- Exploring the client's needs and situation
- Decision-making with the client
- Implementing the decision and helping the client develop an action plan

The REDI framework is appropriate for PAC counseling because: it emphasizes the client's responsibility for making and implementing a decision; it provides guidelines for considering the client's sexual relationship(s) and social context; it takes into consideration gender issues; it addresses the challenges that a client may face in implementing a decision; and it offers skills development to help clients meet these challenges. REDI provides a useful framework for counseling, but it does not necessarily need to be followed exactly or in sequential order. REDI is rather a suggested guide of steps and topics to cover while engaging the client in an interactive, two-way discussion of the client's needs, desires, and method eligibility. The table below provides a summary of each phase of the REDI framework.

---

**Phase 1: Rapport-Building**

- Welcome the client.
- Make introductions.
- Introduce the subject of sexuality.
- Assure confidentiality and privacy.

**Phase 2: Exploring**

- Explore the client’s circumstances, needs, risks, sexual life, social context, and reproductive intentions.
- Assess the client’s knowledge and give information as needed.
- Assist the client to perceive or determine their own HIV and other STI risk.
- Explore reasons for satisfaction or dissatisfaction with FP method(s) for current users.

**Phase 3: Decision-Making**

- Identify what decisions the client needs to make in this session.
- Identify the client's options for each decision (e.g., pregnancy prevention, STI and HIV risk reduction).
- Confirm medical eligibility for any method(s) the client is considering.
- Weigh the advantages, disadvantages, and consequences for each action.
- Confirm that any decision the client makes is informed, well-considered, and voluntary.

**Phase 4: Implementing the Decision**

- Assist the client to make a concrete and specific plan for carrying out the decision.
- Identify barriers that the client may face in implementing the plan.
- Develop strategies to overcome the barriers identified.
- Make a plan for follow-up care and/or provide a referral, as needed.

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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.

Time Allocation
2 hours, 15 minutes

Training Materials
- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Video (on STIs and/or HIV and AIDS)
- Handouts
- National policy guidelines, protocols, job aids, and syndromic management algorithms

Advance Preparation
- Review (and update, as needed) all training materials for the session.
- Print adequate copies of handouts.
- Obtain and review copies of local or official guidelines on STI treatment protocols, HIV counseling and testing, and antiretroviral therapy, if applicable.

Trainer Notes
Include this session in the training only if the country has high STI and/or HIV prevalence (more than 5%), has the human and financial resources to provide STI evaluation and HIV counseling and/or referral for HIV testing, and the government has included training in STI evaluation and HIV counseling and/or referral for HIV testing as a part of PAC training. If this session will not be included in this training, use the allotted time instead for FP counseling and/or skills strengthening for IUD and implant insertion.
Trainer Notes

The content contained within this section is largely adapted from the following sources: Guidelines for the Management of Sexually Transmitted Infections, Sexually Transmitted and Other Reproductive Health Tract Infections, Guidelines for the Treatment of Neisseria Gonorrhoeae, Guidelines for the Treatment of Chlamydia Trachomatis, Guidelines for the Treatment of Treponema Pallidum (Syphilis), and Guidelines for the Management of Symptomatic Sexually Transmitted Infections.


## Session Plan: Module 3, Session 2
### Sexually Transmitted Infection and HIV Service Provision

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session&lt;br&gt;Review learning objectives&lt;br&gt;Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning&lt;br&gt;Display and discuss learning objectives</td>
<td>Warm-up or icebreaker&lt;br&gt;Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Watch a video</td>
<td>Present video on STIs and/or HIV and AIDS</td>
<td>Video presentation&lt;br&gt;Group discussion</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Describe the symptoms and complications of common STIs as well as HIV and AIDS (Objective 1)</td>
<td>Introduce and present symptoms and complications of common STIs</td>
<td>Interactive presentation&lt;br&gt;Group discussion</td>
</tr>
<tr>
<td>15 minutes</td>
<td>List the essential STI information that all PAC clients should receive before discharge (Objective 2)</td>
<td>Review and discuss STI and HIV risks, prevention, and treatment</td>
<td>Group discussion</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Explain how to evaluate, treat, and follow up with clients with STIs using the syndromic approach (Objective 3)</td>
<td>Review and discuss syndromic management of clients</td>
<td>Interactive presentation&lt;br&gt;Group discussion</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Provide counseling within the context of STIs and HIV risk (Objective 4)</td>
<td>Review and discuss approaches to counseling clients on STIs and HIV</td>
<td>Interactive presentation&lt;br&gt;Group discussion</td>
</tr>
</tbody>
</table>

**Trainer Notes**

Review the resources cited in Module 3, Session 2 of the Reference Manual. Update to include additional locally available and relevant materials, such as journal articles, topic-specific curricula, job aids, and websites.
Handout: The Syndromic Approach to Management of Sexually Transmitted Infections

Note: The content contained within this handout is adapted from Guidelines for the Management of Symptomatic Sexually Transmitted Infections.50

Rationale
The syndromic approach to management of sexually transmitted infections (STIs) is commonly used in resource-limited settings because:

- Providers may be constrained by lack of time and resources to diagnose and treat STIs more conventionally.
- Providers may lack equipment or skills to diagnose STIs using laboratory tests and test results may not be available for several days, which makes follow-up care difficult, including in cases where:
  - Laboratory tests or reagents are unavailable.
  - Clients are seeking relief of symptoms immediately and/or may not be willing or able to return later for test results or treatment.
- Clients (and their partners) may not have the resources to present for testing and then again for treatment.

Elements of Success
- A reliable supply of required medications
- Referral clinics
- STI service delivery systems and structures within primary health centers
- Epidemiological surveillance systems to identify the most cost-effective antibiotics
- Readily and cheaply available condoms promoted to the public
- Mass media communication to increase awareness about STIs, promote condom use, support mutual monogamy, and encourage demand for treatment
- Contact tracing and treatment systems
- National standardized treatment protocols for STIs based on international guidelines, including the syndromic approach, that ensure adequate treatment at all levels and facilitate training and supervision

Advantages of Syndromic STI Management
- Improves clinical diagnosis and avoids ineffective treatment
- Can be learned by a variety of providers, including primary health workers, clinical officers, medical assistants, nurses, and/or midwives
- Allows for treatment of symptomatic clients in one visit
- Is effective for diagnosing urethral discharge in men and genital ulcers in men and women
- Can easily be integrated into other health services, such as postabortion care, assuming availability of adequately trained providers, infrastructure, and commodities; this makes this approach to health service provision more client-friendly

Disadvantages of Syndromic STI Management
- Represents a missed opportunity to diagnose and treat individuals who are asymptomatic (symptoms may take up to two weeks to appear)
- Works well for detecting vaginal infections, but not for more serious, often asymptomatic cervical infections
- Potential for over-treatment as clients may be treated for multiple potential infections, despite having no or only one infection; this use of unnecessary medications is costly (particularly in low-resource settings) and may cause microorganisms to develop resistance to antimicrobial medications thereby limiting future treatment options

Syndromic STI Management Flowchart 1: Vaginal Discharge

1. Molecular assays for NG, CT or TV available for all patients
   - Conduct test
   - Results available same day?
     - Yes
       - Treat NG and/o CT based on test result
       - Test positive?
         - Yes
           - Treat NG and/o CT based on test result
         - No
           - No
       - No
       - Test positive?
         - Yes
           - Treat NG and/o CT based on test result
         - No
           - No

2. Low cost rapid point of care test for NG/CT available for all patients (molecular assays not available)
   - Conduct test
   - Test positive?
     - Yes
       - Treat NG and/o CT based on test result
     - No
       - No

3. Speculum available and acceptable (molecular assays or rapid point of care tests not available or for some)
   - Perform speculum exam
   - Evidence of cervicitis
     - Yes
       - Treat NG+CT
     - No
       - No

4. Speculum NOT available or NOT acceptable (tests not available)
   - Vaginal discharge present on genital exam
     - Yes
       - Woman at high risk for STI
     - No
       - Offer HIV testing and syphilis testing, and other preventive services

NG, N. gonorrhoeae; CT, Chlamydia trachomatis; TV, Trichomonas vaginalis; BV, bacterial vaginosis.

*If molecular assay was performed and results were not available on same day, revise the syndromic treatment initially provided according to the test results when available

*perform rapid point of care test or molecular assay if available to confirm NG/CT and treat if positive; if negative do not treat and ask woman to return if symptoms recur

*if woman complains of recurrent or persistent discharge refer to a centre with laboratory capacity
Syndromic STI Management Flowchart 2: Genital Ulcers including Anogenital Ulcers

Person with symptom of genital ulcer

- Take medical and sexual history and assess risk for STIs
- Physical examination of genital and anal areas

Sore or ulcer present?

Yes
- Resources and capacity for molecular assays (e.g., NAAT)
- Perform test

Are results available on same day?

Yes
- Is test positive for HSV and/or syphilis?
  - Yes: Treat based on test results on same day
  - No*

No*

Limited or no laboratory capacity

Yes
- Ulcer vesicular or history of recurrent ulcers in same site?
  - Yes: TREAT for HSV
  - No

No
- History of recent syphilis treatment (past 3 months)?
  - Yes: Treat for syphilis
  - No: Treat for syphilis

Offer HIV and syphilis testing and other preventive services

Review in 1 week if symptoms persist or recur

* HSV, herpes simplex virus

* If molecular assay was performed and results were not available on same day, revise the syndromic treatment initially provided according to the test results when available
Syndromic STI Management Flowchart 3: Lower Abdominal Pain

Sexually active woman with symptom of lower abdominal pain

Take medical and sexual history and assess risk for exposure to STIs

Genital examination (including bi-manual palpation) and speculum examination (where feasible)

Any of the following present?
- Missed/overdue period
- Recent delivery-abortion/miscarriage
- Abdominal guarding and/or rebound tenderness
- Abnormal vaginal bleeding
- Abdominal mass

Yes

Refer patient urgently for surgical or gynaecological opinion and assessment. Before referral set up an IV line and apply resuscitative measures if necessary

No

Is there lower abdominal tenderness or cervical motion tenderness?

No

Any other illness found?

No

Yes

Manage for PID
Test for NG/CT/MG if available*
See patient in 3 days

Yes

Manage appropriately

No

Patient has improved?

