COMPREHENSIVE ABORTION CARE (CAC)

INTEGRATED TRAINERS' MANUAL
THIRD EDITION (2015)
High maternal mortality has continued to be a public health concern for many developing countries including Nepal. The Government of Nepal (GoN) is committed to achieving the Millennium Development Goal of reducing Maternal Mortality Ratio (MMR) to 134 per 100000 live births by the end of 2015. As a result of various interventions by MoHP, Nepal has been able to successfully reduce MMR to 170 per 100000 live births in 2012. A recent study (Henderson et al, 2013) assessing the changes in Nepal pre- and post- abortion legalization demonstrated that this policy change has contributed to a reduction in the national MMR. Expansion of safe abortion service was also highlighted as a major contributing factor for the declining trend in severe abortion complications. However, complications due to unsafe abortion still remain the third leading cause of maternal death (Pradhan et al, 2010). Improving access to safe abortion service while decreasing unsafe abortion is one of the major goals of reproductive health services in its effort to reduce maternal mortality and morbidity.

Following abortion legalization in 2002 by GoN, MoHP approved Nepal’s safe abortion policy, and set norms and standards to implement the abortion law in the country in 2004. Comprehensive abortion care (CAC) services were first initiated at Paropakar Maternity and Women Hospital from March 2004. By 2006 safe abortion service with manual vacuum aspiration (MVA), a surgical method, was implemented in all district level hospitals and a CAC training manual was developed to train providers. Later on, medical abortion (MA) service was also implemented. The subsequent need for the integration of both MVA and MA training led to the drafting of the second edition of the training manual in 2011.

The 2012 update of the WHO manual (2003) “Safe Abortion Technical Guideline” prompted the Family Health Division and National Health Training Center to revise the CAC training manual a third time in order to WHO’s new updates. This manual has undergone extensive review and
revision with CAC trainers, providers and other relevant experts. All first trimester providers will provide services as outlined in this protocol and will be certified only after they have demonstrated the required competencies during the training.

This manual would not have come to fruition without the expertise and commitment of the organizing and coordinating team of the Family Health Division and National health training center. We would like to express our sincere gratitude to all trainers and providers for providing valuable experiences and feedback in order to develop this manual. Similarly, we appreciate the effort taken by the ipas team to facilitate the manual revision process, incorporating international standards adapted to our country context, and to provide technical and financial support required for the revision process and the printing of the manual.

We are hopeful that this manual will serve as guidance for reducing complications due to unsafe abortion and thus will contribute to the reduction of MMR in Nepal through the expansion of quality abortion services.

Mr. Achyut Lamichhane
Director
National Health Training Center

Dr. Pushpa Chaudhary
Director
Family Health Division
ACKNOWLEDGEMENT

The Family health Division, National Health Training Center, and Ipas-Nepal would like to acknowledge the following people for providing support during the development of this manual.

<table>
<thead>
<tr>
<th>Name of participants</th>
<th>Designation</th>
<th>Place of representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Aruna Karki</td>
<td>HOD (Ob &amp; Gyne)</td>
<td>Kathmandu Model Hospital, KTM</td>
</tr>
<tr>
<td>Dr Bandana Sharma</td>
<td>Assistant lecturer</td>
<td>KIST Medical College</td>
</tr>
<tr>
<td>Dr. Ganesh Dangal</td>
<td>Consultant</td>
<td>Kathmandu Model Hospital, KTM</td>
</tr>
<tr>
<td>Dr. Kabin Bhattachan</td>
<td>Senior Registrar</td>
<td>Model Hospital, KTM</td>
</tr>
<tr>
<td>Dr Om Maharjan</td>
<td>Medical Manager</td>
<td>FPAN, Pulchowk</td>
</tr>
<tr>
<td>Dr Punny Paudel</td>
<td>Senior Registrar</td>
<td>PMWH, Thapathali</td>
</tr>
<tr>
<td>Dr Saraswoti M Padhya</td>
<td>Professor</td>
<td>KMC, Sinamangal</td>
</tr>
<tr>
<td>Ms. Sipra Joshi</td>
<td>Staff Nurse</td>
<td>FPAN, Pulchowk</td>
</tr>
<tr>
<td>Ms. Suku Maya Lama</td>
<td>Staff Nurse</td>
<td>PMWH, Thapathali</td>
</tr>
<tr>
<td>Dr Lata Bajracharya</td>
<td>President</td>
<td>NESOG</td>
</tr>
<tr>
<td>Dr Usha Shrestha</td>
<td>Consultant</td>
<td>PMWH, Thapathali</td>
</tr>
<tr>
<td>Ms. Yasodha Giri</td>
<td>Staff Nurse</td>
<td>Bir Hospital</td>
</tr>
<tr>
<td>Dr Shilu Aryal</td>
<td>Sr. Consultant Ob/Gyn</td>
<td>FHD</td>
</tr>
<tr>
<td>Dr Ishwor Prasad Upadhyaya</td>
<td>Sr. Integrated Medical Officer</td>
<td>NHTC</td>
</tr>
<tr>
<td>Dr. Deeb Shrestha Dangol</td>
<td>Sr. health System Advisor</td>
<td>Ipas- Nepal</td>
</tr>
<tr>
<td>Mr. Dirgha Raj Shrestha</td>
<td>National Program Manager</td>
<td>Ipas- Nepal</td>
</tr>
<tr>
<td>Ms. Meena Kumari Shrestha</td>
<td>Health System Advisor</td>
<td>Ipas- Nepal</td>
</tr>
<tr>
<td>Eva Canoutas</td>
<td>Sr. health System Advisor</td>
<td>Ipas</td>
</tr>
<tr>
<td>Sara Dunbar</td>
<td>Health System Advisor</td>
<td>Ipas</td>
</tr>
<tr>
<td>Bill Powll</td>
<td>Senior advisor, Clinical affair</td>
<td>Ipas</td>
</tr>
<tr>
<td>Allison Elderman</td>
<td>Consultant (Ob &amp; Gyn)</td>
<td>Ipas</td>
</tr>
<tr>
<td>Jeannine Herrick</td>
<td>Consultant</td>
<td>Ipas</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td>Blood Pressure</td>
<td></td>
</tr>
<tr>
<td>CAC</td>
<td>Comprehensive Abortion Care</td>
<td></td>
</tr>
<tr>
<td>COC</td>
<td>Combined Oral Contraceptives</td>
<td></td>
</tr>
<tr>
<td>COPE</td>
<td>Client Oriented Provider Efficiency</td>
<td></td>
</tr>
<tr>
<td>D and E</td>
<td>Dilatation and Evacuation</td>
<td></td>
</tr>
<tr>
<td>DMPA</td>
<td>Depo Medroxy Progesterone Acetate (Depo Provera)</td>
<td></td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraception</td>
<td></td>
</tr>
<tr>
<td>EVA</td>
<td>Electric Vacuum Aspiration</td>
<td></td>
</tr>
<tr>
<td>FIGO</td>
<td>International Federation of Gynaecology and Obstetrics</td>
<td></td>
</tr>
<tr>
<td>FHD</td>
<td>Family Health Division</td>
<td></td>
</tr>
<tr>
<td>GoN</td>
<td>Government of Nepal</td>
<td></td>
</tr>
<tr>
<td>HLD</td>
<td>High Level Disinfection</td>
<td></td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
<td></td>
</tr>
<tr>
<td>Hb</td>
<td>Hemoglobin</td>
<td></td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
<td></td>
</tr>
<tr>
<td>Hct</td>
<td>Hematocrit</td>
<td></td>
</tr>
<tr>
<td>HCV</td>
<td>Hepatitis C Virus</td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
<td></td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
<td></td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
<td></td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraceptives</td>
<td></td>
</tr>
<tr>
<td>LMP</td>
<td>Last Menstrual Period</td>
<td></td>
</tr>
<tr>
<td>LSCS</td>
<td>Lower Segment Cesarean Section</td>
<td></td>
</tr>
<tr>
<td>MA</td>
<td>Medical Abortion</td>
<td></td>
</tr>
<tr>
<td>MoHP</td>
<td>Ministry of Health and Population</td>
<td></td>
</tr>
<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
<td></td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Non-steroidal Anti-inflammatory Drugs</td>
<td></td>
</tr>
<tr>
<td>NSV</td>
<td>Non-scalpel Vasectomy</td>
<td></td>
</tr>
<tr>
<td>PAC</td>
<td>Post-abortion Care</td>
<td></td>
</tr>
<tr>
<td>PID</td>
<td>Pelvic Inflammatory Disease</td>
<td></td>
</tr>
<tr>
<td>POC</td>
<td>Products of Conception</td>
<td></td>
</tr>
<tr>
<td>QoC</td>
<td>Quality of Care</td>
<td></td>
</tr>
<tr>
<td>Rh</td>
<td>Rhesus</td>
<td></td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
<td></td>
</tr>
<tr>
<td>SAE</td>
<td>Severe Adverse Event</td>
<td></td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
<td></td>
</tr>
<tr>
<td>USG</td>
<td>Ultrasonography</td>
<td></td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
<td></td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS

1. **Schedule** .................................................................................................................. 3-37
   a. For Physician Participants (10 days) ........................................................................ 3
   b. For Nurse Providers (14 days) .................................................................................. 12
   c. For OB/GYN Specialists (3 days) .............................................................................. 23

2. **About This Trainers’ Manual** .................................................................................. 28-34

3. **Course Introduction** .................................................................................................. 35-38

4. **Modules** .................................................................................................................... 39-171
   - Module 1: Introduction to Comprehensive Abortion Care ......................................... 39
   - Module 2: Clinical Assessment .................................................................................... 51
   - Module 3: Counseling, Information, and Informed Consent ...................................... 65
   - Module 4: Young Women and Abortion Care ............................................................ 79
   - Module 5: Infection Prevention .................................................................................. 89
   - Module 6: Types of Abortion Procedure ................................................................... 104
     - Section 1: Medical Abortion .................................................................................... 105
     - Section 2: MVA Instruments ................................................................................... 113
     - Section 3: Uterine Evacuation Procedure with Ipas MVA Plus .................................. 119
   - Module 7: Post-Procedure Care and Follow-Up ......................................................... 133
   - Module 8: Complications ........................................................................................... 141
   - Module 9: Monitoring, Recording and Reporting ...................................................... 157
   - Module 10: Service Provision ..................................................................................... 166

5. **Knowledge Questionnaire** ....................................................................................... 172-180
   a. Pre-test questionnaire ............................................................................................... 172
   b. Mid-course Knowledge questionnaire ...................................................................... 175

6. **Four corner Activity** ................................................................................................ 181-182

7. **Skill Assessment Checklist** ..................................................................................... 183-203
   A: Clinical Assessment Skills Checklist ........................................................................ 183
   B: Clinical Assessment for Postabortion Care Skills Checklist .................................... 185
   C: Counseling Skills Checklist ..................................................................................... 188
   D: Contraceptive Counseling Skills Checklist ............................................................. 190
E: Instrument Processing Skills Checklist: Ipas MVA Plus and Ipas EasyGrip Cannulae... 192
F: Uterine Evacuation with Medical Methods Skills Checklist – Mifepristone and Misoprostol... 194
G: Misoprostol for Treatment of Incomplete Abortion Skills Checklist.......................... 197
H: Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist.......................... 199
I: Post-Procedure Care Skills Checklist........................................................................ 201
J: Comprehensive Abortion Care (CAC) Clinical Skills Evaluation.............................. 202

8. Service Provision/Monitoring Plan ........................................................................... 204-209
Action Plan Format ....................................................................................................... 204
Minimum Requirements for MVA Service Delivery Site Checklist................................. 206

9. LARC checklists ....................................................................................................... 210-218
   • IUCD checklist (Insertion and Removal) ................................................................. 210
   • Implant Checklist (Insertion and Removal) ........................................................... 212

10. Reporting Format ..................................................................................................... 219-223
    • Client Personal Profile .......................................................................................... 219
    • Monthly Reporting Format (HMIS 9.3/9.4/9.5) ....................................................... 223

11. End-of-Course Evaluation ....................................................................................... 224-225

12. Forms for training .................................................................................................... 227-235
    a. Training Registration Form .................................................................................. 228
    b. Trainer Record ...................................................................................................... 229
    c. Co-Tainer/Facilitator Record ................................................................................ 232
    d. Trainee record form ............................................................................................... 233
    e. Training Report ..................................................................................................... 234
    f. Trainer Registration Form .................................................................................... 235