No

Refer patient

Yes

Offer HIV and syphilis testing and other preventive services

*to support partner notification.
NG, N. gonorrhoeae; CT, C. trachomatis; MG, M. genitalium.
Handout: Sexually Transmitted Infections and Young People (Ages 10 to 24)

Many of the populations most affected by and at risk for HIV are also at increased risk for viral hepatitis and other sexually transmitted infections (STIs). Further, many of these populations experience vulnerabilities, or are at risk due to social and structural determinants of health, including multiple forms of discrimination and conditions of marginalization or exclusion. Adolescent girls and young women face risks associated with gender inequalities and exposure to violence, which compound health risks associated with biological sex.\(^{51}\)

Generally, young people have higher rates of STIs than older adults. A few of the reasons for this include:

- Young people tend to have more partners and shorter relationships so there are more opportunities for STIs to spread.
- Young people may find it difficult or embarrassing to use condoms.
- Young people may find it difficult to refuse sex, particularly in situations with unequal power dynamics, such as within family structures or in situations where they must engage in transactional sex in exchange for money or goods (e.g., clothes, food, or school supplies).
- Young people may not recognize situations and sexual partners where risk of infection is high.
- Young people may lack knowledge about the symptoms of STIs and when to seek care.
- Young people may feel uncomfortable using contraceptives and seeking reproductive health services for fear of biased and judgmental responses from staff.
- Young people may not be aware of where to access confidential, private services.
- Young people may be unable to afford health services.

To address the higher risk among young people, we must increase access to scientifically accurate, age-appropriate, culturally sensitive, and comprehensive sexuality education that provides all adolescents and youth with information on sexual and reproductive health consistent with their evolving capacities. This includes providing information on STI and HIV prevention, communication and risk reduction skills, and developing respectful relationships—in partnership with young persons, parents or legal guardians and caregivers, educators, and healthcare providers.\(^{52}\)

Safer behaviors that providers should promote with young people include:

- Delaying the onset of sexual activity
- Learning how to use condoms consistently and correctly
- Practicing dual protection to prevent unplanned pregnancies as well as STIs
- Limiting the number of sexual partners
- Avoiding high-risk sexual practices (especially unprotected vaginal or anal sex) with any partner
- Recognizing symptoms of STIs and seeking treatment early

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\(^{52}\) Ibid.
Handout: Counseling the Client about Sexuality and Sexually Transmitted Infection and HIV Risk

Note: The content contained within this section is adapted from Counseling the Postabortion Client: A Training Curriculum.53

When providing sexual and reproductive health counseling, we often need to ask clients personal, sensitive questions. This can be challenging for the client, who may not be used to discussing personal issues with someone other than a family member (or with anyone at all). This can also be challenging for providers and counselors, who must be able to obtain the information to address the client’s risk of unintended pregnancy and sexually transmitted infection (STI) and HIV infections, as well as the client’s concerns about sexuality.

Getting Started

It is best to start the conversation with general, open-ended questions. Asking such questions, for instance, asking about a client’s reasons for seeking care or about their general health, will help establish a rapport for the more sensitive questions. Then, asking more explicit questions will be easier. Introduce the discussion in your own way, depending on the setting, the client, and the type of service the client seeks or needs.

Approaches to Starting the Conversation

• Assure the client that the questions you are asking are routine and that all clients are asked the same questions. For example: “I am going to ask some personal questions now. We ask everyone these questions because we believe that a person’s sexual life is an important part of their health.”

• Assure the client that the questions will have a direct bearing on their healthcare and the decisions made during the visit by explaining, “It is important for me to ask you these types of questions so that I can help you to make health decisions that are right for you.”

• Be sure that the client feels comfortable by noting, “If there are any questions you do not feel comfortable answering, please let me know.”

• Introduce the questions within the context of STI and HIV risk. For example: “As you may know, HIV and other STIs are common here. I would like to talk with you more about your situation so that we can determine if you might be at risk. We discuss this information with all our clients to ensure everyone receives the information and contraceptive method that best meets their needs. I will need to ask you some rather personal questions, but I’m asking these questions so I will know how best to help you.”

Other General Questions to Help Start the Conversation

Here are some other general questions to help start the conversation. Use one or more of these as appropriate.

• Can you tell me about your spouse, sexual partner, or partners?

• Are you happy with your sex life? Why or why not? Do you talk with your partner about it?

• Tell me about your first sexual experience. Note: This is especially important for adolescent clients.

Getting Specific: Probing Questions

More sensitive questions may be integrated into a discussion of medical history, demographics, or risk factors pertinent to the service(s) being provided. If the information does not emerge through general discussion, ask probing questions on STI and HIV risk, contraception, or other relevant issues. The list of issues here should not be used as a checklist, but rather as a guide for remembering key issues when obtaining a client’s sexual history. Include questions about the client’s sexual life, sexual practices, sexual risks, and social context as part of a two-way conversation about their individual situation.

Risks Associated with STIs and HIV

Try to obtain information about the following to assist the client in determining their risk for STIs and HIV:

• Number and sex of current and past sexual partners

• Knowledge of partner’s or partners’ sexual practices

• Condom use
• History of STIs, reproductive tract infections, and other related infections
• Sexual practices and behaviors

Contraceptive Concerns
In addition to obtaining information about contraceptive history and needs, reproductive intentions, and potential contraindications, explore factors associated with sexuality that may affect contraceptive choice and continuation, including:

• Fear of becoming pregnant
• Fear of disease
• Concerns about the negative impact of a method on sexual pleasure
• Diminished sexual response due to the use of hormonal methods
• HIV and STI risk (see above)

Other Possible Issues
• Past surgeries or diseases related to sexual functioning
• Sexual concerns associated with the onset of menopause
• Sexual dysfunction in the client or the client’s partner(s)
• Pain during sex
• Lack of desire, orgasm, or sexual satisfaction
• Insufficient lubrication
• Age of sexual debut
• Experience of recent or past sexual coercion or violence\(^{54,55}\)
• Impact of alcohol and/or substance use on sexual activity and associated risks
• Partner’s use of, support for, and communication about contraceptive use and disease prevention


Handout: Sample Questions for Counseling a Client about Sexuality and Sexually Transmitted Infections and HIV Risk

Note: The content contained within this section is adapted from Counseling the Postabortion Client: A Training Curriculum.56

The following questions may be useful when providing counseling about sexually transmitted infections (STIs) and HIV. Choose or adapt questions as needed, avoiding questions that may not be culturally or socially appropriate in your setting or situation. Also note, some questions may not be appropriate or needed for counseling a postabortion client or for clients in other situations.

- When did you first become sexually active?
- Can you tell me how many sexual partners you have had? Were your sexual partners male or female?
- Did you consent or agree to all your past sexual experiences?
- Have you ever used any kind of contraception or family planning method in your sexual relationships? If so, which method(s)? How frequently have you used this method or these methods?
- Have you ever used condoms? If not, would you be interested in using condoms in your current or future relationships?
- To your knowledge, have you or any of your past or current partners ever had an STI?
- Do you have any other partners besides your primary partner? Do you think that your partner may have other partners?
- Have you had more than one sexual partner in the past year? Has your partner had more than one sexual partner in the past year?
- Do you feel any itching, burning, or other discomfort in your genital region? Are you now experiencing, or have you ever experienced, an unusual discharge (from your vagina or penis)?
- Do you have any questions or concerns about your sexual relationship that you would like to discuss?
- Do you think you may be at risk for HIV or other STIs? Do you think that your partner could be at risk for HIV or other STIs?
- What do you do to protect yourself from STIs?
- How would you feel about a (or another) pregnancy at this time? How do you think your partner would feel?

Handout: Management of Sexually Transmitted Infections

Carefully Completing Abdominal and Pelvic Examinations

When conducting abdominal and pelvic exams for a postabortion client (either during an initial assessment or follow-up visit), pay close attention for presence of the following potential signs of a sexually transmitted infection (STI):

- Lower abdominal pain or tenderness
- Genital sores or ulcers, or swelling (buboes) in the groin
- Pain or tenderness on cervical motion
- Presence of discharge from the urethra
- Presence of a purulent (containing mucopurulent) discharge, a friable (easily bleeds) cervix, or unrecognized vaginal discharge
- Suprapubic, adnexa, or pelvic mass

Using Appropriate STI Treatment Flowcharts

Refer to the Syndromic Approach to Management of Sexually Transmitted Infections handout for guidance on vaginal discharge, genital ulcers, and lower abdominal pain. The handout includes three flowcharts:

- Syndromic STI Management Flowchart 1: Vaginal Discharge
- Syndromic STI Management Flowchart 2: Genital Ulcers including Anogenital Ulcers
- Syndromic STI Management Flowchart 3: Lower Abdominal Pain

Using the Four C’s

The four C’s are: (1) compliance, (2) condoms, (3) counseling and education, and (4) contact tracing.

Compliance

Once clients understand the information regarding their care, they play an important part in making decisions about that care and in completing the agreed-upon treatment, including seeking follow-up care. The following table outlines provider and client roles in compliance.

<table>
<thead>
<tr>
<th>Provider Roles</th>
<th>Client Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Give clear, simple instructions regarding relevant medications or treatment using terminology that the client understands.</td>
<td>Take all required medications for the full time prescribed and in the right dosage.</td>
</tr>
<tr>
<td>Emphasize the importance of completing the prescribed course of treatment.</td>
<td>Complete the course of treatment prescribed.</td>
</tr>
<tr>
<td>Explain any side effects and danger signs associated with the treatment and the appropriate response.</td>
<td>Be aware of danger signs and seek care accordingly.</td>
</tr>
<tr>
<td>Encourage the client to ask questions and ensure the client demonstrates understanding of the information by asking the client to repeat information.</td>
<td>Listen carefully and ask questions to be sure you understand the treatment instructions.</td>
</tr>
<tr>
<td>Schedule follow-up appointments.</td>
<td>Return for follow-up appointments.</td>
</tr>
</tbody>
</table>
Condoms

In addition to preventing pregnancy, condoms (external and internal) can prevent the spread of STIs and HIV, if used properly. It is important to feel comfortable talking about condoms and demonstrating condom use with clients. Discuss and demonstrate the correct use of external and internal condoms with a client according to the client’s preferred type of condom. During the demonstration, show the client how to:

- Ensure that the condom is not expired.
- Ensure that the package and the condom are not punctured.
- Properly open the package.
- For the external condom, pinch the tip to remove residual air and create a reservoir for semen.
- Properly roll the external condom on an erect penis or properly insert the internal condom into the vagina and ensure the external genitalia is appropriately covered.
- Safely remove the condom without self-contamination.
- Safely dispose of the used condom.

Note: Postabortion clients should not insert anything into the vagina immediately after emergency treatment for abortion-related complications and until the bleeding stops (usually after five to seven days). These clients may resume sexual intercourse and use condoms as described only after the bleeding has stopped.

Counseling and Education

Counseling includes providing health information and education. Listening to what clients say and how they say it can help you to provide the information they need. Further, many groups that are at risk of contracting STIs and HIV experience vulnerabilities related to social and structural determinants of health, including multiple forms of discrimination and conditions of marginalization or exclusion. Young people (ages 10 to 24), especially adolescent girls and young women, are particularly at risk. Although each encounter with a client is short, it is important to inform every client of the risks of HIV and AIDS. Refer to the handouts entitled Sexually Transmitted Infections and Young People (Ages 10 to 24), Counseling the Client about Sexuality and Sexually Transmitted Infection and HIV Risk, Sample Questions for Counseling a Client about Sexuality and Sexually Transmitted Infections and HIV Risk, and HIV Counseling and Referral to guide counseling sessions about STIs and HIV.