13. Listing Format (Provider and Site) ....................................................................... 236-239
    Application Form for Service Provider Listing ......................................................... 236
    Service Provider Listing Certificate .......................................................................... 237
    Application Form for Site Listing ............................................................................. 238
    Site listing Certificate ............................................................................................... 239
## Schedule Example: Training on Comprehensive Abortion Care Services for Physician Participants (10 days)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAY ONE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:40</td>
<td>Registration Opening and Welcome Introduction Participants expectations Review learning materials</td>
<td>To get to know each other and be introduced to the course 'To identify participants' expectations</td>
<td>Brain storming</td>
<td>Attendance sheet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Meta card, Marker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Training package set</td>
</tr>
<tr>
<td>9:40-10:00</td>
<td>Goals and objectives of the course</td>
<td>To introduce the objective of the training on abortion service</td>
<td>Mini lecture</td>
<td>PPP</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-10:45</td>
<td>Trainers’ &amp; participants' roles, Group norms, Daily work group, Review of logistics, Agenda</td>
<td>To clarify roles, establish norms, and discuss logistical issues</td>
<td>Brainstorm, and discussion</td>
<td>Newsprint, Marker, Clock, Agenda</td>
</tr>
<tr>
<td>10:45-11:30</td>
<td>Pre-course Questionnaire</td>
<td>To assess pre-existing knowledge</td>
<td>Individual exercise</td>
<td>Pre-course questionnaire</td>
</tr>
<tr>
<td>11:30-13:00</td>
<td>Introduction to Comprehensive Abortion Care (MVA/MA) (Module One content)</td>
<td>Describe the global and national impact of unsafe abortion as a cause of maternal mortality Explain why safe abortion services are essential in Nepal Describe the national Safe Abortion Law and Policy Identify and explain the three key elements of CAC To know how to uphold women's reproductive rights Describe preferred methods for evacuating the uterus in the first 12 weeks of pregnancy</td>
<td>Individual exercise, Mini lecture, Q/A, 4 corner activity, Personal reflection</td>
<td>PPP, Safe Abortion Policy Guideline/ Gazett (Rajpatra)</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Clinical Assessment</td>
<td>Describe how to conduct a client assessment (history taking, physical assessment) of women before abortion</td>
<td>Mini lecture, Group works, Case study</td>
<td>PPP, Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td><em>(Module Two content)</em></td>
<td>Address pre-existing conditions relevant to abortion care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain the consideration of women with special needs including youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Clinical Assessment (contd)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day’s activities</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DAY TWO**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaket/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Demonstration and practice of clinical assessment by trainer and then followed by each participants on the model</td>
<td>Describe how to conduct a clinical assessment before abortion</td>
<td>Demonstration, Individual practice, Role play</td>
<td>Zoe pelvic model, Equipment set, Clinical assessment checklist, Client personnel profile</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-11:30</td>
<td>MA review and its regimen</td>
<td>To describe the important role of MA in abortion care</td>
<td>Mini lecture, Q/A, Discussion, Group activity, Debate, Personal reflection</td>
<td>PPP</td>
</tr>
<tr>
<td></td>
<td><em>(Module Six content)</em></td>
<td>To describe the mechanism of action, routes, timing, efficacy, eligibility, indication, precautions, and contraindications of MA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:30-12:00</td>
<td>Describe parts of MVA instrument</td>
<td>Explain the parts of MVA instrument</td>
<td>Mini lecture, Group work, Self-assessment</td>
<td>MVA instrument with cannulae</td>
</tr>
<tr>
<td></td>
<td><em>(Module Six content)</em></td>
<td>Explain way of dissembling and assembling the MVA instrument</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Uterine Evacuation with MVA plus</td>
<td>Describe the precautions and steps for MVA and solve instrumental technical problems</td>
<td>Mini lecture, Group work</td>
<td>PPP, Case study</td>
</tr>
<tr>
<td></td>
<td><em>(Module Six content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Demonstration and practice MVA procedure on the model</td>
<td>Demonstrate the MVA procedures in stimulated practice (using a pelvic model)</td>
<td>Group work, Self-practice</td>
<td>MVA set, Pelvic model, MVA procedure Checklist</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Review PCQ</td>
<td>To review answer of PCQ</td>
<td>Large group</td>
<td>PCQ key</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter, Marker</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DAY THREE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Break/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Pain management on MA/MVA</td>
<td>Make an appropriate pain management plan to address all sources of pain and also taking into account women's preferences.</td>
<td>Mini lecture, Group work, Role play</td>
<td>PPP</td>
</tr>
<tr>
<td></td>
<td><em>(Module Six content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-12:00</td>
<td>Counseling, Information and Informed Consent</td>
<td>To provide essential knowledge, skill, and attitude regarding counseling</td>
<td>Role plays, Discussions, Group activities, Q/A, Brain storming.</td>
<td>PPP, Role play scenario, Instruction sheets, News print, Marker</td>
</tr>
<tr>
<td></td>
<td><em>(Module Three content)</em></td>
<td>Explain the right to contraception and the importance of post abortion contraceptive counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain about post-abortion contraceptive services including long-term methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify situations including need for specialized counseling and referrals for youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify ways of overcoming barriers to post abortion contraceptive services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice counseling skill by role play</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Infection prevention and instrument processing</td>
<td>Explain infection transmission routes in the abortion care setting</td>
<td>Mini lecture, Group work, Q/A, discussions</td>
<td>PPP, Newsprint, Marker, Gloves, Instruments for IP, IP action plan worksheet</td>
</tr>
<tr>
<td></td>
<td><em>(Module Five content)</em></td>
<td>Identify essential elements of infection prevention, including standard precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain procedures for managing occupational exposure to blood and body fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Demonstration by trainers and Practice IUCD/implant on the model by the participants</td>
<td>To describe and to conduct the process of insertion and removal of IUCD/implant to post abortion client for the standardization of skills on LARC</td>
<td>Individual practice, discussion</td>
<td>Models for IUCD and Implant, IUCD set, Implant set, IUCD and Implant checklist, IUCD and Implant commodity</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Practice MVA on Model</td>
<td></td>
<td></td>
<td>MVA sets, Models</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day’s activities</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>D A Y F O U R</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Post procedure Care and Follow – up</td>
<td>Explain post procedure assessment and monitoring</td>
<td>Group work, Discussion, Q/A</td>
<td>PPP</td>
</tr>
<tr>
<td></td>
<td><em>(Module Seven content)</em></td>
<td>Describe the immediate post procedure steps and discharge procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understand the clinical and psychosocial elements during recovery and during follow-up visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understand the need for referrals, including for contraceptive follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>10:15-11:00</td>
<td>Clinical assessment demonstration by trainers followed by practice on the client (client screening)</td>
<td>To gain skill in performing the clinical assessment</td>
<td>Individual practice</td>
<td></td>
</tr>
<tr>
<td>11:00-13:00</td>
<td>Demonstration of CAC (MA/MVA)/LARC on client by trainers. Peer practice CAC/LARC with the client, under supervision</td>
<td>To gain skill in performing the MA/MVA procedure/ IUCD/implant insertion and removal</td>
<td>Peer practice</td>
<td>Real client</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clinical procedure equipment sets, Cu-T set, Implant set</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Diagnosis and management of complication of MA/MVA (Module Eight content)</td>
<td>Identify symptoms and signs of MVA/MA abortion-related complications</td>
<td>Brain storming, Q/A, Discussion</td>
<td>Newsprint, Marker, PPP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify steps of management or referral of complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify post abortion complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Complications (contd)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day’s activities Evaluation of the day by participants</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DAY FIVE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Clinical assessment and CAC/LARC peer practice on client under the supervision of the trainers</td>
<td></td>
<td>Peer practice</td>
<td>Real client</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>MVA equipment sets, Cu-T set, Implant set</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td>Peer practice</td>
<td>Real client</td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>Clinical assessment and CAC/LARC peer practice on client under the supervision of the trainers contd</td>
<td></td>
<td></td>
<td>MVA equipment sets, Cu-T set, Implant set</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Young women &amp; Abortion care</td>
<td>Define what are young women and understand the context of young women in Nepal</td>
<td>Discussion, Q/A, Brainstorming</td>
<td>PPP, Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td><em>(Module Four content)</em></td>
<td>Provide guidance in service delivery on counseling, contraceptives, and clinic care to young women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Young women &amp; Abortion care (contd.)</td>
<td>Barriers on receiving service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(Module Four content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Break/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Service Provision/ Delivery</td>
<td>To identify the requirements of the facilities, supplies, personnel, referral systems, and quality assurance mechanisms contributing to the provision of high-quality services</td>
<td>Mini lecture, discussion, Group work</td>
<td>PPP, Newsprint, Marker, Models of service delivery format</td>
</tr>
<tr>
<td></td>
<td><em>(Module Ten content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>Clinical assessment and CAC/ LARC practice on client contd.</td>
<td></td>
<td>Peer practice</td>
<td>Real client MVA equipment sets, Cu-T set, Implant set</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Monitoring, recording and reporting</td>
<td>Explain the tools needed for recording and reporting</td>
<td>Mini lecture, Discussion, Individual practice</td>
<td>HMIS 3.7 register, Client personnel profile, HMIS 9.3/9.4/9.5 form</td>
</tr>
<tr>
<td></td>
<td><em>(Module Nine content)</em></td>
<td>Define severe adverse event and its reporting need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Monitoring, recording and reporting contd. And practice filling the forms/register</td>
<td></td>
<td>Self-practice</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DAY SEVEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Mid-course questionnaire</td>
<td>To assess the knowledge after the post lecture compared with the pre course</td>
<td>Individual exercise</td>
<td>Mid-course questionnaire</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>CAC / LARC peer practice on client</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>CAC/ LARC peer practice on client</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Practice on filling HMIS and client personal profile</td>
<td></td>
<td>HMIS 3.7 form, Client personnel profile</td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DAY EIGHT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Mid-course questionnaire</td>
<td></td>
<td></td>
<td>Mid-course questionnaire answer key</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>CAC peer practice on client, LARC</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>CAC/ LARC peer practice on client</td>
<td></td>
<td>CAC peer practice</td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Role play on counseling</td>
<td></td>
<td>Role play</td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Clinical skill evaluation of the participants</td>
<td></td>
<td>Clinical skill evaluation</td>
<td>CAC clinical skill evaluation checklist</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>Clinical skill evaluation of the participants (contd.)</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Action Planning for Safe Abortion Services</td>
<td>To develop Action Plan on safe abortion service</td>
<td>Group work and presentation</td>
<td>Action plan format, Minimum requirement for MVA service delivery checklist</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Presentation on developed action plan</td>
<td>Implementation plans in their institutions by the participants</td>
<td>Presentation by participants (institution-wise)</td>
<td>PPT, Newsprint, Marker</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DAY TEN**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Site and provider listing process</td>
<td>To provide knowledge on the process of listing of service facility and participants as service provider</td>
<td>Discussion</td>
<td>Provider and site listing request forms</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>Clinical skill evaluation of the participants (contd)</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Evaluation of the course by the participants</td>
<td>To assess strengths and weaknesses of the training course and trainers and areas to improve for future training</td>
<td>Individual exercise</td>
<td>End-of-course evaluation form</td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Review day’s activities</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Certification and Closing</td>
<td></td>
<td></td>
<td>Certificates</td>
</tr>
</tbody>
</table>
### Schedule Example: Training on Comprehensive Abortion Care Services for Nurse Participants (14 days)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:40</td>
<td>Registration Opening and Welcome Introduction Participants Expectations Review learning materials</td>
<td>To get to know each other and be introduced to the course To identify participants' expectations</td>
<td>Brainstorming</td>
<td>Attendance sheet Meta card, Marker Training package set</td>
</tr>
<tr>
<td>9:40-10:00</td>
<td>Goals and objectives of the course</td>
<td>To introduce the objective of the training on abortion service</td>
<td>Mini lecture</td>
<td>PPP</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-10:45</td>
<td>Trainers' &amp; participants' roles, Group norms, Daily work group, Review of logistics, Agenda</td>
<td>To clarify roles, establish norms, and discuss logistical issues</td>
<td>Brainstorm, and discussion</td>
<td>Newsprint, Marker, Clock, Agenda</td>
</tr>
<tr>
<td>10:45-11:30</td>
<td>Pre-course Questionnaire</td>
<td>To assess pre-existing knowledge</td>
<td>Individual exercise</td>
<td>Pre-course questionnaire</td>
</tr>
<tr>
<td>11:30-13:00</td>
<td>Introduction to Comprehensive Abortion Care (MVA/MA)</td>
<td>Describe the global and national impact of unsafe abortion as a cause of maternal mortality Explain why safe abortion services are essential in Nepal Describe the national Safe Abortion Law and Policy Identify and explain the three key elements of CAC To know how to uphold women's reproductive rights Describe preferred methods for evacuating the uterus in the first 12 weeks of pregnancy</td>
<td>Individual exercise, Mini lecture, Q/A, 4 corner activity, Personal reflection</td>
<td>PPP, Safe Abortion Policy Guideline/Gazzet (Rajpatra)</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Clinical Assessment (Module Two content)</td>
<td>Describe how to conduct a clinical assessment (history taking, physical assessment) of women before abortion Address pre-existing condition relevant to abortion care Explain the consideration of women with special needs including youth</td>
<td>Mini lecture, Group works, Case study</td>
<td>PPP, Newsprint, Marker</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Clinical Assessment (contd)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day’s activities</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DAY TWO**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Break/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Demonstration and practice of clinical assessment by trainer and followed by each participants on the model</td>
<td>Describe how to conduct a clinical assessment before abortion</td>
<td>Demonstration, Individual practice, Role play</td>
<td>Zoe pelvic model, Equipment set, Clinical assessment checklist, Client personnel profile</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>MA review and its regimen (Module Six content)</td>
<td>To describe the important role of MA in abortion care To describe the mechanism of action, routes, timing, efficacy, eligibility, indication, precautions, and contraindications of MA</td>
<td>Mini lecture, Q/A, Discussion, Group activity, Debate, Personal reflection</td>
<td>PPP</td>
</tr>
<tr>
<td>10:15-11:30</td>
<td>Describe parts of MVA instrument (Module Six content)</td>
<td>Explain the parts of MVA instrument Explain way of dissembling and assembling the MVA instrument</td>
<td>Mini lecture, Group work, Self-assessment</td>
<td>MVA instrument with cannulae</td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Uterine Evacuation with MVA plus</td>
<td>Describe the precaution and steps for MVA and solve instrumental technical problems</td>
<td>Mini lecture, Group work</td>
<td>PPP, Case study</td>
</tr>
<tr>
<td></td>
<td><em>(Module Six content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Demonstration and practice MVA/ LARC procedure on the model</td>
<td>Demonstrate the MVA procedures in stimulated practice (using a pelvic model)</td>
<td>Group work, Self-practice</td>
<td>MVA set, IUCD/ Implant set and commodity, Pelvic model, MVA and LARC Checklist</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Review PCQ</td>
<td>To review answer of PCQ</td>
<td>Large group</td>
<td>PCQ key</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAY THREE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Pain management on MA/MVA</td>
<td>Make an appropriate pain management plan to address all sources of pain and taking into account women's preferences.</td>
<td>Mini lecture, Group work, Role play</td>
<td>PPP</td>
</tr>
<tr>
<td></td>
<td><em>(Module Six content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>10:15-12:00</td>
<td>Counseling, Information and Informed Consent</td>
<td>To provide essential knowledge, skill, and attitude regarding counseling</td>
<td>Role plays, Discussions, Group activities, Q/A, Brainstorming, Case studies, stories, 4 corner activities</td>
<td>PPP, Role play scenario, Instruction sheets, Newsprint, Marker Copies of 4 Corners activity</td>
</tr>
<tr>
<td></td>
<td>(Module Three content)</td>
<td>Explain the right to contraception and the importance of post abortion contraceptive counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain about post-abortion contraceptive services including long-term methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify situations including need for specialized counseling and referrals for youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify ways of overcoming barriers to postabortion contraceptive services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice counseling skill by role play</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Infection prevention and instrument processing</td>
<td>Explain infection transmission routes in the abortion care setting</td>
<td>Mini lecture, Group work, Q/A, Discussions</td>
<td>PPP, Newsprint, Marker, Gloves, IP instruments, IP Action plan worksheet</td>
</tr>
<tr>
<td></td>
<td>(Module Five content)</td>
<td>Identify essential elements of Infection prevention, including standard precautions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain procedures for managing occupational exposure to blood and body fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Demonstration by trainers and Practice LARC on the model by the participants</td>
<td>To describe and to conduct the process of insertion and removal of LARC to post abortion client for standardization of LARC skill</td>
<td>Individual practice, discussion</td>
<td>Model for LARC, LARC set, LARC checklist</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Practice MVA/ LARC on Model</td>
<td></td>
<td></td>
<td>MVA sets, Pelvic Model, Model for LARC, LARC set, LARC checklist</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities Evaluation of the day by participants</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaket/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Post procedure Care and Follow-up (Module Seven content)</td>
<td>Explain post procedure assessment and monitoring</td>
<td>Group work, Discussion, Q/A</td>
<td>PPP</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-11:00</td>
<td>Clinical assessment demonstration by trainers followed by practice on the client (client screening)</td>
<td>To gain skill in performing the client assessment</td>
<td>Individual practice</td>
<td></td>
</tr>
<tr>
<td>11:00-13:00</td>
<td>Demonstration of CAC (MA/MVA)/LARC on client by trainers. Peer practice CAC/ LARC with the client, under supervision</td>
<td>To gain skill in performing the MA/MVA procedure/LARC insertion and removal</td>
<td>Peer practice</td>
<td>Real client</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td>Clinical procedure equipment sets, Cu-T set, Implant set, Checklist for LARC</td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Diagnosis and management of complication of MA/MA</td>
<td>Identify signs and symptoms of MVA/MA abortion-related complications</td>
<td>Brainstorming, Q/A, Discussion</td>
<td>Newsprint, Marker, PPP</td>
</tr>
<tr>
<td></td>
<td><em>(Module Eight content)</em></td>
<td>Identify steps of management or referral of complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify post abortion complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Complications, contd.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td>Newprint, Marker</td>
</tr>
</tbody>
</table>

**DAY FIVE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Break/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Clinical assessment and CAC/LARC peer practice on client under the supervision of the trainers</td>
<td>Peer practice</td>
<td>Real client</td>
<td>MVA equipment sets, Cu-T set, Implant set</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>Clinical assessment and CAC/LARC peer practice on client under the supervision of the trainers contd</td>
<td>Peer practice</td>
<td>Real client</td>
<td>MVA equipment sets, LARC set</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Young women &amp; Abortion care</td>
<td>Define what are young women and understand the context of young women in Nepal</td>
<td>Discussion, Q/A, Brainstorming</td>
<td>PPP, Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td><em>(Module Four content)</em></td>
<td>Provide guidance in service delivery on counseling, contraceptives, and clinic care to young women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Young women &amp; Abortion care (contd.)</td>
<td>Barriers on receiving service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>(Module Four content)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Service Provision/ Delivery (Module Ten content)</td>
<td>To identify the requirements of the facilities, supplies, personnel, referral systems, and quality assurance mechanisms contributing to the provision of high-quality services</td>
<td>Mini lecture, discussion, Group work</td>
<td>PPP, Newsprint, Marker, Models of service delivery format</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>Clinical assessment and CAC/ILARC practice on client contd.</td>
<td></td>
<td>Peer practice</td>
<td>Real client MVA equipment sets, LARC set</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Monitoring, recording and reporting (Module Nine content)</td>
<td>Explain the tools needed for monitoring, recording and reporting Define severe adverse event and its reporting need</td>
<td>Mini lecture, Discussion, Individual practice</td>
<td>HMIS 3.7 register, Client personnel profile, HMIS 9.3/9.4/9.5 forms</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Monitoring, recording and reporting (contd) and practice filling forms</td>
<td></td>
<td>Self-practice</td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Mid-course questionnaire</td>
<td>To assess the knowledge after the post lecture compared with the pre course</td>
<td>Individual exercise</td>
<td>Mid-course questionnaire</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>CAC /LARC peer practice on client</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>CAC/LARC peer practice on client</td>
<td></td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Practice on filling HMIS and client personal profile</td>
<td></td>
<td></td>
<td>HMIS 3.7 register, Client personnel profile</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day’s activities Evaluation of the day by participants</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
</tbody>
</table>

**DAY EIGHT**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Mid-course questionnaire review</td>
<td></td>
<td>Mid-course questionnaire answer key</td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>CAC/LARC peer practice on client</td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>CAC/LARC peer practice on client</td>
<td>CAC peer practice</td>
<td></td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Role play on counseling</td>
<td>Role play</td>
<td></td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Review day’s activities Evaluation of the day by participants</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
</tr>
</tbody>
</table>

**DAY NINE**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>CAC/ LARC peer practice on client</td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:15-13:00</td>
<td>CAC/LARC peer practice on client</td>
<td>Peer practice</td>
<td></td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>14:15-15:00</td>
<td>Evaluation of the course by the participants</td>
<td>Assess strengths and weaknesses of the training course and trainers and areas to improve for future training</td>
<td>Individual exercise</td>
</tr>
<tr>
<td>15:00-15:15</td>
<td>Tea Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Review day’s activities</td>
<td>Review the day’s activities and get feedback from participants</td>
<td>Group work</td>
</tr>
<tr>
<td>15:45-16:00</td>
<td>Certification and Closing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Schedule Example: Training on Comprehensive Abortion Care Services for Ob & Gyn Specialists (3 days)

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAY ONE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:30</td>
<td>Registration, Welcome, Introduction</td>
<td>To get to know each other and be introduced to the course</td>
<td>Mini lecture</td>
<td>Attendance sheet</td>
</tr>
<tr>
<td></td>
<td>Participants’ expectations</td>
<td>To identify participants’ expectations</td>
<td>Brain storming</td>
<td>Meta card, Marker</td>
</tr>
<tr>
<td>9:30-9:45</td>
<td>Goals and objectives of the course</td>
<td>To introduce the objective of the training on abortion service</td>
<td>Mini lecture</td>
<td>PPP</td>
</tr>
<tr>
<td>9:45-10:15</td>
<td>Pre-course Questionnaire</td>
<td>To assess pre-existing knowledge</td>
<td>Individual exercise</td>
<td>Pre-course questionnaire</td>
</tr>
<tr>
<td>10:15-11:15</td>
<td>Introduction to Comprehensive Abortion Care (MVA/MA)</td>
<td>Describe the global and national impact of unsafe abortion as a cause of maternal mortality</td>
<td>Individual exercise, Mini lecture, Q/A, 4 corner activity, Personal reflection</td>
<td>PPP, Safe Abortion Policy Guideline/ Gazett (Rajpatra)</td>
</tr>
</tbody>
</table>

- **Mini lecture**
- **Brain storming**
- **Attendance sheet**
- **Meta card, Marker**
- **PPP**
- **Individual exercise**
- **Pre-course questionnaire**
- **PP, Safe Abortion Policy Guideline/ Gazett (Rajpatra)**
<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>11:15-12:00</td>
<td>Clinical Assessment</td>
<td>Describe how to conduct a clinical assessment (history taking, physical assessment) of women before abortion&lt;br&gt;Address pre-existing condition relevant to abortion care&lt;br&gt;Explain the consideration of women with special needs including youth</td>
<td>Mini lecture, Group works, Case study</td>
<td>PPP, Newsprint, Marker</td>
</tr>
<tr>
<td>12:00-13:00</td>
<td>Uterine Evacuation with MVA plus</td>
<td>Describe the precaution and steps for MVA and solve instrumental technical problems</td>
<td>Mini lecture, Group work</td>
<td>PPP, Case study</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-14:45</td>
<td>Describe parts of MVA instruments</td>
<td>Explain the parts of MVA instrument&lt;br&gt;Explain way of dissembling and assembling the MVA instrument</td>
<td>Mini lecture, Group work, Self-assessment</td>
<td>MVA instruments with cannulae</td>
</tr>
<tr>
<td>14:45-15:15</td>
<td>MA review and its regimen</td>
<td>To describe the important role of MA in abortion care</td>
<td>MA review and its regimen</td>
<td>PPP</td>
</tr>
<tr>
<td>15:15-15:30</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:30-16:15</td>
<td>Demonstration and practice MVA procedure on the model</td>
<td>Demonstrate the MVA procedures in stimulated practice (using a pelvic model)</td>
<td>Group work, Self-practice</td>
<td>MVA set, Pelvic model</td>
</tr>
<tr>
<td>16:15-16:30</td>
<td>Review day’s activities Evaluation of the day by participants</td>
<td>To review the day’s activities and get feedback from participants</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
</tbody>
</table>

**DAY TWO**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Topic</th>
<th>Session Objective</th>
<th>Methodology</th>
<th>Materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Uterine Evacuation with MVA plus</td>
<td>Describe the precaution and steps for MVA and solve instrumental technical problems</td>
<td>Mini lecture, Group work</td>
<td>PPP, Case study</td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>10:00-10:45</td>
<td>Counseling, information and Informed Consent</td>
<td>To provide essential knowledge, skill, and attitude regarding counseling</td>
<td>Role plays, Discussions, Group activities, Q/A, Brain storming</td>
<td>PPP, Role play scenario, Instruction sheets, News print, marker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain the right to contraception and the importance of postabortion contraceptive counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain about post-abortion contraceptive services focusing on long-term methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify situations including need for specialized counseling and referrals for youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify ways of overcoming barriers to post abortion care contraceptive services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Practice counseling skill by role play</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:45-13:00</td>
<td>Demonstration of CAC (MA/MVA) on client. Peer practice CAC with the client, under supervision</td>
<td>To gain skill in performing the MA/MVA procedure</td>
<td>Peer practice</td>
<td>Real client</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clinical procedure equipment sets</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-14:45</td>
<td>Review PCQ</td>
<td>To review answer of PCQ</td>
<td>Large group</td>
<td>PCQ key</td>
</tr>
<tr>
<td>14:45-15:30</td>
<td>Monitoring, recording and reporting</td>
<td>Explain the importance of monitoring and reporting</td>
<td>Mini lecture, Discussion, Individual practice</td>
<td>HMIS 3.7 register, Client personnel profile, HMIS 9.3/9.4/9.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Explain the tools needed for recording and reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Define severe adverse event and its reporting need</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:15-15:30</td>
<td>Tea Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>15:30-16:15</td>
<td>Pain management on MA/MVA</td>
<td>Make an appropriate pain management plan to address all sources of pain and taking into account women's preferences.</td>
<td>Mini lecture, Group work, Role play</td>
<td>PPP</td>
</tr>
<tr>
<td>16:15-16:30</td>
<td>Review day's activities</td>
<td>To review the day's activities and get feedback from participants.</td>
<td>Group work</td>
<td>Mood meter chart in Newsprint, Marker</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the day by participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAY THREE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:15</td>
<td>Ice Breaker/ Review of previous day</td>
<td></td>
<td>Group work</td>
<td></td>
</tr>
<tr>
<td>9:15-10:00</td>
<td>Diagnosis and management of complication of MA/MVA</td>
<td>Identify symptoms and signs of MVA/MA abortion-related complications Identify steps of management or referral of complications Identify post abortion complications</td>
<td>Brain storming, Q/A, Discussion</td>
<td>Newsprint, Marker, PPP</td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>Young women and Abortion care</td>
<td>Define what are young women and understand the context of young women in Nepal Provide guidance in service delivery on counseling, contraceptives, and clinic care to young women</td>
<td>Brainstorming, Discussion</td>
<td>PPP, Newsprint, Marker</td>
</tr>
<tr>
<td>10:30-11:00</td>
<td>Post procedure care and follow-up</td>
<td>Explain post procedure assessment and monitoring Describe the immediate post procedure steps and discharge procedure Understand the clinical and psychosocial elements during recovery and during follow-up visit.</td>
<td>Group work</td>
<td>PPP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understand the need for referrals, including for contraceptive follow-up.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Session Topic</td>
<td>Session Objective</td>
<td>Methodology</td>
<td>Materials</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>11:00-13:00</td>
<td>Clinical Skill Evaluation</td>
<td>Clinical skill evaluation</td>
<td>Clinical skill evaluation</td>
<td>checklist</td>
</tr>
<tr>
<td>13:00-14:00</td>
<td>Lunch Break</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00-14:15</td>
<td>Energizer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:15-14:45</td>
<td>Service provision/</td>
<td>To identify the requirements of the facilities, supplies, personnel, referral</td>
<td>Mini lecture, Discussion,</td>
<td>PPP, Newsprint, Marker, Models of service</td>
</tr>
<tr>
<td></td>
<td>delivery</td>
<td>delivery systems, and quality assurance mechanisms contributing to the provision</td>
<td>Group work</td>
<td>delivery format</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of high-quality services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:45-15:15</td>
<td>Mid-course test</td>
<td></td>
<td></td>
<td>Mid-course KQ questionnaire</td>
</tr>
<tr>
<td>15:15-15:45</td>
<td>Action Planning for</td>
<td>To complete the Action Plan and present on Safe Abortion Services implementation</td>
<td>Group work and presentation</td>
<td>Action Planning for Safe Abortion Services,</td>
</tr>
<tr>
<td></td>
<td>Safe Abortion Services</td>
<td>plans in their institutions by the participants.</td>
<td></td>
<td>Minimum requirement for MVA service delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>site checklist</td>
</tr>
<tr>
<td>15:45-16:15</td>
<td>Mid-course test discussion</td>
<td></td>
<td>Large group</td>
<td></td>
</tr>
<tr>
<td>16:15-16:30</td>
<td>End course evaluation</td>
<td>Assess strengths and weaknesses of the training course and trainers and areas to</td>
<td>Participants</td>
<td>End-of-course evaluation form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>improve for future training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16:30-16:45</td>
<td>Session closing and</td>
<td></td>
<td></td>
<td>Certificates</td>
</tr>
<tr>
<td></td>
<td>certificate with tea</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
About This Trainers' Manual

The Comprehensive Abortion Care Trainers' Manual is a resource for trainers who lead training courses on the provision of high-quality, woman-centered, comprehensive abortion care (CAC), including post-abortion care, in Nepal. This manual can be used to train registered MBBS physicians, OB/GYN specialists and Nurses (staff nurse/ senior ANM) who meet the criteria set by the Family Health Division (FHD) and the National Health Training Centre (NHTC).

Purpose

This Comprehensive Abortion Care (CAC) Trainers' Manual has been developed for two main purposes:

- To provide all of the instructions and materials needed to help health workers develop the knowledge and skills necessary to provide high-quality CAC.
- To provide the protocols and checklists required to learn the CAC skills to a specified standard of care.

Structure

The trainers' manual is divided into 10 modules. Each module contains learning activities to achieve a specific set of objectives. Each module begins with a presentation of information and ends with active practice through participatory activities. Trainers are encouraged to adapt the modules to fit different training needs and objectives.

Trainer Guidance in Each Module

- Estimated time
- Purpose
- Preparation
- Step-by-step instructions for teaching the module content

Materials for the Module Activities

The Participants' Manual contains all of the information that participants need. Activity materials and knowledge questionnaires can only be found in the back of this Trainers' Manual. These materials should not be given to participants in advance. Instead, they should be copied and supplied as needed. The questionnaires are also kept in the Participants' Handbook and should be torn taken out from the handbook so as to distribute during the training.