Contact Tracing

Contact tracing is critical for clients who test positive for an STI. Contact tracing requires a strong rapport between the provider and the client. Clients need to understand the importance of discussing STI and HIV risks with their partners and encouraging their partners to seek treatment. Help clients think about how they will discuss the issue with their partner(s), recognizing that this can be an extremely difficult task for some clients, including those who may fear stigma or physical abuse. Let clients know that anyone with whom they have had sexual contact should seek treatment for the STI even if they are asymptomatic. Providers can increase the number of contacts who seek treatment by giving clients appointments for their contacts and offering to discuss the risk with them and their contacts together.

Providing Return Visit and Follow-Up Care

Refer to the Syndromic Approach to Management of Sexually Transmitted Infections handout, particularly the appropriate syndromic management flowchart, for return visit guidelines.

Preventing and Addressing STIs: Information for Clients

- To prevent STIs, remember the ABCs:
  - Abstain from sex.
  - Be faithful, stay with one sex partner.
  - Consistently use condoms.
• Protect yourself against HIV by protecting yourself from other STIs, which can increase the risk of contracting HIV.
• Understand that while there may be treatment for some STIs, some STIs cannot be cured, including HIV.
• If you think you may have an STI:
  » Seek care quickly, even if you do not have symptoms.
  » Avoid sex or at least use condoms every time you have sex to reduce the spread of STIs.
• If you are diagnosed with an STI:
  » If you are prescribed medicine for an STI, take all prescribed medicine as directed, even if symptoms cease or you feel better. Additionally, avoid sex until three days after you have taken all of your medication and until you are no longer experiencing any symptoms.
  » Help your sex partner(s) seek treatment by referring them for care and/or accompanying them.
  » Return for care when instructed to ensure you are cured. If you continue to experience symptoms, you can also obtain more medication to cure your infection during a follow-up visit.
  » Protect your baby by attending (or encouraging your partner to attend) an antenatal clinic within the first three months of pregnancy for a physical exam, syphilis test, and voluntary HIV screening test.
Handout: HIV Counseling and Referral

HIV prevention counseling should focus on the client’s unique circumstances and risks and should help the client set and reach an explicit behavior-change goal to reduce the chance of contracting or transmitting HIV. Counseling clients about HIV in a nonjudgmental way is critical. Imposing guilt or conveying disapproval does not help people deal responsibly with HIV or any sexually transmitted infection (STI). Help clients learn how to prevent transmission to others and how to protect themselves from other infections.

HIV counseling is usually, but not always, conducted in the context of HIV testing. The role of the postabortion care provider is to provide HIV information and prevention counseling to postabortion clients (as appropriate) and to refer clients to other services for testing and treatment (unless the client declines).

The provider should be familiar with and able to share information about facilities that offer HIV testing and treatment services and the associated costs. In some countries, self-testing kits are available, and clients should be informed of this option.57

While counseling postabortion clients about HIV, providers should:
- Explain HIV and AIDS and the ways in which HIV is transmitted.
- Discuss ways to prevent the spread of HIV.
- Provide information related to accessing testing and treatment, including pre-exposure prophylaxis, as appropriate.

Detailed information on testing methods is a part of the pretest counseling at the test site. Posttest counseling includes notifying the client of the HIV test results, addressing the client’s reaction to the test results, and offering individualized information related to the client’s results.

Refer to the handouts entitled Sexually Transmitted Infections and Young People (Ages 10 to 24), Counseling the Client about Sexuality and Sexually Transmitted Infection and HIV Risk, Sample Questions for Counseling a Client about Sexuality and Sexually Transmitted Infections and HIV Risk, and Management of Sexually Transmitted Infections for more information. Additionally, the Basic Facts about HIV and AIDS handout outlines fundamental information about HIV and AIDS that may be useful in providing pre- and posttest counseling and health information to postabortion clients.

Handout: Basic Facts about HIV and AIDS

What Is HIV?
- HIV is an acronym for human immunodeficiency virus.
- HIV is the virus that causes AIDS. Most people who contract HIV will eventually develop AIDS.
- The HIV virus is found in amniotic fluid, breastmilk, blood, semen, pre-ejaculate, rectal fluids, and vaginal fluids of infected persons.
- A person may be diagnosed as HIV-positive or HIV-negative based on a blood test:
  - A person whose blood test result is HIV-positive has been infected by HIV; this person may be described as seropositive, HIV-positive, or HIV-infected.
  - A person whose blood test result is HIV-negative is said to be seronegative, HIV-negative, or not infected with HIV. Note: If a person with an HIV-negative test result has engaged in behavior that places them at risk for HIV in the past three months, then the test result may not be an accurate indication of the person’s HIV status because the person might be in the window period and should be re-tested later.
- There is no cure for HIV; however, there are medications that effectively suppress the virus.

What Are the Different Types of HIV?
- HIV-1 and HIV-2 are the two types of HIV; both types are transmitted the same way and both are associated with similar opportunistic infections and AIDS.
- In some cases, a person may become infected with both HIV-1 and HIV-2.
- HIV-1 is more common worldwide. HIV-2 is found primarily in Angola, Mozambique, and West Africa.
- HIV-1 is more easily transmitted than HIV-2 and it is more pathogenic (meaning that the period between initial infection and illness is shorter).
- While HIV-2 can be transmitted from an infected mother to her child, this appears to be rare (0% to 5% transmission rate in breastfed infants in the absence of any interventions).

What Is AIDS?
- AIDS is an acronym for acquired immunodeficiency syndrome:
  - Acquired: differentiating from a genetic or inherited condition that causes immune dysfunction
  - Immuno: the immune system
  - Deficiency: the inability to protect against illness
  - Syndrome: the group of symptoms or illnesses that result from the HIV infection
- AIDS refers to the most advanced stage of HIV infection. Most people who contract HIV will eventually develop HIV-related disease(s) and AIDS.
- AIDS is a group of serious illnesses and opportunistic infections that develop after a person has been infected with HIV for a long period of time.
- A diagnosis of AIDS is based on specific clinical criteria and laboratory test results.

How Do HIV and AIDS Progress?
- HIV is the virus that causes the initial infection.
- HIV destroys specific white blood cells (CD4 cells) thereby weakening the immune system. When the immune system becomes weak or compromised, the body loses its protection against infection and disease.
The progression of HIV is measured by CD4 count and viral load:

- **CD4 count** is the number of CD4 T-lymphocyte cells in the blood. CD4 cells are the type of white blood cells that are the immune system’s key infection fighter. The CD4 count reflects the health of the immune system.

- **Viral load** refers to the amount of HIV in the blood. The viral load can be measured by polymerase chain reaction testing. The test can be used to check the person's response to antiretroviral therapy.

When HIV actively multiplies, it infects and kills CD4 cells. The CD4 count is usually expressed as the number of cells per cubic millimeter. The typical CD4 count of a healthy adult is between 500 and 1,400 cells/mm³. As the CD4 count falls below 200 cells/mm³, the risk of opportunistic and serious HIV-related infections becomes higher.

The viral load is extremely high shortly after a person first becomes infected with HIV. A high viral load leads to a higher transmission risk. The viral load falls steeply when the body develops antibodies to HIV. The viral load rises again after several years as the immune system weakens and the CD4 count drops. A high viral load (after the initial infection period) can also be a sign of more severe disease progression.

People infected with HIV usually develop antibodies within four to six weeks of becoming infected, but it may take as long as three months for antibodies to develop.

The period between when a person is infected and when they test positive for HIV is called the window period.

Seroconversion refers to the point at which the result of an HIV test changes from negative to positive. Some people experience a flu-like illness (enlarged lymph nodes, fever, joint pains, and rash) at the time of seroconversion. This is referred to as acute retroviral syndrome.

Without antiretroviral therapy, as time passes, the immune system becomes unable to fight the HIV infection and the infected person may develop serious and deadly diseases, including other infections and certain types of cancer.

As the HIV infection progresses, the infected person becomes susceptible to opportunistic infections.

- An opportunistic infection is an illness caused by an organism that might not cause illness in a healthy person but will cause illness in a person who has a weakened immune system.

- People living with advanced HIV infections may suffer from opportunistic infections of the brain, eyes, lungs, and other organs. For example, coinfection with tuberculosis is common among people living with HIV.

- Other common opportunistic infections in persons living with AIDS include cryptosporidiosis; histoplasmosis; pneumocystis carinii pneumonia; other parasitic, viral, and fungal infections; and some types of cancers, such as Kaposi’s sarcoma.

### What Is an Asymptomatic HIV Infection?

- A person who is HIV-infected may have no signs of illness and may look and feel healthy—meaning they do not have physical signs or symptoms of HIV; this person is asymptomatic.

- A person with an asymptomatic HIV infection can still transmit the infection to others.

- The duration of the asymptomatic phase varies greatly from person to person—some may develop HIV symptoms within a few months of primary infection, others may take up to 15 years to develop symptoms.

### What Is a Symptomatic HIV Infection?

- A person who has developed physical signs and symptoms of HIV is symptomatic.

- The immune system weakens and CD4 count decreases during this phase.

- The progression of HIV depends on the type of virus and specific host characteristics including general health, nutrition, and immune status.
When Does HIV Progress to AIDS Infection?

- As HIV progresses, the CD4 count continues to decrease, and the infected person becomes more likely to develop opportunistic infections and other HIV-related infections.
- Most people who are HIV-infected will eventually develop advanced HIV infection and AIDS. The duration of this progression varies: it may occur within several months or not occur for more than 15 years.
- Even if the symptoms of AIDS develop and then subside for a while, the virus that causes them is still present, and the infected person can still transmit the disease.

How Is HIV Contracted?

- HIV can be contracted through sexual contact (anal, oral, or vaginal intercourse) with an infected person, during which semen or vaginal fluids and/or blood come into contact with the penis, the lining of the mouth, rectum, or vagina. The HIV in these fluids can then infect the blood stream. HIV can enter the blood through open genital or oral sores or cuts.
- HIV can be contracted through transfusions or treatments with infected blood products.
- HIV can be contracted through skin-piercing instruments that have been in contact with infected blood or body fluids and have not been properly disinfected; this includes: needles, syringes, and razor blades, as well as instruments used to provoke an abortion and circumcision instruments.
- Infants can contract HIV from an infected mother during pregnancy, childbirth, or breastfeeding. In the absence of intervention, there is a 15 to 45% chance that a mother living with HIV will transmit the infection to their newborn child. A child’s risk of HIV infection must be weighed against the risk of the child dying from other causes if it is not breastfed; for instance, diarrheal disease, which can be fatal, is often attributed to the use of contaminated water and food in place of breastfeeding. A client who is living with HIV (or suspects they are) and wishes to breastfeed should consult a skilled provider for up-to-date information and counseling.

How Is HIV Not Contracted?

HIV is not contracted through any of the following:

- Insect bites
- Kissing a person living with HIV
- Hugging, shaking hands with, or having other ordinary social contact with a person living with HIV
- Living with a person living with HIV
- Saliva from a person living with HIV
- Sharing clothes with a person living with HIV
- Sharing or touching food or dishes used by a person living with HIV
- Sweat from a person living with HIV
- Tears from a person living with HIV
- Toilet seats used by a person living with HIV

What Are the Symptoms of HIV and AIDS?

Persons infected with HIV may be asymptomatic. It can take years between HIV infection and the diagnosis of AIDS. Once symptoms begin to develop, they may include:

- A cough that persists for more than one month
- An unexplained loss of 10% of body weight within one month
- A white coating on the tongue
- Diarrhea for one month or more

vvention,from%202015%25%20to%2045%25.
Enlarged or sore glands in the armpit and/or neck
 Persistent fever of unknown origin
 Persistent symptoms of vaginitis

Since these symptoms may represent other diseases (a persistent cough may be a symptom of tuberculosis, diarrhea may indicate an intestinal illness), a blood test is required to confirm the presence of HIV. People living with HIV may look as healthy as any other person.

Who Is at Risk?
Anyone can become infected with HIV, but only through the means described above. Clients who are at high-risk include:

- Sex workers
- Men who have sex with men
- People who have multiple sexual partners, or whose sexual partners have multiple partners
- People who use intravenous drugs
- People who have received unscreened blood products
- Healthcare workers who have direct contact with infected blood

<table>
<thead>
<tr>
<th>Adolescents and HIV</th>
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</thead>
</table>
| HIV testing and counseling—with linkages to prevention, treatment, and care—is recommended for adolescents from key populations in all settings. Adolescents should receive counseling about the potential benefits and risks of disclosing their HIV status to others as well as support to determine if, how, when, and to whom to disclose. All forms of HIV testing and counseling must adhere to the five Cs: (1) consent, (2) confidentiality, (3) counseling, (4) correct test results, and (5) connections to treatment, care, and prevention services. Adolescents consistently indicate preferences for compassionate, friendly, and competent staff as well as counseling linked with testing and other services along the continuum of HIV care, including rapid testing, free of charge. When counseling adolescents about HIV:
  - Be open to listening to their needs, emotions, and concerns.
  - Encourage and praise behavior(s) that lessens the risk of infection.
  - Assist adolescents in identifying alternatives to high-risk behavior(s).
  - Be nonjudgmental.
  - Explain risks and dispel myths in an objective manner.

*Note: The content contained within this section is adapted from HIV and Adolescents: Guidance for HIV Testing and Counseling and Care for Adolescents Living with HIV.*

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Are HIV and AIDS Preventable?

**Strategies to Prevent HIV Transmission through Transfusions or Treatments**

- Screen all blood and blood products for HIV.
- Follow universal precautions, including:
  - Personal protective equipment use
  - Pre- and postexposure prophylaxis
  - Safe disposal of contaminated waste products
  - Safe use and disposal of sharps
  - Sterilization of equipment

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Strategies to Prevent HIV Transmission through Sexual Contact

- Promote abstinence or being faithful to one uninfected partner.
- Provide instructions on the consistent and correct use of barrier methods:
  - External or internal condoms for penile-vaginal intercourse
  - External condoms (without lubrication) for oral intercourse on a penis
  - Dental dams, plastic wrap, or latex underwear for oral intercourse on a vagina
  - External condoms for anal intercourse
- Prevent, identify, and provide early treatment for STIs.
- Provide access to HIV testing and counseling.
- Provide access to pre-exposure prophylaxis, as outlined in national guidance documents.\(^\text{60}\)

Note: Condoms provide protection from HIV as well as other STIs when used correctly and consistently.

Strategies to Prevent HIV Transmission through Intravenous Drug Use

- Provide education about the risks of infection via drug use with contaminated needles and syringes.
- Provide referrals for treatment of substance abuse and misuse.

Is there Treatment for People Living with HIV?

- Though there is currently no cure for HIV, there are several different types of medications to treat people living with HIV. These medications attack various aspects of the process used by the virus to replicate itself.
- Because HIV quickly mutates to become resistant to any single medication, people living with HIV must take a combination of medications to achieve maximum suppression. The combination of medications used for this treatment is known as antiretroviral therapy.
- Antiretroviral therapy changes the natural course of HIV infection, significantly extending the period between initial infection and the development of symptoms.
- It is important to start antiretroviral therapy before AIDS symptoms develop. However, even those who start therapy after being diagnosed with AIDS can receive major and long-lasting health benefits.
- Although effective in slowing the progression of HIV-related diseases, antiretroviral therapy is not a cure. Additionally, because there is no cure for HIV, these medications must be taken for life. Antiretroviral medications are also used to prevent HIV infection among clients at risk of contracting HIV or immediately after exposure to the virus. In addition to treatments for HIV itself, therapies exist to prevent and/or treat many HIV-related opportunistic infections.

What Are the Best Contraceptive Methods for Clients with a History of STIs and/or HIV and AIDS?

- People living with HIV who use antiretroviral medications can live similarly to those without HIV but must always be cautious of transmitting HIV to any sexual partners. Therefore, it is critical to emphasize dual-method protection for all clients during STI and HIV counseling.
- Dual method protection—combining condoms with a second, more effective contraceptive method (oral contraceptives, implants, etc.)—increases the level of protection against both STIs and unintended pregnancies—meaning, condoms should be used with all methods.
- When condoms are the primary method, a spermicide should also always be used.
- Clients with chlamydia, gonorrhea, pelvic inflammatory disease, or purulent cervicitis should not have an intrauterine device (IUD) inserted until the infection is resolved.
- Clients who are extremely high risk of STIs should only use an IUD if there no other appropriate or acceptable methods available; clients who opt for an IUD should be directed to use condoms as well.\(^\text{61}\)


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 antisepsis, use of barriers, maintenance of the procedure area, waste management, and processing of medical devices and other items for reuse. Note: For settings where autoclaving equipment is common, adapt the content of this session accordingly.

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.

Time Allocation

6 hours, 30 minutes

Training Materials

- Projector, laptop, and PowerPoint slides
- Flip chart stands, paper, and markers
- Case studies
- Handouts
- Videos on infection prevention
- Current national and institutional guidelines, protocols, and job aids on infection prevention
- Demonstration and practice materials, including alcohol handrub, chlorine solution and water for preparing chlorine solution, and personal protective equipment

Advance Preparation

- Review (and update, as needed) all training materials for the session.
- Print adequate copies of handouts.
- Review and select (or modify, as appropriate) case studies based on local conditions.
- Obtain and review copies of national and institutional guidelines, protocols, and job aids on infection prevention, including waste management. Consider printing as handouts or saving electronic copies of these materials to distribute to participants.
- Set up demonstration and participant workstations.
**Session Plan: Module 4, Session 1**
**Infection Prevention including Reprocessing Medical Devices Used for Postabortion Care in Health Facilities**

<table>
<thead>
<tr>
<th>Time</th>
<th>Objectives &amp; Activities</th>
<th>Training Content</th>
<th>Learning Activities &amp; Methodologies</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 minutes</td>
<td>Introduce the session&lt;br&gt;Review learning objectives&lt;br&gt;Allow participants to ask questions and respond, as needed</td>
<td>Select an activity to set the stage for learning&lt;br&gt;Display and discuss learning objectives</td>
<td>Warm-up or icebreaker&lt;br&gt;Presentation (consider involving participants in reading objectives)</td>
</tr>
<tr>
<td>25 minutes</td>
<td>Watch the video (optional)</td>
<td>Present video and discuss infection prevention</td>
<td>Video presentation&lt;br&gt;Group discussion</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Explain the principles of infection prevention, including standard precautions (Objective 1)</td>
<td>Introduce and discuss infection prevention principles</td>
<td>Interactive presentation&lt;br&gt;Group discussion</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Demonstrate effective hand hygiene procedures (Objective 2)</td>
<td>Demonstrate and practice hand washing and use of alcohol handrub</td>
<td>Interactive presentation&lt;br&gt;Demonstration and return demonstration (practice can begin during this session and continue later, as time allows)&lt;br&gt;Case studies (time permitting)</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Describe the appropriate use of antiseptics and the no-touch technique (Objective 3)</td>
<td>Demonstrate and practice use of antiseptics and the no-touch technique</td>
<td>Note: Use supplies and equipment used in local health facilities, preferably from participants’ facilities, and emphasize adherence to national infection prevention guidelines and protocols.</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Demonstrate appropriate gloving practices (Objective 4)</td>
<td>Demonstrate and practice gloving</td>
<td></td>
</tr>
<tr>
<td>30 minutes</td>
<td>Demonstrate correct use of personal protective equipment (Objective 5)</td>
<td>Demonstrate and practice use of personal protective equipment</td>
<td></td>
</tr>
<tr>
<td>30 minutes</td>
<td>Demonstrate safe handling of sharps (Objective 6)</td>
<td>Demonstrate and practice safe handling of sharps</td>
<td></td>
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<tr>
<td>30 minutes</td>
<td>Demonstrate safe disposal of contaminated waste (Objective 7)</td>
<td>Demonstrate and practice safe disposal of waste</td>
<td></td>
</tr>
<tr>
<td>30 minutes</td>
<td>Describe recommended housekeeping practices (Objective 8)</td>
<td>Demonstrate and practice recommended housekeeping</td>
<td></td>
</tr>
<tr>
<td>2 hours</td>
<td>Demonstrate how to process reusable equipment and other items used in PAC provision (Objective 9)</td>
<td>Demonstrate and practice processing reusable equipment and related items</td>
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</tr>
</tbody>
</table>
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?
Case Studies: Infection Prevention—Answer Key

Case Study 1: Marie and Nathalie
Marie and Nathalie should have received infection prevention training when they were hired to learn that sweeping with a dry sweeper or straw broom scatters dirt and dust rather than trapping it. Instead, they should mop floors with a damp mop and clean surfaces with a damp cloth. They should clean all PAC procedure areas and surgical theater furniture using a damp cloth soaked in chlorine solution every morning to decrease the potential for infection. This applies to procedure areas and operating theaters that are used daily and to those that are not.

Case Study 2: Ms. P.
The incorrect practices include:
- Improper disposal of syringes and needles.
- Disposal of medical waste in a shallow pit that is easily accessible to the community.
- Lack of knowledge of appropriate practices by providers and other clinic staff as well as members of the community (including the teens scavenging in the pit, those to whom they give the syringe barrels, and others who could contract an infection through exposure to one of the girls or those using the syringe barrels)—all of whom are at risk of infection.