Course Schedule

The course schedule for physicians is 10 days, three days for OB/GYN specialists and for nurse providers it is 14 days.
Recording, Certification and Legal Requirement

Trainers are responsible for ensuring that someone is assigned to record relevant information about participants and course delivery (such as attendance and results of pre- and post-training tests). There are checklists for each skill set covered in this manual, and a separate final evaluation form in the Clinical Practicum module to certify participants as competent in providing abortion-related care. Trainers should determine whether the process for participant certification meets local regulations. Trainers should also consider any legal requirements for conducting the onsite practicum included in this curriculum. Trainers are responsible for collecting all the documents from the participants during the training so that the trainers can obtain the training certificates. Listing process for providers and sites should also be informed to the participants so that prompt service delivery after the training can be delivered. The required documents for the process have been added to this Training Manual.

CAC Training Goals

- To create positive attitudes among health workers regarding the provision of CAC services.
- To develop competence and confidence to provide high-quality, woman-centered CAC, which includes post-abortion care.

CAC Learning Objectives

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

- Explain Nepal abortion law, procedural process and policy.
- Describe the three key elements of CAC.
- Describe a woman’s rights in an abortion and post-abortion care setting.
- Perform a clinical assessment for abortion care.
- Provide abortion counseling and offer choice regarding manual vacuum aspiration (MVA) and medical abortion (MA); and obtain informed consent.
- Offer post-abortion family planning counseling and contraceptive services including long-term methods.
- Provide CAC to young women.
- Identify the elements of infection prevention.
- Use and process properly the Ipas MVA Plus® aspirator and Ipas EasyGrip™ cannulae.
- Develop an individualized pain management plan.
- Perform uterine evacuation using MVA.
- Describe mechanism, regimen, route and possible side effects of MA drugs.
- Identify steps to diagnose and manage complications during and after abortion.
- Provide post-procedure and follow-up care after MVA and MA.
- Describe the steps for establishing an abortion-care services monitoring system.
- Design an action plan to establish a CAC center in their setting.
Core Principles of the Course

This course is based on the following core principles:

- **Woman-centered care**: This means that providers ask for and focus on each woman's concerns and interests and take a comprehensive approach to meet her medical and psychological needs.

- **Effective approaches to training**: These include training methodologies based on principles of adult education, competency-based skills acquisition, and participant-centered, participatory activities to promote learning.

- **Competency-based training**: Clinical skills are developed through a structured process of demonstration, feedback, coaching, practice with models until competency is gained and evaluation of competency of each skill using a checklist before the first client contact.

Characteristics of Effective Training

- Trainers and participants understand the purpose of the training.
- Trainers and participants understand exactly what participants are expected to do at the end of the course.
- Training content and methods enable participants to meet the objectives of the training.
- Training builds on the existing knowledge, skills and experience of participants.
- New knowledge and skills are presented in a context that is meaningful and relevant to participants.
- Participants are actively engaged in the learning process.
- Training utilizes an effective mix of training methods to meet the needs of different learning styles and accomplish learning objectives.
- Participants have the opportunity to practice applying new knowledge and skills.
- Participants receive constructive feedback on their performance.
- Participants have enough time to meet the objectives of the training.
- Trainers accept feedback from participants and use this feedback to improve the training.
- Training is evaluated in terms of whether participants met the training objectives.

Competency-Based Training

- Use of a standard training package with learning guides/checklists for each skill.
- Use of anatomic models and other teaching aids.
- The clinical trainer demonstrates the required skill on the model first for trainees to observe.
- Trainer coaches trainees during skill practice on the model and then later, on the clients.
- Positive and corrective feedback is given during and after the practice of a skill.
- All trainees will have an equal opportunity to practice on the models and later, on the clients under close supervision from trainers.
- Only after obtaining and demonstrating competency on the model the trainees will have the first contact with the client.
The trainees will perform the skill on the client under the close supervision of a clinical trainer to obtain competency in the required skill.

The trainees will be evaluated on both their levels of the skill competency and theoretical knowledge.

Only trainees evaluated as competent will then become a successful candidate to be listed as CAC service providers.

**Competency-Based Training Terms**

- **Skill Acquisition**: Knows the steps and their correct sequence to perform the required skill or activity but needs assistance.

- **Skill Competency**: Knows the steps and their correct sequence and adequately performs the required skill or activity.

- **Skill Proficiency**: Knows the steps and their correct sequence and efficiently and precisely performs the required skill or the activity.

**Training/Learning Methods Used**

- Presentation with question and answer (illustrated with PowerPoint slides if possible)
- Discussion (full group, small group, or pairs)
- Brainstorming
- Personal reflection
- Reading assignments and reporting back
- Small group and pairs activities
- Role plays
- Demonstration (live, video or CD-Rom)
- Simulated practice with anatomic models
- Supervised procedures on clients

**Evaluation**

**Participants:**

- Knowledge is assessed with the Knowledge Questionnaire.
- Skills are assessed first by simulated practice with coaching and feedback in the classroom and then by hands-on practice during the clinical practicum module. Participants are evaluated for competency using skills checklists.

**Training:**

It is recommended that, at the end of each day, the trainer collect feedback about participant satisfaction with the day's topics and activities. When trainers review feedback from participants daily, they can often make immediate improvements to the training. It is also recommended that participants complete a final evaluation at the end of the course, which can provide valuable information for modifying future training courses.
Nepal Comprehensive Abortion Care (CAC) Training Package

Reference Manual: This should be given to every learner (participant). In addition, every trainer needs a copy. It is generally recommended that the Participant’s Reference Manual be distributed in the course introduction. This contains 10 modules.

Participants’ Handbook: This should be given to every learner (participant). In addition, every trainer needs a copy. It is generally recommended that the Participant Handbook be distributed in the course introduction. This Handbook consists of Schedule, Checklists, Role Plays, Case Studies, Questionnaires without answer keys, etc.

Trainers’ Manual: This document tells the trainer what to do to conduct each session. It also contains the knowledge questionnaires with answer keys and a few handouts to copy for participants.

Reference Materials: Trainers may want to have available for reference:
- Rajapatra (Gazette)

Daily Opening and Closings

Each day begins and ends in a standard way.

Daily opening: Each day should begin with a brief opening session to discuss the day’s schedule. The schedule should be posted on a flip chart where all can see for reference during the day. Trainers should greet the participants by name, invite questions and address them, and thank participants for their participation.

Daily closing: The final activity every day is a closing session. At this time, the trainer should review the day’s activities and determine how to address any outstanding issues and to briefly present the next day’s schedule. Trainers should thank the participants for their participation. Each participant should complete the daily evaluation form. Some other type of daily evaluation exercise can also be used (e.g. using the mood meter).

Preparation

Trainers are responsible for the following preparations for every session:
- Make sure the following tools are available: paper, pencils, pens, flipchart easels, flipchart paper, markers, tape for posting flipchart pages, and suggestion box.
- Arrange the room to accommodate the module activities and promote shared learning (e.g. circle or horseshoe shape).
- Review the trainer’s module carefully and thoroughly, including reading the relevant reference materials.
• Review materials for the module in the Participants’ Handbook.
• Prepare icebreaker and energizer activities.
• Make any special preparations necessary for specific module activities (listed in the preparation section of the module).

Trainers need to be aware on the selection criteria for different cadre of participants as well the process for the listing for the site and as a provider. Trainers need to provide clear information that the training certificate is different to the listing as a provider which is mentioned below.

Participants Selection Criteria

According to National safe abortion policy the trainees should meet the following criteria:

**Criteria for first trimester abortion service for physician (10 days):**
• Physicians who are registered in Nepal Medical Council

**Criteria for first trimester abortion service for nurses (14 days):**
• Staff Nurse who are registered in Nursing Council
• Have obtained training in Skilled Birth Attendant (SBA)/IUCD / PAC

**Criteria for first trimester abortion service for Ob/Gyn specialists (3 days):**
• Post graduate in Ob/Gyn registered in Nepal Medical Council as specialist
• Has worked in Ob/Gyn department for at-least 2 years after completion of post graduate education

**Requirement for training certification**

Participants need to tear the training registration form completely and submit to the trainers along with passport size photo. The trainers will submit the forms along with other forms that trainers need to fill to obtain the training certification. Below are the documents required:
• Training registration form (back of the handbook )
• Passport size photo-2 copies
• Number of citizenship
• Number of respective registered council
• Number of HURDIC (government employee only)

**Requirements for Listing**

**CAC Providers:** In order to provide CAC services legally, the service provider must be trained in a CAC training course approved by the National Health Training Center (NHTC). Upon completion of the CAC training course, successful trainee participants need to submit the following for the listing process to FHD.
• Complete application form (back of the handbook)
• NHTC approved CAC training certificate (photocopy)
• Passport size photo-1
FHD, after reviewing the basic requirements for listing, will provide the listing certificate to the applicants. For private service provider listing, an additional fee as per government rules is to be paid.

**CAC Facilities:** In order for a health facility to be listed following documents are needed
- Application form
- Provider listing certificate (Photocopy)
- Site assessment checklist

The FHD after reviewing the basic requirements for listing, will provide the listing certificate to the institution.

**Note:** In addition to above documents, private site need to provide 1) Provider commitment letter 2) Private institution registered certificate 3) Approval from MOHP to run as private facility( as per the criteria set by Government) 4) Registration fee.

**RECORDING AND REPORTING TRAINING FORMS**

The trainers should note that after the completion of the training, the following forms are completely filled and send to National Health Training center for the training certification process. All the cells in the form provided need to be compulsory filled very clearly. The list of forms which need to be sent to the NHTC are:

1. **Trainer Record Format:** This form is to capture the information of all trainers involved in conducting the training.

2. **Co-trainer/Facilitator record Format:** If there are any co-trainer or facilitators for conducting the training, this form need to be filled.

3. **Training Registration Format:** This form is to capture all the detailed information about participants who have participated during the training period. This form need to be filled by the participants which are available in the Participants handbook and collected by the trainers.

4. **Trainees Record Format:** This form is filled by the trainers based on the training registration form submitted by the participants. This form provides detail information of the trainees as well the scoring of the participants in pre and post test.

5. **Training Report Format:** This form need to be filled by the trainers to be submitted to NHTC to provide overall training report where number of participants and trainers involved as well as the issues and challenges with recommendation is mentioned.

6. **Trainees Registration Format:** This form need to be filled by the trainer once so that NHTC has a list of National trainers on different expertise.

**Note:** All format are at the back of the manual for reference. Beside the above mentioned forms, the trainers also need to ensure that all the participants has provided documents for certification.
Course Introduction

Estimated Time: 1 hr 30 min

Purpose

This module welcomes participants, introduces participants to trainers and each other, asks about expectations, explains the goal and objectives, presents the agenda, discusses trainer and participant roles, and establishes group norms.

Preparation

- Ensure that a Participant Handbook is available for each participant. (If handbooks are not available for everyone, prepare copies of all materials for distribution to participants in the sessions when they will be used.)
- Prepare flip charts with the following titles:
  - Course Expectations
  - Trainers’ Roles
  - Participants’ Roles
  - Group Norms
  - Parking Lot
- Adapt the agenda if desired and make copies for participants
- Prepare a suggestion box and cards or paper

Step-by-Step

1. Opening, welcome, introduction (10 min)

Tell the participants your name, professional background, and any other pertinent information. Have the participants introduce themselves giving their name and a brief description of themselves.

2. Brainstorm: Course expectations (10 min)

- Ask participants what they are hoping to learn in this training and write down their ideas on the flipchart without responding.
- Review the list of training expectations, identify which are likely to be met, and acknowledge any that may be beyond the scope of the training.
- Keep this list to review with participants at the end of the training to ensure that realistic expectations were met.
3. Review training goals, objectives, course content, training and learning methods, and criteria for course completion (10 min)

Show and review slide: *CAC Training Goals*
- To create positive attitudes among health workers regarding the provision of CAC services.
- To develop competence and confidence to provide high-quality, woman-centered CAC, which includes postabortion care.

Show and review slides: *Learning Objectives*

By the end of this training course, participants should be able to:
- Explain Nepal abortion law, procedural process and policy.
- Describe the three key elements of CAC.
- Describe a woman’s rights in an abortion and postabortion care setting.
- Perform a clinical assessment for abortion care.
- Provide abortion counseling and offer choice regarding manual vacuum aspiration (MVA) and medical abortion (MA) and obtain informed consent.
- Offer postabortion family planning counseling and contraceptive services including long-term methods.
- Provide CAC to young women.
- Identify the elements of infection prevention.
- Use and process properly the Ipas MVA Plus® aspirator and Ipas EasyGrip® cannulae.
- Develop an individualized pain management plan.
- Perform uterine evacuation using MVA.
- Describe mechanism, regimen, route and possible side effects of MA.
- Identify steps to diagnose and manage complications during and after abortion.
- Provide post-procedure care and follow-up care after MVA and MA
- Describe the steps for establishing an abortion-care services monitoring system.
- Design an action plan to establish a CAC center in their setting.

Show and review slides: *Overview of Course Content*
- Course introduction
- Comprehensive abortion care
- Clinical assessment
- Counseling, information, and informed consent
- Young women and abortion care
- Infection prevention
- Types of abortion procedures
- Post-procedure care
- Follow-up care
- Complications
- Recording and reporting
- Service provision
- Clinical practicum
Show and discuss slide: Training/Learning Methods Used
- Presentation with question and answer
- Discussion (full group, small group, or pairs)
- Brainstorming
- Personal reflection
- Reading assignments and reporting back
- Small group and pairs activities
- Role plays
- Demonstration (live, video, or CD-Rom)
- Simulated practice with anatomical models
- Supervised procedures on clients

Explain to participants that the training is based on adult learning principles. A variety of training methods will be used throughout the course to help acquire the necessary knowledge and skills. Simulated and clinical practice using skills checklists helps participants reach competency.

Show slide and review: Participant and Course Evaluation
- Knowledge is assessed with the Knowledge Questionnaire.
- Skills are assessed first by simulated practice with coaching and feedback in the classroom and then by hands-on practice during the clinical practicum module. Participants are evaluated for competency using skills checklists.
- The course is evaluated daily and at the end of the course.

Explain that a variety of evaluation methods will be used throughout the course to evaluate participants’ knowledge, skills, and overall understanding of the material.

Present the suggestion box (if using).
- Place index cards and pens next to it.
- Invite participants to write comments on the cards and place them in the box.
- Names do not need to be included.
- Invite participants to offer feedback to trainers.
- Suggest they give feedback in private.

Show slide and review: Course Completion

This is a National Health Training Center-approved CAC clinical skills course. To be listed as an abortion provider, participants must complete this course and then submit:
- Application Form for provider listing
- Training Certificate and a request to be listed as an abortion provider.

This process is also used for listing abortion facilities/sites.
4. Review roles: Trainers and participants (10 min)

You may brainstorm a list, writing the answers on a flipchart if you wish. Make sure to mention the roles listed below and to let the group know that you welcome feedback.

<table>
<thead>
<tr>
<th>Trainer’s Roles</th>
<th>Participants’ Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providing information</td>
<td>• Participating fully according to comfort level and group norms</td>
</tr>
<tr>
<td>• Asking and answering questions</td>
<td>• Sharing knowledge and experiences</td>
</tr>
<tr>
<td>• Facilitating discussions and activities</td>
<td>• Taking responsibility for own learning (ask for help, ask questions)</td>
</tr>
<tr>
<td>• Making sure the group stays on task and on time</td>
<td>• Abiding by group norms</td>
</tr>
<tr>
<td>• Modeling effective training and clinical skills Maintaining a productive learning environment</td>
<td></td>
</tr>
</tbody>
</table>

5. Establish group norms, parking lot (10 min)

Group norms are mutually agreed upon “rules” to guide how the group will work together, to create a safe and respectful learning environment and to enable tasks to be accomplished efficiently. Ask participants to suggest group norms and write them on the flipchart (examples: speak one at a time, cell phones on vibration or turned off, be respectful, start and end on-time).

Brainstorm a list and write it on the labeled “Group Norms” flipchart. After the list is created, briefly discuss it to make sure everyone understands. Ask the participants to agree to what is on the list, and to raise their hands to show their commitment to maintaining these norms. Point out that everyone has agreed to abide by the norms. Leave the list posted throughout the course and use it as needed to maintain a positive learning environment.

Point out the flipchart labeled “Parking Lot,” which will be posted throughout the course. Topics that come up during the session, which will be held for discussion later, will be listed here. Time will be set aside to discuss these issues later in the course.

6. Review logistics and agenda (10 min)

Examples of logistics include: break time, lunch time, location of restrooms, etc. Hand out and review the agenda.

7. Administer the CAC Pre-Course Questionnaire (30 min)

Explain that the questionnaire will help you tailor the course to what the participants already know and what they do not know and that it is not expected that participants will already know everything on the questionnaire.
MODULE 1:

COMPREHENSIVE ABORTION CARE

Estimated Time: 3 hrs 40 mins

Purpose

This module discusses the legal status of abortion in Nepal and gives an overview of the three key elements of woman-centered CAC and women’s rights in an abortion-care setting; explores providers’ values and attitudes with regard to uterine evacuation; and introduces uterine evacuation and other elements of care.

Preparation

- Research Nepal’s national law and regulations on abortion services.
- Read the World Health Organization’s (WHO), Safe Abortion: Technical and Policy Guidance for Health Systems.
- Copy “Four Corners Worksheet A” and “Four Corners Worksheet B” for each participant.
- Make signs that say “Strongly Agree,” “Agree,” “Disagree,” “Strongly Disagree.” Post these signs in the four corners of the room.
- Prepare the International Planned Parenthood Federation (IPPF) principles and principle description strips and put them in a basket.
- Prepare the instructions for the Reproductive Rights activity on a Newsprint.

Step-by-Step

1. Introduce module and state objectives (5 min)
   Show and review slide: Module Overview
   - Legal status of abortion in Nepal
   - Overview of three key elements of CAC
   - Women’s reproductive rights
   - Provider values and attitudes
   - Introduction to uterine evacuation methods

   Show and review slides: Module Objectives
   By the end of this module, participants should be able to:
   1. Describe the global and national impact of unsafe abortion as a cause of maternal mortality.
   2. Explain why safe abortion care services are essential in Nepal.
   3. Explain Nepal abortion law, procedural process, and policy.
4. Describe the three key elements of CAC.
5. Describe a woman’s rights in an abortion-care setting.
6. Explore personal beliefs about CAC, as well as professional responsibilities.
7. Describe and compare the two recommended methods for evacuating the uterus in the first 12 weeks of pregnancy.

2. Activity: Personal reflection story (15 min)

Ask all participants to think of someone they know, a story they heard, or an experience they had involving a woman who had an unwanted pregnancy and chose to have an abortion. Give them a few minutes to think.

Ask for one or two volunteers to share their story. Remind them not to use any identifying information in order to protect the woman’s confidentiality. Encourage them to describe psychosocial as well as medical information.

Summarize. Points may include:

• Most of us have had some experience, direct or indirect, with a woman facing an unwanted pregnancy.
• Not all women needing abortion care have unwanted pregnancies (some are miscarriages or terminations for medical reasons).
• Many men and families are involved with these women.
• The WHO estimates that 45% of women will have an abortion during their reproductive years.

3. Activity: 4 Corners (20 min)

Introduce the activity: We all have values and beliefs about abortion, as well as other reproductive health issues. As CAC providers, you will come in contact with individuals who share your core beliefs and those with whom you may strongly disagree. This activity requires you to think about your beliefs and those of others.

Hand out Four Corners Worksheet A. Ask participants to fill out the sheet, being completely honest about their opinion. Tell them NOT to write their names on the sheets. They should not discuss the sheet with others. Turn the sheet over (facedown) when they have finished.

Hand out Four Corners Worksheet B. and fill out as above. Instruct them to respond as if they were a woman in that situation (Post four signs “Strongly agree,” “Agree,” “Disagree,” and “Strongly Disagree” in four corners of the room, if you have not already done so.)
After participants have finished, tell them that Part A asks about their beliefs for women in general and Part B asks about their personal values. Ask the following discussion questions:

• What similarities or differences do you see in the beliefs you hold for women in general versus yourself?
• If there are differences, why do you think that is?
Take a few comments. Point out that differences between responses on worksheets A and B can sometimes indicate a double standard. Some people believe that women in general should not be allowed to freely access abortion services, but they should be able to access abortion services if they or a family member need them.

**Collect Part A only.** Shuffle them and hand them back out. No individual should get his or her own sheet. Tell the group that they must now represent the view on the sheet they have, regardless of their own opinion.

**Read aloud the first statement from Part A.** Participants move to stand by the sign that corresponds to the response on their sheet.

The group gathered under each sign has one minute to discuss why someone would have that opinion.

**Ask a spokesperson for each group to report.** Start with "Strongly agree" and move in sequence to "strongly disagree." Repeat with other statements. Please note that this activity will be too long if you try to discuss all, or even most, of the statements. Three statements are normally enough to gain the desired effect from the activities. If participants want to see how the group responded to all of the statements, you can have them move to the four corners for each statement and see how the responses are distributed, but then only discuss a select number of them. Select the statements that will elicit the most important discussion.

**Review the activity.** Sample questions include:

- What did it feel like to represent a point of view that is different from your own?
- What was it like to hear your view expressed by others?
- Were you surprised by the differences and similarities of the group members?

**Summarize.** As people working in health care, your values and attitudes about other people's choices and behaviors affect your clients and your ability to give high-quality care.

4. **Global and national impact of unsafe abortion as a cause of maternal mortality (20 min)**

Explain the following key points:

- The need for safe abortion
- Unsafe abortion causes about 13% of maternal mortality worldwide

**Show and review slides:** *Global Impact (WHO Data, 1995-2008)*

- Abortion is one of the most common obstetric events.
- Every year an estimated 46 million pregnancies end in induced abortion.
- Worldwide, nearly 22 million unsafe abortions occur every year.
- 98% of unsafe abortions occur in developing countries.
- 47,000 women die each year as a result of unsafe abortion, which is 13% of all maternal deaths.
- 1 in 8 pregnancy related deaths are due to unsafe abortion.
Module 1

Show and review slide: *Unsafe Abortion by Region (WHO Data, 2012)*

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of Unsafe Abortions (rounded)</th>
<th>Unsafe Abortion Rate (per 1000 women)</th>
<th>No. of Maternal Deaths due to Unsafe Abortion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developed Regions</td>
<td>360,000</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>Developing Regions</td>
<td>21,200,000</td>
<td>16</td>
<td>220</td>
</tr>
<tr>
<td>Africa</td>
<td>61,900,000</td>
<td>28</td>
<td>460</td>
</tr>
<tr>
<td>Asia</td>
<td>10,780,000</td>
<td>11</td>
<td>160</td>
</tr>
<tr>
<td>Europe</td>
<td>360,000</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Latin America/Caribbean</td>
<td>4,230,000</td>
<td>31</td>
<td>30</td>
</tr>
</tbody>
</table>

Show and discuss slide: *Abortion in Nepal Before 2002*
- Abortion was strictly illegal and considered a crime.
- Abortion was not accepted socially, culturally, or religiously.
- Many women got unsafe abortions in unsafe environments.
- Abortion-related injury and death rates were high.

Explain that, prior to 2002, over 50% of hospital deaths were due to unsafe abortion, and 54% of OB/GYN admissions to the hospital were due to abortion complications.

Show and discuss slide: *Women Were in Prison*
Prior to 2002, women were imprisoned for 6 months up to five years for having an abortion.

Show and review slide: *Liberalization of Nepal's Abortion Law*
- 27 September, 2002: Received Royal Assent.
- Technical Committee for Implementation of Comprehensive Abortion formed.
- Senior OB/GYNs trained on provision of abortion services.
- March 2004: First safe and legal abortion services offered at Maternity Hospital, Thapathali.

Show and review slide: *Liberalization of Nepal's Abortion Law (contd)*
Resulting reduction in maternal deaths:
- 1996: 539/100,000 live births.
- 2006: 281/100,000 live births.
- 2010: 170/100,000 live births.

However, unsafe abortion remains the third leading cause of maternal death.

5. Activity: *Abortion Law of Nepal (45 min)*

Assign participants to read Abortion Law of Nepal in their Participant Handbook and ask them to consider the following study questions (you may want to write them on a flipchart or overhead). Allow 10 minutes for study. Present key points and lead a discussion to ensure understanding. Study questions:
1) What is unsafe abortion?
Answer: Abortion by an untrained provider in an unhygienic way.

2) What is the effect of unsafe abortion in Nepal?
Answer: Increased maternal mortality and morbidity.

3) What is safe abortion?
Answer: Abortion by a listed trained provider in a hygienic way in the listed site.

4) What is first trimester abortion?
Answer: Abortion up to 12 weeks LMP.

5) Under what circumstances is abortion legal in Nepal?
Answer: Up to 12 weeks on demand; Up to 18 weeks in case of rape or incest; Up to any gestation if certified as harmful to the woman or the fetus is deformed.

6) Does the woman have to accept having an abortion and does her husband need to consent?
Answer: No, neither.

7) How do you obtain consent if the woman is younger than 16 or incompetent?
Answer: In Nepal, a young woman who is less than 16 years old must be accompanied by someone who can give consent for the procedure. This person may be a parent or guardian.

Show and review slides: Legal Conditions for Abortion

Under the 11th Amendment of the Country Code, abortion is legal (with the consent of the pregnant woman):
- Within the first 12 weeks of pregnancy for any woman
- Within the first 18 weeks of pregnancy in cases of rape and incest
- At any time if the pregnancy poses a danger to the life or physical or mental health of the pregnant woman or if the fetus is seriously deformed and it is recommended by the doctor.

Under the 11th Amendment of the Country Code, abortion is not legal:
- Without the consent of the pregnant woman (coercion, pressure, threats, lies)
- If the pregnant woman wants an abortion because of the sex of the fetus (sex selective abortion)
- If the procedure is conducted beyond the approved legal conditions and/or timeframe

6. Women-Centered Comprehensive Abortion Care Services (15 min)

Show and review slide: What is CAC?

An approach to abortion care services that:
- Addresses each woman's health needs (physical and emotional)
- Is sensitive to a woman's personal circumstances and her ability to access services
- Is linked with other reproductive health services such as contraceptive counselling and method provision; and STI prevention, detection, and treatment
- Has a strong referral network
Show and review slide: *Key Elements of CAC*

- Choice
- Access
- Quality

Show slide: *Framework for Woman-Centered Care*

Show and discuss slide: *Choice*

- The right and opportunity to select between options
- The right to determine if and when to become pregnant
- The right to continue or terminate a pregnancy
- The right to select among available abortion procedures, contraceptives, providers, and facilities

Ask participants to list some ways that they, as providers, can support a woman’s choice. Make sure that the following are mentioned:

- Giving complete and accurate information
- Offering the opportunity to ask questions and express concerns
- Recognizing her right to a choice, regardless of age, marital status, or other characteristics

Show and review slide: *Access*

- Trained, technically competent providers who use up-to-date clinical technologies
- Easy-to-reach services, preferably in local communities
- Timely delivery of services
- Affordable and non-discriminatory care

Show and review slides: *Quality*

- Information and counseling to support fully-informed choices regarding uterine evacuation and postabortion contraception
- Respectful, private, confidential services
- Tailored to each woman’s individual needs
- Using international standards of care
- Offering other related sexual and reproductive health services, and referrals for emergency back up

Show and discuss slide: *CAC Services*

The services should be:

- Available, affordable, and timely
- Tailored to the medical and personal needs of the woman
- Safe and with confidentiality ensured
- Respectful of the right to information, privacy, and a range of choice
- Provided regardless of marital status, age, or other background factors

Show and discuss slide: *Who are CAC Providers*

- Health workers at listed health facilities (up to 8 weeks)
- Physicians at listed health facilities (up to 12 weeks)
- Ob/Gyn and MDGP specialists at listed health facilities (CEO site) where emergency
services like blood bank and emergency back-up are available (after 12 weeks of pregnancy).

Explain that, when performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure (WHO).

7. Activity: Reviewing the three elements of CAC (20 min)

Distribute cards of three different colors to each participant. Ask them to write on each card one element of CAC (choice, access, quality) according to what they think is included in each element. Collect the cards and post them on the wall grouped by color.

Examine the cards and ask the discussion questions below.

Elements:

Choice
Cards should include:
- The right and opportunity to select between options
- The right to determine if and when to become pregnant
- The right to continue or terminate a pregnancy
- The right to select among available abortion procedures, contraceptives, providers, and facilities

Discussion question - What situations can compromise a woman's autonomy and restrict her ability to make choices?

Answers may include:
- Pressure or coercion by family members
- Health providers charging high fees
- Services provided only if a woman agrees to sterilization or IUCD insertion
- Providers refusing to serve young or unmarried women

Access
Cards should include:
- Trained, technically competent providers.
- Up-to-date clinical technologies.
- Easy-to-reach services, preferably local
- Affordable and non-discriminatory care.

Discussion question - What kinds of things limit a woman's access to abortion services?

Answers may include:
- Excessive traveling time to access services
- Disrespectful or negative attitudes from providers, which can discourage and frighten women
- Providers' refusal to provide care, even to the extent allowed by local laws and policies
- Societal stigma associated with seeking abortion or postabortion care
- Women's financial dependence on other members of the family
- Societal expectations for women to produce children
- Gender roles and cultural expectations, such as the preference for male children
Quality
Cards should include:
• Information and counseling to support fully-informed choices regarding uterine evacuation and postabortion contraception
• Respectful, private, confidential services
• Tailored to each woman’s individual needs
• Using internationally standards of care
• Offering other related sexual and reproductive health services, and referrals for emergency back up

Discussion question – How do you see the three key elements of CAC – choice, access, and quality – interacting in your setting?