Ms. P. should inform clinic administration and staff of the situation and organize an infection prevention update for all staff on safe use and disposal of needles and syringes. The clinic should then develop and implement a plan to:
- Improve the waste disposal site so that it is not easily accessible to members of the community.
- Purchase safety boxes and other infection prevention and control items as well as purchase and install fencing or other protective barriers around the areas used for temporary storage and/or disposal of waste.
- Ensure availability and appropriate use of safety boxes for disposal of sharps and disposal of the safety boxes according to the national guidelines; for instance, disposal by incineration or by burying the needles and syringes so that both are inaccessible and unusable.
- Hold educational sessions for the clinic’s clients and community members in the surrounding area about the potential hazards of medical waste.

Case Study 3: Dr. T.
The inappropriate practices here include the improper sharps disposal and the dumping of medical waste in areas that are accessible to the community. After treating the injury and explaining the potential risk to the injured man, Dr. T. should undertake the following immediate actions:
- Hold a meeting with the staff responsible for waste disposal to discuss the incident and explain the risk to the community from such accidents.
- Assess overall waste management practices, including collection, transportation, and disposal practices among all levels of staff.
- Institute a program to ensure staff sort waste so that the only waste directed to the incinerator is medical waste that can cause infection or injury if not incinerated.
- Establish an in-service refresher course for all staff to clarify and reinforce roles in waste management for infection prevention, including the safe use and disposal of sharps. This refresher should be followed by periodic evaluations to continually assess the consistency of correct waste disposal practices.
- Ensure availability of postexposure prophylaxis for HIV as a preventive measure for providers and clients.
Case Study 4: Mrs. D.
No, the chlorine solution from yesterday should not be used today because chlorine loses its effectiveness over time. Also, the chlorine should be used when cleaning blood and spills of blood products and other body fluids, not for processing instruments. Chlorine may also be used for wiping surfaces in the procedure area and in the wards at a lower concentration. Mrs. D. should make a new solution at the beginning of each day and whenever the solution appears cloudy. Note, however, that when bleach powder is used, the solution is likely to look cloudy at the start.

Case Study 5: Ms. A.
The PAC procedure area should be a “clean area” and washing used instruments and other items is a “dirty” procedure. Dirty procedures should not be performed in clean areas. When a PAC procedure is being performed, washing dirty instruments in the vicinity increases the risk contamination of sterile instruments and other items as well as the sterile field established by the PAC provider. Ms. A. should mop the PAC room and clean the instruments and other items immediately after the procedure and before a new procedure begins, or clean the instruments in another room. In addition, a new client should not enter the PAC procedure area until after all instruments and items from the prior case have been removed and any potentially contaminated surfaces are cleaned.

Case Study 6: Dr. C.
The problem is that the sharps box is too full, making it easy for accidental needle sticks to occur. Dr. C. should:
- Immediately wash the area with soap and water.
- Obtain prophylactic treatment for HIV as soon as possible.
- Ensure staff receive instructions about removing sharps boxes that are too full to protect healthcare workers and clients from future accidents.
Handout: Spaulding's Classification on the Level of Decontamination Required to Render Medical Devices Safe for Reuse

Note: The content contained within this handout is adapted from Decontamination and Reprocessing of Medical Devices for Health-care Facilities.62

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Recommended Level of Decontamination</th>
<th>Examples of Medical Devices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High (Critical)</strong></td>
<td>Sterilization</td>
<td>Surgical instruments, implants, rigid endoscopes, syringes, needles, MVA Plus® cannulae</td>
</tr>
<tr>
<td>Items that break the skin or mucous membranes or enter a sterile body cavity</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate (Semi-Critical)</strong></td>
<td>Disinfection (high-level)</td>
<td>Respiratory equipment, noninvasive flexible endoscopes, bedpans, urine bottles</td>
</tr>
<tr>
<td>Items that come into contact with mucous membranes or body fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low (Noncritical)</strong></td>
<td>Cleaning (until visibly clean)</td>
<td>Blood pressure cuffs, stethoscopes</td>
</tr>
<tr>
<td>Items that come into contact with intact skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Handout: Formulas for Preparation of Dilute Chlorine Solution**

**Using Liquid Bleach**

Chlorine in liquid bleach comes in different concentrations. You can use any concentration to make a 0.5% dilute chlorine solution using the following formula:

\[
\frac{\text{% chlorine in liquid bleach} - 1}{\text{% chlorine desired}} = \text{Total parts of water for each part of bleach}
\]

*Example:* To make a 0.5% chlorine solution from 3.5% bleach:

\[
\frac{3.5\% \text{ chlorine bleach} - 1}{0.5\% \text{ chlorine desired}} = \frac{2.5}{0.5} = 5 \text{ parts of bleach to 5 parts water}
\]

Therefore:

Add 1 part bleach to 6 parts water to make a 0.5% chlorine solution.

**Using Bleach Powder (such as calcium hypochlorite 35%)**

Using bleach powder, calculate the ratio of bleach to water by using the following formula:

\[
\frac{\text{% chlorine desired}}{\text{% chlorine in bleach powder}} \times 1,000 = \text{Number of grams of powder for each liter of water}
\]

*Example:* To make a 0.5% chlorine solution from calcium hypochlorite powder containing 35% active chlorine:

\[
\frac{0.5\%}{35\%} \times 1,000 = 0.0143 \times 1,000 = 14.3
\]

*Note:* When bleach powder is used, the solution often looks cloudy and the smell is not as strong as when liquid bleach is used.
### Handout: Recommended Dilutions of Bleach

Note: The content contained within this handout is adapted from Infection Prevention: Guidelines for Healthcare Facilities with Limited Resources.

<table>
<thead>
<tr>
<th>Bleach Brand (Country)</th>
<th>Percent Available Chlorine</th>
<th>Dilution Necessary to Achieve 0.5% Concentration (for decontaminating tabletops and other surfaces, blood spills, soiled equipment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>JIK (Africa), Robin bleach (Nepal), Ajax (Jamaica)</td>
<td>3.5%</td>
<td>1 part bleach to 6 parts water, or 160 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Household bleach, Clorox (United States, Canada), ACE (Turkey), Jif, Red &amp; White (Haiti), Odex (Jordan), Eau de Javel (France, Vietnam), (15° chlorum), Clorox (Peru)</td>
<td>5%</td>
<td>1 part bleach to 9 parts water, or 110 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Blanqueador, Cloro (Mexico), Hypex (Jordan)</td>
<td>6%</td>
<td>1 part bleach to 11 parts water, or 90 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Lavandina (Bolivia)</td>
<td>8%</td>
<td>1 part bleach to 15 parts water, or 70 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Chloros (United Kingdom), Liguria (Peru)</td>
<td>10%</td>
<td>1 part bleach to 19 parts water, or 50 ml bleach to 1 liter water</td>
</tr>
<tr>
<td>Extrait de Javel (France) (48°chlorum), Chloros (United Kingdom)</td>
<td>15%</td>
<td>1 part bleach to 29 parts water, or 30 ml bleach to 1 liter water</td>
</tr>
</tbody>
</table>

Note: In countries where French products are available, the amount of active chlorine is often expressed as degrees chlorum. One degree chlorum (°chlorum) contains approximately 0.3% active chlorine. Eau de Javel, for example, contains 15°chlorum, which is equal to approximately 5% active chlorine.

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Handout: Use of Chlorine and Recommended Solution Strengths

Note: The content contained within this handout is adapted from Decontamination and Reprocessing of Medical Devices for Health-care Facilities.64

<table>
<thead>
<tr>
<th>Use</th>
<th>Available Chlorine ppm*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood spills</td>
<td>10,000</td>
</tr>
<tr>
<td>Laboratory discard jars</td>
<td>2,500</td>
</tr>
<tr>
<td>General environment disinfection</td>
<td>1,000</td>
</tr>
<tr>
<td>Disinfection of clean instruments</td>
<td>500</td>
</tr>
<tr>
<td>Infant feeding bottles and teats</td>
<td>125</td>
</tr>
<tr>
<td>Food preparation areas and catering equipment</td>
<td>125</td>
</tr>
<tr>
<td>Eradication of Legionella from the water supply system, depending on exposure time</td>
<td>5–50</td>
</tr>
<tr>
<td>Hydrotherapy pools:</td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<td>1.5–3</td>
</tr>
<tr>
<td>Blood spills</td>
<td>6–10</td>
</tr>
<tr>
<td>Routine water treatment</td>
<td>1.5–1</td>
</tr>
</tbody>
</table>

* Undiluted commercial bleach products are usually available between 5.25% or 6.00% to 6.15% sodium hypochlorite depending upon the manufacturer. Sodium dichloroisocynaurate (NaDCC) tablets are also available and may be used for the preparation of chlorine solutions. There are test strips available for measuring the level of available chlorine in a diluted bleach solution to ensure the desired concentration as outlined above.
## Handout: Antiseptic Effectiveness

<table>
<thead>
<tr>
<th>Group</th>
<th>Gram-positive</th>
<th>Most gram-negative</th>
<th>Tuberculosis</th>
<th>Viruses</th>
<th>Fungi</th>
<th>Endospores</th>
<th>Relative Speed of Action</th>
<th>Affected by Organic Matter</th>
<th>Surgical Scrub</th>
<th>Skin Preparation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol (60 to 90%) (Ethyl or isopropyl)</td>
<td>Very Good</td>
<td>Very Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>None</td>
<td>Fast</td>
<td>Data Varies</td>
<td>Yes</td>
<td>Yes</td>
<td>Not for use on mucous membranes</td>
</tr>
<tr>
<td>Chlorhexidine gluconate (4%) (Hibitane, Hibiscrub)</td>
<td>Very Good</td>
<td>Good</td>
<td>Fair</td>
<td>Fair</td>
<td>Fair</td>
<td>None</td>
<td>Slow</td>
<td>Slight</td>
<td>Yes</td>
<td>Yes</td>
<td>Has good persistent effect</td>
</tr>
<tr>
<td>Iodine preparations (3%) (Iodine and alcohol tincture of iodine)</td>
<td>Very Good</td>
<td>Very Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Poor</td>
<td>Intermediate</td>
<td>Slight</td>
<td>Yes</td>
<td>Yes</td>
<td>Not for use on mucous membranes</td>
</tr>
<tr>
<td>Iodophors (1.2.500) (Betadine)</td>
<td>Very Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>None</td>
<td>Slow</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Can be used on mucous membranes</td>
</tr>
</tbody>
</table>
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 participants 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 here are also included in the participant guide and should be used to evaluate each participant’s performance at the end of the course.

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

- Assist the participant in learning the correct steps and the sequence in which the steps should be performed (skill acquisition).
- Measure progressive learning incrementally as participants 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 each participant to chart their 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 a participant attempts 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 the participant has completed the skill or activity, the trainer (or evaluator) should debrief with the participant. 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. The participant’s performance of each step should 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

Participants should 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 participants as they 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, participants should 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, the participants should trade roles, so everyone has the opportunity to practice demonstrating the skill and providing feedback. During this initial learning phase, trainers should 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 participants progress through the course and gain experience, their dependence on the detailed learning guides should decrease. When this occurs, participants should shift to using the practice checklists. Further, once participants feel confident performing a procedure, they should use the practice checklist to rate each other’s performance. These classroom practice sessions can also help facilitate discussion during a clinical conference before the participants begin practicing serving clients in the clinical setting.

For the clinic practice sessions, participants should 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 should 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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>1. Assess the client for shock and other life-threatening conditions.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td><strong>Medical Evaluation</strong></td>
<td></td>
</tr>
<tr>
<td>3. Obtain the client’s medical history, including reproductive health history.</td>
<td></td>
</tr>
<tr>
<td>4. Perform a physical examination of the client, including pelvic examination.</td>
<td></td>
</tr>
<tr>
<td>5. Perform indicated laboratory tests.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<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>
<tr>
<td>10. Counsel client on FP and allow them to make a free and informed decision:</td>
<td></td>
</tr>
<tr>
<td>» Explain that short-acting methods (such as oral contraceptives and injectables) and implants can be provided immediately after the MVA procedure.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</table>
### Getting Ready

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Tell the client what is going to happen and encourage them to ask questions.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>13. Ask the client about any allergies to antiseptics, medications for pain management, and anesthetics.</td>
<td></td>
</tr>
<tr>
<td>14. Confirm that the following are available in the procedure room:</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>» FP methods and sterile kits for long-acting reversible contraceptives (including IUD and implant insertion kits), as required</td>
<td></td>
</tr>
<tr>
<td>15. Confirm that emergency medications and equipment are available.</td>
<td></td>
</tr>
<tr>
<td>16. Confirm that the appropriate size cannulae and adapters are available.</td>
<td></td>
</tr>
<tr>
<td>17. Check the MVA syringe and charge it (establish vacuum).</td>
<td></td>
</tr>
<tr>
<td>18. Check that the client has recently emptied their bladder.</td>
<td></td>
</tr>
<tr>
<td>19. Check that the client has thoroughly washed and rinsed their perineal area.</td>
<td></td>
</tr>
<tr>
<td>20. Assist the client onto the couch or exam table and position them in lithotomy position with drape.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>22. Put on a clean plastic or rubber apron and other personal protective equipment, such as eye shields or goggles. Wash hands thoroughly with soap and water and dry with a clean cloth or allow them to air dry.</td>
<td></td>
</tr>
<tr>
<td>23. Put new sterile surgical gloves on both hands.</td>
<td></td>
</tr>
<tr>
<td>24. Arrange sterile instruments on a sterile tray or trolley covered with a sterile drape.</td>
<td></td>
</tr>
<tr>
<td>25. Continue communicating with the client and providing emotional support throughout the procedure. Have an assistant provide this support, if possible.</td>
<td></td>
</tr>
<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td><strong>Pre-MVA Tasks</strong></td>
<td></td>
</tr>
<tr>
<td>26. Perform a bimanual pelvic examination, checking the size and position of the uterus and the degree of cervical dilatation.</td>
<td></td>
</tr>
<tr>
<td>27. Insert the speculum and remove blood or tissue from the vagina using sponge holding forceps and sterile gauze.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>29. Apply antiseptic to the cervix and vagina twice, using gauze or a cotton sponge held with sponge holding forceps.</td>
<td></td>
</tr>
<tr>
<td>30. Put single-tooth tenaculum or vulsellum forceps on the anterior lip of the cervix.</td>
<td></td>
</tr>
<tr>
<td><strong>Administering Paracervical Block</strong> (administer only if you will perform cervical dilatation)</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>35. Wait a minimum of two minutes for the anesthetic to have the maximum effect.</td>
<td></td>
</tr>
<tr>
<td><strong>MVA Procedure</strong></td>
<td></td>
</tr>
<tr>
<td>36. Gently apply traction on the cervix to straighten the cervical canal and uterine cavity.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</table>
### Steps and Tasks

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.</td>
<td>Release the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity.</td>
</tr>
<tr>
<td>41.</td>
<td>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>
</tr>
<tr>
<td>42.</td>
<td>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>
</tr>
<tr>
<td>43.</td>
<td>Gently push the plunger to empty the products of conception into the strainer.</td>
</tr>
<tr>
<td>44.</td>
<td>Recharge the syringe, reattach it to the cannula, and release the pinch valve(s); proceed with the evacuation of the uterine cavity.</td>
</tr>
<tr>
<td>45.</td>
<td>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>
</tr>
<tr>
<td>46.</td>
<td>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>
</tr>
<tr>
<td>47.</td>
<td>Rinse the tissue with water or saline.</td>
</tr>
<tr>
<td>48.</td>
<td>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>
</tr>
<tr>
<td>49.</td>
<td>If no products of conception are seen, reassess the situation to be sure the client does not have an ectopic pregnancy.</td>
</tr>
<tr>
<td>50.</td>
<td>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>
</tr>
<tr>
<td>51.</td>
<td>Perform a bimanual examination to check the size and firmness of the uterus.</td>
</tr>
<tr>
<td>52.</td>
<td>If the uterus is still soft or bleeding persists, repeat steps 38 to 51.</td>
</tr>
<tr>
<td>53.</td>
<td>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>
</tr>
<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Post-MVA Tasks</strong></td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>55. Place the speculum and metal instruments in a container filled with clean water.</td>
<td></td>
</tr>
<tr>
<td>56. Dispose of the needle and syringe in a puncture-proof container or safety box.</td>
<td></td>
</tr>
<tr>
<td>57. Place the used MVA syringe and cannula in a container filled with clean water.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>59. Thoroughly wash the instruments and the MVA kits before drying and processing for reuse.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>61. Wash your hands thoroughly with soap and water; dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>62. Give oxytocin, ergometrine, and/or misoprostol.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>64. Use the pain scale to determine the client’s level of pain and/or discomfort.</td>
<td></td>
</tr>
<tr>
<td>65. Monitor the client’s vital signs before assisting them to move from the couch or exam table to the recovery area.</td>
<td></td>
</tr>
<tr>
<td>66. Check for bleeding at least once and ensure that cramping has decreased before discharging the client.</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<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>
<td></td>
</tr>
</tbody>
</table>
### Steps and Tasks

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<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>
<td></td>
</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>
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</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>
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</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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</tr>
<tr>
<td>Steps and Tasks</td>
<td>Cases</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Pre-MVA Tasks and MVA Procedure</strong></td>
<td></td>
</tr>
<tr>
<td>14. Explain each step of the procedure to the client prior to performing it.</td>
<td></td>
</tr>
<tr>
<td>15. Perform a bimanual pelvic examination, checking the size and position of the uterus and the degree of cervical dilatation.</td>
<td></td>
</tr>
<tr>
<td>16. Check the vagina and cervix for any tissue fragments and remove them.</td>
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</tr>
<tr>
<td>17. Apply antiseptic twice to the cervix and vagina.</td>
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</tr>
<tr>
<td>18. Put the tenaculum or vulsellum forceps on the anterior lip of the cervix.</td>
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</tr>
<tr>
<td>19. Correctly administer the paracervical block, if necessary.</td>
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<tr>
<td>20. Dilatate the cervix, if needed.</td>
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</tr>
<tr>
<td>21. While holding the cervix steady, insert the cannula gently through the cervix and into the uterine cavity.</td>
<td></td>
</tr>
<tr>
<td>22. 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>23. 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>24. Inspect the contents removed to ensure it contains the products of conception.</td>
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<tr>
<td>25. 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>26. Perform a bimanual examination to check the size and firmness of the uterus.</td>
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</tr>
<tr>
<td>27. Reinsert the speculum and check for bleeding.</td>
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</tr>
<tr>
<td>28. If uterus is still soft or bleeding persists, repeat steps 21 to 27.</td>
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</tr>
<tr>
<td><strong>Post-MVA Tasks</strong></td>
<td></td>
</tr>
<tr>
<td>29. Before removing your gloves, dispose of all waste materials and soak instruments and MVA equipment in clean water.</td>
<td></td>
</tr>
<tr>
<td>30. Remove your gloves by turning them inside out and dispose of them by placing them in a leak-proof container or plastic bag.</td>
<td></td>
</tr>
<tr>
<td>31. Wash your hands thoroughly with soap and water; dry with a clean, dry cloth or air dry.</td>
<td></td>
</tr>
<tr>
<td>32. 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>
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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>
<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>
<th>Cases</th>
</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>
<td></td>
</tr>
<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>
<tr>
<td>6. Inform the client of any laboratory examinations needed and perform the test(s).</td>
<td></td>
</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>
<td></td>
</tr>
<tr>
<td>8. Explain all findings to the client, demonstrating respect and empathy; provide emotional support, as appropriate.</td>
<td></td>
</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>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
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.
<table>
<thead>
<tr>
<th>Steps</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>18. Counsel the client (with their partner, if the client wishes) on contraception.</td>
<td></td>
</tr>
<tr>
<td>19. Discuss the need for STI and reproductive tract infection (RTI) prevention and treatment and voluntary HIV counseling and testing, as needed.</td>
<td></td>
</tr>
<tr>
<td>20. Provide misoprostol and analgesics to take at the facility and/or at home.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>22. Provide follow-up care instructions—verbally and in writing, if possible—to the client:</td>
<td></td>
</tr>
<tr>
<td>» 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.</td>
<td></td>
</tr>
<tr>
<td>» Clients who choose IUD or female sterilization should return to the facility after one week to receive the FP method (following a health assessment).</td>
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</tr>
<tr>
<td>» Do not have sex until the bleeding stops, usually within five to seven days.</td>
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</tr>
<tr>
<td>» Do not insert anything in the vagina until the bleeding stops.</td>
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</tr>
<tr>
<td>» Do not resume chores until two or three days after a complete expulsion.</td>
<td></td>
</tr>
<tr>
<td>» Return to the facility if they experience any problems or warning signs.</td>
<td></td>
</tr>
<tr>
<td>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>23. Complete the client record and relevant registers.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
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</tr>
</tbody>
</table>
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

### Steps

<table>
<thead>
<tr>
<th>Steps</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. 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>
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</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>
<td></td>
</tr>
<tr>
<td>7. If the client opts for medical treatment with misoprostol, provide additional information and instructions:</td>
<td></td>
</tr>
<tr>
<td>&gt; Name and dosage of medication</td>
<td></td>
</tr>
<tr>
<td>&gt; Route of administration</td>
<td></td>
</tr>
<tr>
<td>&gt; When and where to take the medication</td>
<td></td>
</tr>
<tr>
<td>&gt; Timing for medication to take effect</td>
<td></td>
</tr>
<tr>
<td>8. Explain and ensure that the client understands expected effects and possible side effects of the medication, such as:</td>
<td></td>
</tr>
<tr>
<td>&gt; Cramping and lower abdominal pain</td>
<td></td>
</tr>
<tr>
<td>&gt; Diarrhea</td>
<td></td>
</tr>
<tr>
<td>&gt; Fever and chills</td>
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</tr>
<tr>
<td>&gt; Light to moderate vaginal bleeding with some clots followed by expulsion of any remaining products of conception</td>
<td></td>
</tr>
<tr>
<td>&gt; Nausea and vomiting</td>
<td></td>
</tr>
</tbody>
</table>
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:
   - 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

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.