8. Activity: Protecting women’s rights in an abortion-care setting (Optional activity: 15 min)

Show slide: Reproductive Rights

These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children…free of discrimination, coercion and violence 1994 UN International Conference on Population and Development (ICPD)

Explain that this next activity is based on the International Planned Parenthood Federation’s (IPPF) Charter on Sexual and Reproductive Rights.
• IPPF's Charter on Sexual and Reproductive Rights is based on 12 internationally recognized human rights.
• The Charter applies internationally agreed-upon language from human-rights treaties, (which have the status of international law) to sexual and reproductive health and rights.

Post flipchart titled “Instructions for Rights Matching Activity” with the following instructions listed:
• Each of the sexual and reproductive rights, numbered 1 to 12, is listed on a strip of paper.
• The corresponding descriptions of those rights are listed on a second set of paper strips.
• Each person will choose a paper strip and then find the person who holds the matching right or its description.
• The pairs will discuss the right and its description and answer the following questions. After, they will report their responses to the larger group.
  ○ What is one way that health care workers can ensure this right is upheld in abortion or postabortion care service delivery?
  ○ How can health care workers ensure this right is upheld specifically for young and unmarried women?

Provide this example: One possible response for the right to decide whether or when to have children is: ensure contraceptive services are accessible to all women who want them. For young and unmarried women, ensure service delivery policies include provision regardless of age or marital status and remove all barriers to access so that young and unmarried women can easily access and use contraceptive services.
Pass around a basket with the paper strips and ask each participant to take one strip. When everyone has a strip, instruct them to begin by finding the match to their strip. After ten minutes, sound chime to bring pairs back to the larger group. Have each pair read their right, its description and their two responses.

Refer participants to the Reproductive Rights section of their manual for the full version of IPPF’s Charter on Sexual and Reproductive Rights.

Show slide: *Four Key Rights Related to CAC and Postabortion Care*
- The right to life
- The right to privacy
- The right to information and education
- The right to decide whether or when to have children

Tell participants that adolescents and young women have these same four key rights, as well as additional protections under the Convention on the Rights of the Child (applicable to adolescents 18 years and younger).

Continue with a brief, interactive discussion on upholding women’s rights in an abortion-related care setting.

Refer participants to the WHO Safe Abortion: Technical and Policy Guidance for Health Systems, Second Edition, in particular the sections on women’s health and human rights, to review how the service provision in their facilities compares to the WHO guidance. Ask for specific examples of how they can improve their service delivery practices to ensure that they are upholding women’s rights.

Show and review slide: *Support Rights in an Abortion-Related Care Setting*
- Have empathy and respect for all women, regardless of age or marital status.
- Maintain positive interactions.
- Respect privacy and confidentiality.
- Adhere to the voluntary, informed consent process.

Show and discuss slide: *Conscientious Refusal of Care*
- Health care providers cannot refuse life-saving postabortion care
- Women are legally entitled to abortion care to save her own life in most countries.

Explain that some health care professionals refuse to provide induced abortion based on personal objections. This is a barrier to access.

Only health care providers authorized to perform abortion have the right to decline to provide the procedure based on moral or religious reasons (as long as the woman’s life is not in danger). Those health care providers who refuse to perform abortion are ethically bound to ensure the woman can access safe services at a nearby facility within a reasonable time period.

Facilitate a short discussion with participants regarding their professional experiences with providers refusing services or treating woman who were refused services elsewhere. Ask participants what health-care managers can do to improve women’s access to care related to conscientious refusal of care. Refer participants to the section on Conscientious Refusal of Care in their participants’ manual for suggestions.
9. Values, Attitudes, Empathy, and Respect (15 min)

Ask participants to think back to the Four Corners activity. Gently encourage participants to consider whether they maintain a double standard for themselves versus women in general and ask them to reflect on this more deeply. Stress the impact these kinds of attitudes and beliefs can have on the accessibility and quality of abortion services, social stigma on abortion, and laws and policies on abortion.

Ask the participants what might be some biases that health care workers might have toward women seeking abortion related care. Ask them to consider the following:

- Women who have had multiple abortions
- Women who have had difficulty using contraception consistently or do not use contraception even though they do not want to become pregnant
- Women who have multiple sexual partners
- Women who are young
- Women who have been sexually assaulted
- Women who are of a different ethnicity, religion, or sexual orientation
- Women who have had an unsafe abortion

Show and discuss slide: *Health-Care Workers' Attitudes and Beliefs*

CAC providers should strive to:

- Identify their values and attitudes regarding sexuality and reproductive health
- Separate their values from those of their clients
- Recognize how their attitudes can affect client interactions and quality of care
- Ensure they are able to provide compassionate and empathetic care

Explain that providers should separate their personal attitudes and biases from their professional responsibilities. Negative biases affect women’s trust in providers and reduce the likelihood that they will seek care from them.

Show and discuss slide: *The Empathetic Provider*

- Listens actively
- Is genuine
- Seeks to understand the woman’s feelings from her viewpoint
- Shows caring
- Responds honestly
- Is friendly and helpful

Explain that empathy is an important part of high-quality, abortion-related care. Empathy is the ability to understand another person's feelings from their point of view and to communicate this understanding to the person. It does not mean feeling sorry for that person.

10. Activity: Introducing uterine evacuation (UE) methods (40 min)

Some of the participants may have some knowledge and experience with uterine evacuation, perhaps as providers of postabortion care. Find out about their experience and concerns using question and answer. Questions might include:
• What is uterine evacuation?
• What methods of uterine evacuation are you familiar with?
• Does anyone have experience with MVA? Electric vacuum aspiration (EVA)?
• Has anyone seen women who have used medications to try to start an abortion? Which medications?

Divide participants into four groups, as listed below in the chart (show on slide). Assign each group to read about the uterine evacuation method listed in Column A of the chart below in the Participant Manual (Module One, Section 5: Uterine Evacuation Methods). The small groups will report back on their topics, listed in Column B. Ask groups to write the key points of their report on a flipchart or overhead transparency. Allow 15 minutes to study and 15 minutes for all groups to present. Once each group presents, you or other participants can suggest additional information that was missed.

Show slide: UE Method Activity

<table>
<thead>
<tr>
<th>Group</th>
<th>UE Method</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA)</td>
<td>Description, Safety and Effectiveness</td>
</tr>
<tr>
<td>2</td>
<td>Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA)</td>
<td>Cost, Acceptability</td>
</tr>
<tr>
<td>3</td>
<td>Medical Abortion (MA)</td>
<td>Description, Safety and Effectiveness</td>
</tr>
<tr>
<td>4</td>
<td>Medical Abortion (MA)</td>
<td>Cost, Acceptability</td>
</tr>
</tbody>
</table>

Discuss and Summarize

Point out that the World Health Organization and other expert groups prefer vacuum aspiration (manual or electric) or medical abortion as the safest, most effective techniques for abortion in the first trimester.

Highlight the fact that MVA and MA can be performed by trained midlevel providers and can be used in decentralized, rural settings with intermittent electrical supplies.

Emphasize that the risk associated with abortion increases as length of pregnancy increases. Therefore, when women seek abortion, it is important that they get the abortion without delay.

Use the Parking Lot to list questions or issues about the methods that should be discussed at a later time.

11. Considerations for Post-abortion Care (5 min)

Tell participants that there are certain considerations regarding care for women who present to the clinic with a spontaneous, threatened, missed or incomplete abortion; complications from a safe or unsafe induced abortion; or complications from previous postabortion care.
Show and review slides: *Postabortion Care*

- If uterine size at the time of treatment is equivalent to a pregnancy of gestational age 13 weeks or less, either EVA/MVA or treatment with misoprostol is recommended for women with incomplete abortion.
- Uterine size may be smaller than the woman’s report of her LMP because some of the uterine contents have already been expelled. A woman’s eligibility for uterine evacuation method for postabortion care should be guided by uterine size rather than LMP.
- Expectant management is also a UE method for postabortion care.
- Wherever possible, women should be given a choice of uterine evacuation methods based on her eligibility.
- Both EVA/MVA and treatment with misoprostol are clinically- and cost-effective and highly acceptable to women and providers.

12. **Summary (5 min)**

- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 2: CLINICAL ASSESSMENT

Estimated Time: 3 hrs 40 mins

Purpose
This module describes how to take a relevant history of women seeking abortion services, perform a complete physical examination of women seeking abortion services and determine the duration of pregnancy and any special precautions needed for providing abortion care, including a special consideration for young women.

Preparation
- Have a marker available for each participant.
- Label four flipchart pages: “Client History,” “Psychosocial Assessment,” “Physical Examination,” and “Investigations”
- Select or adapt appropriate Role Play Scenarios and make copies of the scenarios for participant use.

Step-by-Step

1. Introduce module and state objectives (5 min)

Show and review slide: Module Overview

Purpose:
- Take a relevant history of women seeking CAC services.
- Perform a complete physical examination of women seeking CAC services.
- Determine the duration of pregnancy and any special precautions needed for providing CAC, including a special consideration for young women.

Show and review slide: Module Objectives

By the end of this module, participants should be able to:
1. Describe how to conduct a complete clinical assessment before uterine evacuation for CAC, including postabortion care.
2. Address preexisting conditions relevant to abortion care.
3. Explain the considerations and needs of special populations.
2. Introduction to the clinical assessment (5 min)

Show and discuss slide: Why Complete a Clinical Assessment?
- It allows the provider to quickly and properly evaluate the woman's health and identify and treat any life-threatening complications.
- It is important to evaluate the woman’s emotional state and circumstances.
- It allows a provider to determine appropriate options for care.

Explain to participants that open, supportive communication and a gentle, reassuring manner help ensure that the provider obtains the relevant information needed to offer the best possible care for the woman.

The clinical assessment must be private (conducted in a place where the woman and provider cannot be seen or heard by others).

Show and review slide: Four Components of Clinical Assessment
- Client history
- Physical examination, including pelvic exam
- Psychosocial assessment
- Laboratory investigations

3. Activity: Elements of clinical assessment (20 min)

The purpose of the activity is to draw on what participants already know.

Post four flipchart pages, each labeled with one of the four components of a clinical assessment. Supply markers to all participants.

Have participants get up, move around and list the information that we need and will use from each element of the assessment. Allow 10 minutes for participants to complete their work. After the flipcharts have been completed, refer participants to the Skills Checklist for Clinical Assessment (Appendix A).

Review the activity by discussing each flipchart. Comparing each flipchart to the skills checklist, identify information that is needed and also information that participants may have suggested but that is NOT necessary.

Emphasize that it is important to collect relevant information, but not ask intrusive questions that are not relevant.
4. Client history (20 min)

Show and review slides: Client History

Ask the woman about and record her clinical history, including:
- Age, occupation, and address
- First day of LMP
- Signs and symptoms of pregnancy
- Whether she has/had a pregnancy test or ultrasound and the results of the test
- Whether she has or had any bleeding or spotting during the pregnancy
- Sexual history
- Obstetric and gynecologic history

(Explain to participants) that “obstetric and gynecological history” includes number of previous pregnancies, live births, miscarriages or abortions, menstrual history, fibroids, or infections, previous ectopic pregnancy or tubal surgeries
- Any recent abortion related care
- Recent abortion medications taken including misoprostol or herbal medications

(Explain to participants) that no specialized treatment is indicated. If she has used a recommended medical abortion regimen, she may not need additional procedures, depending on the time passed since taking the medications. Some women may present with significant bleeding that needs further treatment. Women with an ongoing pregnancy should be counseled about the very rare risk of birth defects if they choose to continue the pregnancy. Cervical dilatation may not be needed during an MVA procedure.
- Physical or cognitive disabilities or mental illness
- Previous medical and surgical history
- Any bleeding tendencies or disorders
- History of/presence of sexually transmitted infections (STIs)
- Drugs allergies especially of xylocaine and prostaglandins
- Any symptoms of domestic violence or coercion
- HIV status

(Explain to participants) that HIV testing may be offered but is not mandatory to receive services
- History of contraceptive use
- Alcohol, tobacco, drug use or substance abuse
- Other relevant history

Give participants about five minutes to review the tables in the Reference Manual that list the abortion-relevant pre-existing conditions.
Show and discuss slide: *Pre-Existing Conditions that May Require Referral*
- Suspected ectopic pregnancy
- History of a blood clotting disorder
- Severe symptomatic heart disease
- Severe anemia
- Seizure disorder

Explain to participants that these pre-existing conditions may be more likely to result in a need for more intensive medical support. Emphasize that if the woman is unstable for any reason, she should be transferred for treatment immediately.

5. Gestational Age (10 min)

Show and discuss slide: *Gestational Age*
- For EVA/MVA, mistaken gestational age can increase risk of complications.
- For MA, mistaken gestational age unlikely to be clinically important.
- Gestational age can be accurately estimated by:
  1. LMP
  2. Bimanual pelvic examination
  3. Other signs of pregnancy

Stress the importance of identifying clinical signs of pregnancy (especially uterine size) and accurately determining the length of pregnancy. Underestimating the length of pregnancy is one of the most frequent errors that lead to complications. In some instances, providers have performed uterine evacuation procedures on women who are not pregnant.

Emphasize that LMP should not be used as the sole factor in determining gestational age; a provider should also complete a bimanual pelvic exam. Ultrasound is not required for first-trimester CAC, and can increase the cost of the procedure and likelihood of unnecessary intervention. However, ultrasound may be used for women in whom LMP is not clear based on history and exam, to help detect ectopic pregnancies, and to assess abortion completion.

Ask participants to brainstorm some questions that may help women remember their LMP, writing them on a flipchart. Answers may include:
- What were you doing the day that your period started?
- Where were you?
- Who were you with?
- What day of the week was it?
- Was it close to a holiday, special event, market day or weekend?
- What was the weather like?
Ask participants to share some factors that might make it difficult for women to accurately estimate LMP; these might include:

- Bleeding during early pregnancy might be mistaken for a period
- Breastfeeding women may become pregnant even if they do not have regular periods

6. Physical Examination (15 min)

Quickly review the flipchart completed earlier that lists the elements of the physical exam.

Emphasize that the provider should explain to the woman all the steps of the physical examination, why it is being done and what she can expect. This is especially important if this is the woman's first pelvic exam.

Show and review slide: *General Health Examination*

- Check vital signs
- Note weakness, lethargy, anemia, swelling, malnourishment
- Check abdomen for masses, tenderness
- Check for signs of sexually transmitted infections (STIs)
- Check heart and lung sounds

Show and discuss slide: *Pelvic Examination*

- Ask the woman to empty her bladder.
- Help her move into lithotomy position.
- Use drapes or linens to make sure her privacy is protected.
- Attend to any special physical needs.
- Ensure that she feels as comfortable as possible.