11. Provide contact information so that they can call if a problem or emergency arises.

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.

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

14. Discuss the need for STI and RTI prevention and treatment and voluntary HIV counseling and testing, as needed.

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

16. Provide the contraceptive method of choice on the same day as the misoprostol, unless the client opts for an IUD or female sterilization.

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.

18. Complete the client record and relevant registers.

19. Provide the client with any referrals and related information needed.
# 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.

- **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
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<table>
<thead>
<tr>
<th>Steps and Tasks</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Interview</strong></td>
<td></td>
</tr>
<tr>
<td>1. Greet the client respectfully and with kindness.</td>
<td></td>
</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>
<tr>
<td>6. Ask if client was using contraception before becoming pregnant. If so, find out if they:</td>
<td></td>
</tr>
<tr>
<td>» Used the method correctly</td>
<td></td>
</tr>
<tr>
<td>» Discontinued use</td>
<td></td>
</tr>
<tr>
<td>» Experienced any trouble using the method</td>
<td></td>
</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>
<td>8. Provide general information about FP.</td>
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<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>
### Steps and Tasks

<table>
<thead>
<tr>
<th>Steps and Tasks</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Give the client information about their preferred contraceptive method, including:</td>
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<tr>
<td>› Risks and benefits associated with the method</td>
<td></td>
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<tr>
<td>› The effectiveness of the method</td>
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<tr>
<td>› When and how to use the method</td>
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<tr>
<td>› Common side effects and other health problems associated with the method</td>
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</tr>
<tr>
<td>› Where and how to obtain resupplies, if applicable</td>
<td></td>
</tr>
<tr>
<td>11. Discuss any needs, concerns, and fears the client expresses in a thorough and sympathetic manner.</td>
<td></td>
</tr>
<tr>
<td>12. Assist the client in making a free and informed decision about the most appropriate FP method for their situation.</td>
<td></td>
</tr>
</tbody>
</table>

### Client Screening

<table>
<thead>
<tr>
<th>Client Screening</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>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).</td>
<td></td>
</tr>
<tr>
<td>14. Help the client implement their decision.</td>
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</tr>
<tr>
<td>15. Provide the FP method.</td>
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<tr>
<td>16. Review with the client how to use the method correctly.</td>
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<tr>
<td>17. Discuss what to do if the client experiences any side effects or problems.</td>
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<tr>
<td>18. Provide instructions for a follow-up visit, as necessary.</td>
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</tr>
<tr>
<td>19. Assure the client they can return to the facility at any time to receive additional advice or medical attention.</td>
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<tr>
<td>20. Ask the client to repeat the instructions to confirm understanding.</td>
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</tr>
<tr>
<td>21. Provide written instructions for the client to take home.</td>
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</tr>
<tr>
<td>22. Answer any questions the client may have and refer the client for any related reproductive health issues and concerns, as needed.</td>
<td></td>
</tr>
</tbody>
</table>
Mid-Course Questionnaire

Using the Questionnaire

This knowledge assessment is designed to help participants monitor their progress during the course. Print copies and ask participants to complete this questionnaire after completing delivery of all subject area content. By the end of the course, all participants are expected to achieve a score of 85% or higher, to indicate knowledge-based mastery of the material. For anyone who scores less than 85% on their first attempt, review the results with the participant individually and guide them in using the reference manual to learn the required information. Participants who score less than 85% can retake the questionnaire at any time during the remainder of the course, but only after the participant has had sufficient time to study the Reference Manual.
Mid-Course Questionnaire

Instructions: Write the letter of the single best answer to each question in the blank next to the corresponding number on the attached answer sheet.

Initial Assessment

1. The postabortion complication that needs to be assessed first is:
   a. Uterine perforation
   b. Shock
   c. Severe vaginal bleeding
   d. Infection and/or sepsis

2. The first step in conducting an initial assessment is to:
   a. Check the client’s vital signs
   b. Obtain a complete medical history
   c. Perform a bimanual examination
   d. Order laboratory tests, if available

3. The best way to determine uterine size is by:
   a. Looking at the cervix
   b. Reviewing the history of amenorrhea based on last menstrual period
   c. Bimanual examination
   d. Abdominal examination

4. A client presenting with vaginal bleeding and signs and symptoms of pregnancy may have a/an:
   a. Threatened abortion
   b. Incomplete abortion
   c. Ectopic pregnancy
   d. All of the above

5. Infection due to an incomplete abortion is indicated by:
   a. Little or no abdominal pain
   b. Foul-smelling vaginal discharge
   c. High blood pressure
   d. Nausea and/or vomiting
Infection Prevention

6. Surgical (metal) instruments that have been thoroughly cleaned can be sterilized by:
   a. Heat (autoclave or dry heat sterilizer)
   b. Soaking for 30 minutes in fresh 1 to 3% iodine solution
   c. Boiling for 20 minutes
   d. Exposure to ultraviolet light for one hour

7. Other than sterilization, the only acceptable alternative method for processing surgical (metal) instruments used for manual vacuum aspiration (MVA) is by soaking the instruments in:
   a. Chlorhexidine (e.g., Savlon®)
   b. Povidone iodine solution (e.g., Betadine®)
   c. 2% glutaraldehyde (e.g., Cidex®)
   d. All of the above

8. To minimize the risk of staff contracting hepatitis B or HIV while cleaning instruments, the provider should:
   a. Rinse the instruments in water and scrub them with a brush before boiling
   b. Put on utility gloves and other appropriate personal protective equipment
   c. Rinse the instruments in water and scrub them with a brush before sterilizing
   d. Soak the instruments overnight in 8% formaldehyde

9. Cannulae are sterilized by:
   a. Autoclaving for 20 minutes at 121°C
   b. Dry heat sterilizing
   c. Boiling for 20 minutes
   d. None of the above

10. After cleaning with detergent and water, the MVA syringe must be:
    a. High-level disinfected
    b. Sterilized
    c. Cleaned
    d. Discarded

Vacuum Aspiration Provision

11. One of the three signs that the vacuum aspiration (VA) procedure is considered complete is when:
    a. The walls of the uterus feel smooth
    b. The vacuum in the syringe decreases
    c. Foam is visible in the syringe
    d. The uterus relaxes
12. Pain management for treatment of an uncomplicated incomplete abortion usually only requires:
   a. Client support and a nonnarcotic analgesic
   b. Paracervical block and a nonnarcotic analgesic
   c. General anesthesia
   d. Client support (verbal anesthesia), nonsteroidal anti-inflammatory drugs, and mild sedative

13. The client should return to the facility if they experience:
   a. Uterine cramping over the next few days
   b. Severe, persistent, or increased lower abdominal pain
   c. Spotting or light vaginal bleeding
   d. All of the above

14. MVA is an effective method for treating an incomplete abortion if the uterine size is less than or equal to:
   a. 8 weeks
   b. 10 weeks
   c. 12 weeks
   d. 14 weeks

15. The vacuum will be lost if:
   a. The syringe is full
   b. The cannula is withdrawn from the uterine cavity
   c. The uterus is perforated
   d. All of the above

**Medical Evacuation Methods**

16. Misoprostol can be used with clients with:
   a. A first or second trimester incomplete abortion
   b. A history of allergies to misoprostol or similar medication
   c. A septic abortion
   d. Severe vaginal bleeding or shock

17. Common side effects of misoprostol include:
   a. Diarrhea
   b. Abdominal cramps
   c. Fever
   d. All of the above
18. Clients who opt for misoprostol to manage an incomplete abortion should be:
   a. Treated as outpatients if they are in stable condition and if they can return to the facility within an hour if they notice any danger signs
   b. Offered any contraceptive method of their choice with the first dose of misoprostol
   c. Instructed to return to the facility to confirm if the treatment was successful
   d. Treated with a single dose of misoprostol

**Postabortion Family Planning**

19. The most important part of family planning (FP) counseling is:
   a. Providing brochures about contraceptive methods to the client for review with their partner
   b. Helping the client identify their reproductive intentions and exercise their right to choose a preferred FP method
   c. Obtaining formal consent for the procedure from the client
   d. Describing side effects to the client

20. All postabortion clients need counseling to ensure that they understand:
   a. That they can become pregnant again before their next menses
   b. That there are safe methods to prevent or delay pregnancy
   c. Where and how they can obtain FP services and methods
   d. All of the above

21. A contraceptive method is best selected by:
   a. The client
   b. The physician providing health services to the client
   c. The counselor who sees the client
   d. The client’s spouse or partner

22. The FP method not recommended for immediate use by postabortion clients is:
   a. Oral contraceptives
   b. Contraceptive implant
   c. Natural FP
   d. Condoms

23. After a first-trimester abortion, a client’s fertility usually returns:
   a. After six weeks
   b. After their first menstrual period
   c. Within two weeks
   d. Immediately
**Mid-Course Questionnaire Answer Sheet**

**Initial Assessment**
1. ____ Module 2, Session 1, Objective 3 and Module 2, Session 6, Objective 2
2. ____ Module 2, Session 1, Objective 3
3. ____ Module 2, Session 1, Objective 3
4. ____ Module 2, Session 1, Objective 3 and Module 2, Session 6, Objective 1
5. ____ Module 2, Session 1, Objective 3 and Module 2, Session 6, Objective 2

**Infection Prevention**
6. ____ Module 4, Session 1, Objective 9
7. ____ Module 4, Session 1, Objective 9
8. ____ Module 4, Session 1, Objective 9
9. ____ Module 4, Session 1, Objective 9
10. ____ Module 4, Session 1, Objective 9

**Vacuum Aspiration Provision**
11. ____ Module 2, Session 5, Objective 4
12. ____ Module 2, Session 3, Objectives 1, 2, and 3
13. ____ Module 2, Session 5, Objective 5
14. ____ Module 2, Session 2, Objective 4
15. ____ Module 2, Session 2, Objectives 1 and 2

**Medical Evacuation Methods**
16. ____ Module 2, Session 6, Objectives 1 and 2
17. ____ Module 2, Session 6, Objectives 1 and 2
18. ____ Module 2, Session 6, Objectives 3 and 4

**Postabortion Family Planning**
19. ____ Module 3, Session 1, Objectives 1, 2, and 3
20. ____ Module 3, Session 1, Objectives 1 and 2
21. ____ Module 3, Session 1, Objective 3
22. ____ Module 3, Session 1, Objective 3
23. ____ Module 3, Session 1, Objective 3
Mid-Course Questionnaire: Answer Key

Instructions: Use this answer key to evaluate questionnaires completed by training participants. The correct answer is presented in bold text for each question below.