Ask participants why a woman must empty her bladder before the start of the exam. Explain that a full bladder can make it difficult to assess the uterus and can mask findings.

Show and discuss slide: *Speculum Examination*

- Inspect the external genitalia, for any ulcers, signs of STIs, or other abnormalities.
- Gently insert an appropriate-sized speculum and inspect vaginal canal and cervix.
- Check for bleeding, discharge, pus, lesions, or foreign bodies

If infection is suspected, take samples for culture. Women with signs and symptoms of a reproductive tract infection should be treated immediately and the procedure can be performed without delay. Administer antibiotics and then do the procedure after 30 minutes or so, when the antibiotics have taken affect.

If a woman is screened for STIs, the uterine evacuation can be provided before results are returned. If positive, she may be treated after the procedure. It is important that the woman not have to return to the clinic at a later time before she can have an MVA.
Refer to the Reference Manual for the recommended Nepal regimens of prophylactic antibiotics and therapeutic antibiotics.

Show and discuss slide: Bimanual Examination

- Assess size, consistency, and position of the uterus and adnexa
- Compare the size of the uterus with history of amenorrhea.
- Assess for tenderness, mobility, and masses.
- It may be her first bimanual exam, especially if she is young. If so, treat her with extra care and gentleness.

Emphasize the importance of knowing the position of the uterus before a EVA/MVA procedure; a uterus tilted forward, backward, or to one side may increase the risk of perforation.

7. Activity: Uterine Size (20 min)

Divide participants into pairs.

Ask participants to discuss the following questions with their partner. Give participants 10 minutes to discuss the questions. Post flipcharts of each question at the front of the room.

Review each question with the full group, writing responses on the flipchart. Key answers are listed below each question. Take 10 minutes to solicit and discuss participant responses.

During a bimanual exam, if you find that the uterus is smaller than expected, what might this indicate?

Key answers include:

- The woman is not pregnant
- Estimation of length of pregnancy was inaccurate
- Ectopic pregnancy
- Early pregnancy failure, including spontaneous or incomplete abortion, missed abortion
- Abnormal intrauterine pregnancy such as a molar pregnancy
- Normal variation between women
- Acutely retroverted uterus

During a bimanual exam, if you find that the uterus is larger than expected, what might this indicate?

Key answers include:

- Inaccurate estimation of length of pregnancy
- Multiple pregnancies
- Uterine abnormalities such as fibroids or bicornuate uterus
- Gestational trophoblastic neoplasm/molar pregnancy (although the uterus can sometimes also be smaller which can be confusing)
- Normal variation between women
- Full bladder

What would you do if you were uncertain about uterine size?
- If uncertain about pregnancy and uterine size, ultrasound and laboratory tests such as a HCG may be useful for confirmation.
- Another provider may also perform a bimanual exam to confirm an uncertain estimate.
- Situations that might make it difficult to assess the size of the uterus include: fibroids, retroversion of the uterus, obesity, full bladder, and the woman not relaxing her abdomen.

8. Psychosocial Assessment (10 min)

Quickly review the flipchart completed earlier that lists the elements of psychosocial assessment.

Show and discuss slide: Psychosocial Assessment
- Purpose is to assess the woman’s current emotional state, relevant relationship circumstances, and support systems.
- Note any cognitive disabilities, mental illness or indication that the woman has been subjected to violence.

Some women will talk about their pregnancy situation and decision to terminate it. However, others will not want to talk about it. Maintain open communication. Use a gentle, nonjudgmental tone; display a sense of concern, support and confidentiality.

Violence is very common, but it may be difficult to ask about it. Some providers ask about it routinely (e.g. “Violence against women is common, unfortunately, so we are asking all our clients about abuse. Has anyone ever hurt you or forced you to have sex?”)

Women who have been subjected to violence may have specific, different emotional and physical needs. For example, a pelvic exam may be very difficult for someone who has been raped.

Ask participants to suggest questions that may be appropriate to ask during a psychosocial assessment, to obtain all relevant information needed to determine the best possible care for the woman.

Questions may include:
- Is there anything she feels you need to know?
- Does she have a stable family and support system?
- Has she been subjected to violence?
- Does she have a history of drug use?
9. Laboratory Investigations (10 min)

Quickly review the flipchart completed earlier that lists the elements of psychosocial assessment.

Show and discuss slide: Laboratory Investigations

No laboratory tests are needed for CAC procedure.

Some lab tests can beneficial in special situations.
- Urine pregnancy test
- Haemoglobin/hemocrit
- Rhesus (RH) immunization
- STI/RTI screening
- Ultrasonography (USG)

Ask participants to discuss in what circumstances these laboratory tests might be beneficial. Refer participants to the Reference Manual for more information.

10. Considerations for Postabortion Care (10 min)

Tell participants that clinical assessment is one area of comprehensive abortion care that is somewhat different for PAC compared to induced abortion services.

Show and discuss slide: Determine Whether Postabortion Care Is Needed

If a woman presents with:
- Vaginal bleeding and/or
- Lower abdominal pain or cramping
- And is pregnant

ASK: What types of abortion may have occurred?

ANSWER: threatened, spontaneous, missed, or incomplete abortion, safe or unsafe abortion, self-induced abortion, complications from previous abortion care.

Show and discuss slide: Determine Whether Emergency Treatment Is Needed

1. Perform rapid assessment for shock
2. Assess for other severe complications
3. Provide immediate treatment if woman is unstable

Tell participants that the woman may be unstable due to hemorrhage or sepsis, and treatment should be started immediately. Treatment may include immediate uterine evacuation. In these cases, clinical assessment occurs at the same as treatment. Treating abortion-related complications will be covered further during the Complications module.
Show and review slide: *Rapid Initial Assessment for Shock*

Signs of shock:
- Low blood pressure (SBP <90mm Hg)
- Fast pulse
- Pallor or cold extremities
- Decreased capillary refill
- Dizziness or inability to stand
- Low urine output (<30 ml per hour)
- Difficulty breathing
- Impaired consciousness, lethargy, agitation, confusion

Show and review slide: *Most Women Presenting for Postabortion Care...*
- Are clinically stable
- Have light to moderate bleeding
- Can proceed with:
  - Client history
  - Physical exam
  - Lab tests if needed

Show and discuss slide: *Once the Woman Is Stable Determine...*
- Type of abortion
- Whether there are non-life-threatening complications that need attention
- Eligibility for methods of UE

Explain to participants that if UE has already been performed to treat a woman in an unstable condition, her eligibility will have already been determined.

A noncritical condition may worsen and become life-threatening if treatment is delayed.

Show and review slide: *Management of the Abortion*

Depends on:
- Type of abortion
- Size of uterus
- Medical eligibility
- Availability of equipment and supplies
- Women's preference

Refer participants to Appendix B: Clinical Assessment for Postabortion Care Skills Checklist in their Participants' Manuals for further information.
10. Considerations for Postabortion Care (10 min)

Tell participants that clinical assessment is one area of comprehensive abortion care that is somewhat different for postabortion care compared to induced abortion services.

Show and discuss slide: *Determine Whether Postabortion Care Is Needed*

If a woman presents with:
- Vaginal bleeding and/or
- Lower abdominal pain or cramping
- And is pregnant

**ASK:** What types of abortion may have occurred?

**ANSWER:** threatened, spontaneous, missed, or incomplete abortion, safe or unsafe abortion, self-induced abortion, complications from previous abortion care.

Show and discuss slide: *Determine Whether Emergency Treatment Is Needed*

1. Perform rapid assessment for shock
2. Assess for other severe complications
3. Provide immediate treatment if woman is unstable

Tell participants that the woman may be unstable due to hemorrhage or sepsis, and treatment should be started immediately. Treatment may include resuscitation and immediate uterine evacuation. In these cases, clinical assessment occurs at the same time as treatment. Treating abortion-related complications will be covered further during the Complications Module.

Show and review slide: *Rapid Initial Assessment for Shock*

Signs of shock:
- Low blood pressure (SBP <90 mm HG)
- Fast pulse
- Pallor or cold extremities
- Decreased capillary refill
- Dizziness or inability to stand
- Low urine output (<30 ml per hour)
- Difficulty in breathing
- Impaired consciousness, lethargy, agitation, confusion

Show and review slide: *Most Women Presenting for Postabortion Care...*

- Are clinically stable
- Have light to moderate bleeding
- Can proceed with:
• Client history
• Physical exam
• Lab tests if needed

Show and discuss slide: *Once the Woman Is Stable Determine*...

• Type of abortion
• Whether there are non-life-threatening complications that need attention
• Eligibility for methods of UE

Explain to participants that if UE has already been performed to treat a woman in an unstable condition, her eligibility will have already been determined.

A non-critical condition may worsen and become life-threatening if treatment is delayed.

Show and review slide: *Management of the Abortion*

Depends on:
• Type of abortion
• Size of uterus
• Medical eligibility
• Availability of equipment and supplies
• Women’s preference

Refer participants to Appendix B: Clinical Assessment for Postabortion Care Skills Checklist in their Participants’ Handbooks for further information.

11. Activity: Clinical assessment role plays (45 min)

Divide the participants into groups of 3-4 persons. Refer them to the Clinical Assessment Role Play (Appendix L) and the Clinical Assessment Skills Checklist (Appendix A) in their Participants’ Handbooks. Assign one Role Play to each group.

Tell participants that one participant plays the woman, another plays the provider, and the third (and fourth, if in a group of four) acts as observer(s). The participant playing the woman silently reads her history, and then the provider acts out a clinical assessment while the observer evaluates the provider’s skills performance. For the provider and woman, unless a symptom or condition is mentioned in the case study history, consider her health and situation to be normal. Where an exam would be indicated, the provider should pretend they are doing it by asking the woman about the issue. The observer(s) should use the Clinical Assessment Skills Checklist to assess the provider’s skills, paying attention to how the provider conducts the assessment. Was the assessment done completely and in the correct order? Did the provider give support? At the end of the role play, the woman and the observer(s) should give feedback to the provider and make suggestions for improvement.
Participants will first act out the case studies assigned to them, and then respond to the corresponding question(s).

Each group should present their assessment findings along with a probable diagnosis and management considerations.

Use the information below to lead the discussion.

Case Study 1 (Ajita):

You are Ajita, a 32-year-old woman who returns to the clinic after being seen yesterday in anticipation of a vacuum-aspiration procedure. You come to the clinic with your best friend. Your LMP was about 10 weeks ago. Yesterday, after leaving the clinic to “think about whether you wanted a vacuum-aspiration procedure,” you took some drug which your friend gave you “to terminate the pregnancy at home.” Since taking the drug, you have been experiencing nausea and vomiting almost constantly. You are very upset and “want an abortion completed now.”

What is her probable diagnosis? Ongoing pregnancy following self-administration of unauthorized misoprostol.

What are the management considerations for Ajita?

- Counsel her regarding her options, and if she chooses to proceed with an aspiration procedure, then perform uterine evacuation as soon as possible.
- Provide her with an anti-emetic and if she is dehydrated from her nausea and vomiting, consider fluid resuscitation.
- Discuss pain management for her aspiration procedure
- Provide prophylactic antibiotics before, during or after vacuum aspiration.
- Consider that cervical dilatation may or may not be necessary depending on what medication she was exposed to.
- Counsel her about unsupervised use of misoprostol.
- Provide contraceptive counseling and referrals.

Case Study 2 (Sachi):

You are Sachi, an extremely nervous 12-years girl. You come to the clinic with your mother. You have been referred to the clinic from a local emergency room, where you were treated for rape several weeks ago. You have a rather large, but healing, bruise on your left arm from the rape incident. Upon examination, your provider detects a foul-smelling purulent discharge coming from your cervix. It hurts when the provider presses on your cervix and uterus during the pelvic examination. Her uterus is six weeks size and soft.

What is her probable diagnosis? Infection: Acute purulent cervicitis post-rape with pregnancy

What are the management considerations for Sachi?

- Provide age-sensitive, supportive care.
• Counsel her, then administer therapeutic antibiotic regimen and perform uterine evacuation as soon as coverage has been established. Vacuum aspiration should be performed in conjunction with pain management.
• Continue appropriate antibiotic therapy after uterine evacuation.
• Refer her to other services for women who experience violence.
• Provide contraceptive counseling.

Case Study 3 Jaya:

You are Jaya, a 28-years single woman. You have been treated by this provider for several RTIs over the past few years. You are more than two weeks late for your period and, believing you are pregnant, have come to the clinic for an abortion. Upon conducting a bimanual examination, the provider finds that your uterus is smaller than expected and detects a possible mass on your left adnexa. While putting on your clothes after the exam, you experience an episode of sudden and intense lower abdominal pain.

**What is her probable diagnosis?** Possible ectopic pregnancy

**What are the management considerations for Jaya?**
• Urgent diagnosis and treatment of her suspected ectopic pregnancy is paramount.
• Refer her immediately for treatment (aid in transportation), if treatment cannot be provided at this site.

Case Study 4 (Neena):

Neena is 24 years old with twins aged 3 years old as well as a 5 year-old. She wants to get the abortion pill and she plans to tell her family that she is having a miscarriage. She does not want to tell her husband or anyone else that she is having an abortion. She had her period about 9 weeks ago.

You review her menstrual history. Since she stopped breast-feeding the twins two years ago, she has had regular periods. She remembers that her last period came when there was a shortage of water in her community because the well went dry. You know that the problem with the community’s well happened 9 weeks ago. The woman has noticed that her breasts became larger and tender about 5 weeks ago, and she has had some nausea on and off since then. She has never used contraception.

You perform a bimanual exam and the uterus is retroverted and feels about 9-week size.

**Do you feel confident she is within the eligible range for MA?** Depending on the gestational eligibility criteria in this particular setting, the woman is a candidate for MA if it is provided through 9 weeks. Even if the clinician’s assessment by bimanual exam and LMP is a slight underestimation, using the most effective regimen for MA (mife-miso) has a high chance of success.
Case Study 5 (Deepa):

Deepa is 32 years old and has children who are 11, 15, and 16 years old. She has regular monthly periods. She is certain that her period was 8 weeks ago. She does not want any more children and requests a MA. You perform a bi-manual exam and feel that the uterus is about 10 weeks in size.

**What do you do next?** There are several possible reasons why a discrepancy might exist between the results of her bimanual examination and her estimated LMP:

- She may have uterine fibroids that cause the uterus to feel larger by palpation.
- She may be pregnant with twins or multiple gestations, in which case she would still be eligible for MA if she is 8 weeks LMP. Or she may be 10 weeks pregnant.
- An ultrasound would be needed to determine which situation is true. If ultrasound is reasonably available, she could be informed of her choices:
  - That an ultrasound may be able to determine that she meets the criteria for MA, or
  - She could receive a vacuum aspiration without the need for further assessment or ultrasound. Another alternative is to inform her of the option of MA past 9 weeks, with a slightly reduced efficacy, and ask her if that would be her preference. MA beyond 9 weeks has been studied in settings in which women can remain in the health setting for 4 hours after receiving misoprostol where they can be monitored until the abortion is completed.