Initial Assessment

1. The postabortion complication that needs to be assessed first is:
   a. Uterine perforation
   b. Shock
   c. Severe vaginal bleeding
   d. Infection and/or sepsis

2. The first step in conducting an initial assessment is to:
   a. Check the client’s vital signs
   b. Obtain a complete medical history
   c. Perform a bimanual examination
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   a. Looking at the cervix
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   a. Little or no abdominal pain
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   b. Povidone iodine solution (e.g., Betadine™)
   c. 2% glutaraldehyde (e.g., Cidex™)
   d. All of the above

8. To minimize the risk of staff contracting hepatitis B or HIV while cleaning instruments, the provider should:
   a. Rinse the instruments in water and scrub them with a brush before boiling
   b. **Put on utility gloves and other appropriate personal protective equipment**
   c. Rinse the instruments in water and scrub them with a brush before sterilizing
   d. Soaked the instruments overnight in 8% formaldehyde

9. Cannulae are sterilized by:
   a. **Autoclaving for 20 minutes at 121°C**
   b. Dry heat sterilizing
   c. Boiling for 20 minutes
   d. None of the above

10. After cleaning with detergent and water, the MVA syringe must be:
    a. High-level disinfected
    b. **Sterilized**
    c. Cleaned
    d. Discarded

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   a. Providing brochures about contraceptive methods to the client for review with their partner
   b. Helping the client identify their reproductive intentions and exercise their right to choose a preferred FP method
   c. Obtaining formal consent for the procedure from the client
   d. Describing adverse side effects to the client

20. All postabortion clients need counseling to ensure that they understand:
   a. That they can become pregnant again before their next menses
   b. That there are safe methods to prevent or delay pregnancy
   c. Where and how they can obtain FP services and methods
   d. All of the above

21. A contraceptive method is best selected by:
   a. The client
   b. The physician providing health services to the client
   c. The counselor who sees the client
   d. The client’s spouse or partner

22. The FP method not recommended for immediate use by postabortion clients is:
   a. Oral contraceptives
   b. Contraceptive implant
   c. Natural FP
   d. Condoms

23. After a first-trimester abortion, a client’s fertility usually returns:
   a. After six weeks
   b. After their first menstrual period
   c. **Within two weeks**
   d. Immediately
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?
Appendices
Appendix A: Addendum to Participant Invitation Letter

**Trainer Notes**

Participants will need to be prepared for training sessions held in classroom and clinical (inpatient and outpatient) settings. This sample list includes items participants may need to bring to the training. Adapt this list according to what is appropriate for the local setting and include this information in the participant invitation materials.

**Attire**

Instruct participants to wear, or bring to wear, the following for the clinical practice sessions:

- Clinical uniform and/or lab coat (one, or preferably two, to allow for changing if soiled)
- Scrubs, or similar clothing appropriate to the setting (at least two for changing if soiled)
- Closed-toe shoes
- A watch

*Note:* Personal protective equipment and other equipment and supplies will need to be provided during the training.

**Credentials and Identification**

Based on the requirements of the facility where the clinical practice sessions will occur, participants may also need:

- Identity card or other form of identification
- Evidence of current licensure and/or practice permit and other credentials, such as:
  - Required certifications
  - Registration as nurse, midwife, physician, etc.

**Relevant Health Data and Related Information (as applicable)**

Participants should bring relevant health data and information from their districts, regions, or provinces to contribute to classroom discussions. Trainers should obtain national-level data in advance of the training. *Note: In some settings, only national-level data may exist.* This includes data related to the following:

- Family planning and fertility data, including contraceptive prevalence rate and method mix data
- Maternal mortality and morbidity statistics
- Policies on postabortion care and family planning service delivery policies and guidelines (including which cadre or cadres of staff are permitted to provide which methods)
- Information on postabortion service delivery (for instance, where postabortion care is offered, types of emergency treatment available, postabortion family planning available, recovery and discharge norms and standards, client service fees and related costs)
Appendix B: Experience and Confidence in Postabortion Care

Instructions: Thank you for taking the time to complete this form. Your answers will assist in ensuring the appropriate selection of participants for this training. All answers are confidential and will not be shared with your supervisors or affect your job in any way.

Basic Information about You and Your Institution
1. Name of person completing this form: ______________________________ Date: _______________
2. Age: ___ years
3. Gender:  ___ Female   ___ Male ___ Unspecified or another gender identity
4. What is your profession? (please check only one)
   ___ Physician and/or surgeon   ___ Medical student
   ___ Nurse   ___ Nursing student
   ___ Midwife   ___ Intern or resident
   ___ Nurse or nurse midwife   ___ Other (please specify): _________________________________
5. What year did you complete your pre-service training? ______________________________________
6. What is your current job title? ________________________________________________________
7. What is your primary job responsibility?
   ___ Healthcare provider
   ___ Clinical supervisor
   ___ Tutor, educator, or instructor
   ___ Other (please specify): ____________________________________________________________
8. Please estimate the percentage of your professional time each week spent serving as the following:
   (total should equal 100%)
   ___ Healthcare provider
   ___ Clinical supervisor
   ___ Tutor, educator, or instructor
   ___ Other (please specify): ____________________________________________________________
9. Please provide the name and address of the institution where you provide healthcare.
   • Institution name: _________________________________________________________________
   • Address: ______________________________________________________________________
   • City and Country: _________________________________________________________________
10. Type of institution:
   ___ Health dispensary or health post
   ___ Health center
   ___ District hospital
   ___ Regional hospital
   ___ Referral or teaching hospital
   ___ Private clinic or hospital
   ___ Nursing, midwifery, or medical teaching institution
   ___ Other (please specify): ___________________________________________________________

11. Affiliation of institution:
   ___ Government
   ___ Quasi-government
   ___ Nongovernmental
   ___ Religious or missionary
   ___ Private
   ___ Other (please specify): ___________________________________________________________

Information about Your Skills

This section focuses on how often you perform specific clinical skills and your level of confidence in performing each of these skills. Please use extra paper for comments or remarks if the space provided is insufficient.

12. Please list any skills-based training courses that you have completed related to postabortion care. For each course, provide the following information:
   • Dates of course(s)
   • Topic or content
   • Place where skills training was conducted

13. Please complete the table on the next page according to the following instructions:
   » **Column A:** How many cases have you performed since completing the skills-based training course?
   » **Column B:** Rate your level of confidence in performing the skills using the scale provided below.
     1. Very confident—I do not need any additional coaching to perform this skill.
     2. Not very confident—I need additional coaching to perform this skill.
     3. Not confident—I cannot perform this skill.
     4. Not applicable—I am not permitted to perform this skill, based on country or institutional policies.
   » **Column C:** Please indicate skills that you have taught to others (through on-the-job training or in a training workshop) using a checkmark (√).
<table>
<thead>
<tr>
<th>Skill</th>
<th>Column A: Number of Cases</th>
<th>Column B: Confidence Level</th>
<th>Column C: Taught the Skill</th>
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<tbody>
<tr>
<td>Family planning counseling</td>
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<tr>
<td>Family planning method provision:</td>
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<tr>
<td>Condoms and other barrier methods</td>
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<tr>
<td>Emergency contraception</td>
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<tr>
<td>Implants</td>
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<tr>
<td>Injectable contraceptives</td>
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<td></td>
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<tr>
<td>Intrauterine device (including postpartum)</td>
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<tr>
<td>Oral contraceptives</td>
<td></td>
<td></td>
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<tr>
<td>Standard Days Method</td>
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<tr>
<td>Tubal ligation</td>
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<tr>
<td>Vasectomy</td>
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<tr>
<td>Management of the following methods:</td>
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<tr>
<td>Condoms and other barrier methods</td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Standard Days Method</td>
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<td></td>
<td></td>
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<tr>
<td>Other postabortion care skills:</td>
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<tr>
<td>Use of speculum</td>
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<tr>
<td>Uterine sizing (early pregnancy before 12 weeks or nonpregnant)</td>
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<td>Manual vacuum aspiration</td>
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<tr>
<td>Rapid initial assessment</td>
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<tr>
<td>Treatment of shock</td>
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</table>
Appendix C: Tracking Participant Progress

**Trainer Notes**

*Use or adapt this form to track participants’ progress in completing practice sessions and gaining skill competencies. A sample completed form is included on the next page.*

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Month</th>
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<tbody>
<tr>
<td>Participants</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Month</th>
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</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Day</td>
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</table>

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>Day</td>
</tr>
</tbody>
</table>

M: Practice with model  
MC: Competent with model  
P: Practice with clients  
PC: Competent with clients  
S: Simulation (using role play to practice counseling)  
O: Observation practice with model and clients, other classroom activities (e.g., case studies, role play exercises, group discussion)  
MCA: Competent with model and advanced clinical practice (supported peers during practice with models)
Sample Chart: Tracking Participant Progress

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Participants</th>
<th>Month</th>
<th>Day</th>
<th>April</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Marcelo Perez</td>
<td>M</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rodrigo Diaz</td>
<td>M</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td></td>
<td>José Cárdenas</td>
<td>M</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Miguel Smith</td>
<td>M</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bertha Sanchez</td>
<td>S, M</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alicia Lewis</td>
<td>S, M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitators</td>
<td>Sarah</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Binta</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>Pape Diop</td>
<td>M</td>
<td>25</td>
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M: Practice with model
MC: Competent with model
P: Practice with clients
PC: Competent with clients
S: Simulation (using role play to practice counseling)
O: Observation practice with model and clients, other classroom activities (e.g., case studies, role play exercises, group discussion)
MCA: Competent with model and advanced clinical practice (supported peers during practice with models)
Appendix D: Selection of the Postabortion Care Clinical Training Site

Note: The content contained within this appendix is adapted from Postabortion Care Individual Learning Package: Supervisor’s Guide.

The number of participants, their skill level, the type of training (e.g., on-the-job, centralized, follow-up, etc.), and the availability of postabortion clients are among the many factors that affect the selection of a clinical site for conducting this postabortion care (PAC) training. To provide an effective learning experience, the site must meet the following criteria:

• Provide high-quality PAC according to evidence-based standards (consistent with national standards).
• Support documentation of PAC procedures, including postabortion family planning services and management or referral services for sexually transmitted infections and HIV.
• Confirm clinical staff and administrative management are interested in hosting a PAC training.
• Employ staff who are willing to assist with training participants, as needed (for instance, by supporting individualized on-the-job training and serving as trainers or being willing to be trained as trainers).
• Offer adequate space for the training.
• Routinely serve an average of 5 to 10 postabortion clients per week.
• Have established infection prevention practices.
• Have enough water to maintain high infection prevention standards.
• Demonstrate a consistent stock of supplies, equipment, and medications required to meet the needs of clients.
• Provide family planning counseling and services.
• Maintain links with other reproductive health service providers to which PAC clients can be referred.