Case Study 6 (Maya):

Maya, a 26 year woman comes to the clinic 2 weeks after her missed period, or 6 weeks since her LMP. She was not using a method of birth control, and usually has regular periods every 28-30 days. She says she’s been having mild nausea and breast tenderness. You perform a bimanual exam and find her uterus to be anteverted, and consistent with 6 weeks LMP. You find no adnexal masses or tenderness. She has heard about MA and asks if she can start the process today or does she need an ultrasound.

**How do you respond?** This is a straightforward case of early pregnancy diagnosed by a reliable LMP and a consistent pelvic exam done by an experienced clinician. There is no need for an ultrasound and the woman is within the gestational range eligible for medical abortion. However to be completely reassured, make sure that you include all of the history questions to make sure she is at low risk for an ectopic pregnancy (prior history of RTIs, prior history of ectopic, IUD in place or prior history of a tubal ligation).

Women’s report of their LMP in combination with review of pregnancy symptoms and bimanual exam can safely be substituted for routine ultrasound in the absence of significant discrepancies or inconsistencies for gestational dating in most cases of MA (Clark 2007b).

12. Summary (5 min)

- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 3: COUNSELING, INFORMATION, AND INFORMED CONSENT

Estimated Time: 5 hrs

Purpose
This module covers essential information women need; voluntary, informed consent and counseling for abortion-related care; postabortion contraception counseling and method provision; and how providers can interact and communicate with women in a respectful, effective manner.

Preparation
- Label two newsprint papers “Counseling is” and “Counseling is not”
- Bring samples of contraceptive methods, including EC, and educational materials
- Bring sample of Nepal’s informed consent form

Step-by-Step

Show and discuss slide: Module Overview
- Elements of effective counseling for abortion-related care
- Informed consent
- Postabortion contraceptive counseling and method provision
- Counseling for special populations, including young women

1. Introduce module and state objectives (5 min)

Explain that this module will first address overall comprehensive counseling skills for an abortion care setting. Postabortion contraceptive counseling is an important component of counseling in CAC and will be specifically addressed in the second half of this module.

Show and review slide: Module Objectives

By the end of the module, participants should be able to:
- Demonstrate essential knowledge, skills, and attitudes regarding counseling for abortion services.
- Offer information and choice regarding MVA and MA, and obtain informed consent.
• Provide high quality postabortion contraceptive counseling including early return of fertility and method provision.
• Identify women’s eligibility for contraceptive methods following abortion care.
• Explain emergency contraception (EC) use and administration protocol.
• Describe how to address the needs of special populations, including young women.

2. Key concepts for comprehensive counseling in abortion care (30 min)

Ask participants why providing high-quality counseling prior to, during, and after providing abortion-related care is important. Responses may include:
• To help women explore their feelings, decisions, and coping.
• To affirm women’s ability to make informed decisions.
• To help women feel more comfortable and confident about their health-care staff and the care they will receive.
• To identify any special needs.
• To make sure women clearly understand what to expect during and after a uterine evacuation procedure.
• To ensure that women can recognize the warning signs of a complication and know where to go to get help.

Show and discuss slide: Supporting the Woman’s Decision
• Before coming for care, many women have already made the decision to have an abortion
• Her decision should be respected.
• Pregnancy counseling should not be required or serve as a barrier.

Tell participants that if a woman does have questions about her pregnancy options, providers can discuss them with her. These include continuing the pregnancy to term and parenting the child or releasing the child for adoption, or ending the pregnancy.

Emphasize that counseling should be voluntary and confidential. Providers should make sure that a woman can make a decision free from coercion.

Post two newsprint papers, one saying “Counseling is” and one saying “Counseling is not”

Explain to participants that you will read the following phrases one at a time and ask them to state whether they think it belongs in the “Counseling is” or “Counseling is not” category. Record their answers on the newsprint.
• Asking about the woman’s thoughts and feelings
• Strictly providing information
• Accepting the woman’s thoughts and feelings
• Respecting privacy and confidentiality
• Voluntary
• Focusing on the woman’s needs and concerns
• Influencing the woman's attitudes, beliefs, and behaviors
• Communicating effectively
• Supporting the woman's decisions

When you have finished the list and participants have given their opinions as to which category each phrase belongs in, show the following slides.

Show and discuss slide: *Counseling Is*
• Asking about the woman's thoughts and feelings
• Accepting the woman's thoughts and feelings
• Respecting privacy and confidentiality
• Voluntary
• Focusing on the woman's needs and concerns
• Communicating effectively
• Supporting the woman's decisions

Tell participants that counseling involves two-way communication; each person spends time talking, listening, and asking and answering questions. Counselors should never insist that a woman talk or reveal information that she is not comfortable sharing.

Show and review slide: *Counseling Is Not*
• Strictly providing information
• Influencing the woman's attitudes, beliefs, and behaviors

Show and discuss slide: *What is Women-Centered Counseling?*
• A structured interaction in which a woman voluntarily receives emotional support and guidance from a trained person in an environment that allows her to openly share thoughts, feelings, and concerns.
• Needs are determined by asking open-ended questions
• Woman's needs guide the counseling

Tell participants that counseling can be provided by any staff member with appropriate training and experience. Counseling should be offered to all women seeking abortion-related care.

Show and discuss slide: *Barriers to Counseling*
• Lack of time
• Differences in language, culture, social values
• Special considerations for adolescent and young women

Tell participants that it is the counselor's responsibility to address these barriers and reach a place of empathy and understanding so that each woman's needs are met.
Emphasize that young people are capable and have the right to make health-care decisions and provide consent for themselves.

**Show and discuss slide: Privacy and Confidentiality**
- Should take place in a setting where no one else can see or overhear
- Communication should not be shared.
- Meet alone with the woman first before inviting others.
- At the start, inform the woman that any medical and personal information is confidential.
- Information cannot be released without the woman’s voluntary authorization.

Ask why confidentiality is especially important for adolescents and young women. Take a few responses, then explain that when confidentiality and privacy are not maintained, it may deter many women, particularly adolescents and unmarried young women, from seeking safe, legal abortion services, and may drive them to use secret and unsafe abortion services.

Emphasize that confidentiality is a key principle of medical ethics and an aspect of the right to privacy which must be guaranteed at all times.

**3. Abortion-Related Counseling (15 minutes)**

Ask participants when abortion care counseling should take place. Take a few responses, then explain that counseling should take place before, during, and after the procedure. Furthermore, there should be a formal counseling session at some point in a woman’s visit.

**Show and review slide: Counseling Key Components**
- Explain pregnancy options (if desired by the woman)
- Explain procedure options
- Answer the woman’s questions
- Obtain informed consent

**Show and discuss slide: Voluntary Informed Consent**

Involves an important discussion between the counselor and the woman in which she understands:
- Her clinical condition.
- Full information on options.
- The risks and benefits of the various procedure options.
- Her right to decide freely what course of action to take.

Explain that voluntary, informed consent should be confirmed by the provider before beginning care or giving any medications. Stress that each woman should be given as much time as she needs to make her decisions.

Take some time to explain about Nepal’s informed consent forms that are required. Show example.
Tell participants that now they will learn about what content is covered in the various opportunities for counseling throughout abortion care.

**Show and review slides: Pre-Procedure Counseling**
- Inform the woman of clinical examination findings
- Provide options counseling based on gestational age or preference
- Inform what will be done before, during, and after the procedure
- Review eligibility, effectiveness, regimen, and protocol
- Explain what she is likely to experience
- Inform how long the procedure process may take
- Explain pain management options
- Inform about side effects, risks and complications associated with method
- Discuss postabortion contraception options

**Show and review slide: Counseling during the Procedure**
- Communicate with the woman constantly during the procedure
- Explain what to expect, periodically reassuring and encouraging her

**Show and review slides: Post-Procedure Counseling**
- Inform how long she will rest at the facility
- Describe the amount of bleeding and cramping she can expect
- Explain how to identify complications and what to do
- Discuss whether a follow up visit is needed or not
- Explain when she can resume normal activities including sexual intercourse
- Provide a contraceptive method if desired and available
- Provide referrals for other services if needed

### 4. Effective Communication (10 min)

Ask participants to think of a time when they were having a serious, private conversation, and they did not feel that the other person was listening carefully to them. Ask: what about the person's verbal and nonverbal communication made you feel that they were not listening well? Take a few examples from the participants.

Now ask the participants to think of a time when they were having a serious private conversation, and they felt that the other person was actively listening to them. Ask: what about the person's verbal and nonverbal communication made you feel that they were actively listening? Take a few examples from the participants.

**Show and review slides: Effective Communication**
- Stay attentive and focused on the woman and her needs
- Use nonverbal cues to convey interest and concern
- Observe her nonverbal cues
- Ask open-ended questions
• Let her talk before providing information
• Help her explore her feelings
• Follow up with appropriate feedback
• Use encouraging words
• Use words that are easily understandable, including for young women

Remind participants that effective counselors show, through verbal and nonverbal communication, that they are open, empathetic, and nonjudgmental.

Show and discuss slides: *Ineffective Communication*
• Make judgments about the woman
• Make assumptions about the woman and her needs
• Focus on your concerns, not those of the woman
• Show lack of interest or distraction through nonverbal cues
• Do not listen carefully or pay attention to her nonverbal cues
• Ask only close-ended questions
• Interrupt or speak over the woman
• Allow interruptions (telephone calls, other people interrupting)
• Use technical language that is difficult to understand
• Do not check back to make sure that she understands

Ask participants to demonstrate non-verbal cues that would indicate interest, concern, judgment, lack of interest, and distraction.

Ask participants for examples of open and close-ended questions.

5. Postabortion Contraceptive Counseling (5 min)

Explain that now the training will focus on an important part of abortion-related counseling: postabortion contraceptive counseling and services. Access to contraceptive services is a basic human right and is fundamental to reproductive and sexual health.

Show and discuss slide: *Postabortion Contraception as a Reproductive Right*

• The World Health Organization (WHO) recommends all women should receive contraceptive information and be offered counseling for and methods of postabortion contraception, including emergency contraception, before leaving the health-care facility.

Emphasize to participants that while all women receiving abortion-related care, regardless of age, marital status, or number of children, should be offered contraceptive counseling and services, providers should not make assumptions about women's reasons for having an abortion or needing postabortion care, whether the pregnancy was wanted, and their desires for future pregnancies. Women seek abortion-related care for many different reasons, and some may wish to get pregnant again right away.
Ask participants what is the goal of contraceptive counseling. Take a few responses.

Show and discuss slide: **Goal of Contraceptive Counseling**

- To help a woman decide if she wants to prevent pregnancy in the short- or long-term and to assist her in choosing an appropriate and acceptable contraceptive method.

Tell participants that, ideally, contraceptive counseling should happen before, during and after her uterine evacuation (UE) procedure. It is helpful to discuss contraceptive and UE options at the same time, as the UE method has implications for whether and how certain contraceptive methods can be provided.

**ASK:** why allow a woman to begin her chosen method immediately following an abortion?

**ANSWER:** To increase the likelihood that she will continue it’s correct and consistent use and avoid unintended pregnancies in the future.

**6. Activity: Read story, discuss, and summarize (15 min)**

Gita is a student who works hard to pay her tuition. Gita tried to get birth control pills at the local clinic but was told she was too young and needed to be married to get the pills. She and her boyfriend, who is also a student, have sexual intercourse, but he doesn’t always have money to buy condoms. When they don’t use condoms, they use the withdrawal method. When Gita was about to enter her second year of schooling, she became pregnant. She felt that she couldn’t have the baby so she had an abortion. The provider did not provide any counseling as part of her visit. When she asked the provider about contraception, he told her to go to a clinic. Remembering her earlier experience, she did not go. Six months later, she became pregnant again. She sought another abortion.

**Discussion question:** Have you encountered situations like this?

**Discussion question:** What points does this story make about contraceptive services?

The story shows the cycle of unwanted pregnancy and repeat abortion. It also shows that judgmental provider attitudes towards women’s, especially young women’s, sexuality can have a big impact upon contraceptive access and use and possible subsequent unwanted pregnancy.

**Show and discuss slide: Quick Return to Fertility**

Every woman should be informed that on average:

- She will ovulate within 20 days of MA
- She can ovulate as early as 8 days after MA, or 10 days after EVA/MVA

Emphasize that the woman should be offered contraceptive counseling and a method of her choice on site if possible. If referral services are needed, a woman should be provided with an interim method of contraception such as condoms or birth control pills until she can access her chosen method.
7. Activity: Contraceptive failure (15 min)

Break into three groups and assign the topics below. Each group has five minutes to discuss the topic.

1) Reasons why contraceptives fail (failure of method OR failure to use method)
2) Ways the health system fails women regarding contraceptive provision
3) Policies and protocols that can limit the use of contraception

Have each group write their findings on a flipchart, and present a summary.

Group One's (reasons why contraceptives fail: failure of method OR failure to use method) list may contain:
- No method is 100% effective.
- The woman may not remember to consistently take or use the method.
- Not being able to afford contraceptives on a regular basis
- The woman may be persuaded by popular myths to discontinue use (e.g., condom use)
- The woman may experience unacceptable side effects and discontinue use
- The woman's husband or family members may not approve of contraceptive use.
- The woman may face disapproval of her husband/partner, mother-in-law, other family members, religious leaders, or other influential people if she attempts to prevent a pregnancy
- The sexual contact was non-consensual
- The woman has concerns about being stigmatized due to cultural attitudes that equate contraceptive use with promiscuity.

Group Two's (ways health system fails women regarding contraceptive provision) list may contain:
- Counselors do not adequately explain how to use the method.
- Contraceptive methods are too expensive.
- Family planning clinics do not reliably stock the woman's preferred methods.
- Contraceptive service locations and times are not convenient.
- Clinics cannot provide a reliable supply of chosen methods.
- Services are not located in the community.
- Contraceptive service protocols limit re-supply. For example, dispensing only one-month supply at a time.

Group Three's (policies and protocols that can limit the use of contraception) list may contain:
- Requirement that women be married or of a certain age to use contraception.
- A protocol that mandates dispensing only one month's supply of pills at a time.
- National reproductive health policies limit access to contraception for certain women, such as young women or unmarried women.
Key discussion points for the activity:

- Successful use of contraception may be beyond a woman's control. It is important not to blame her for failing to prevent unwanted pregnancy.
- Blaming women continues a cycle whereby a woman who is made to feel guilty when she seeks abortion care becomes reluctant to seek additional services, including contraception.
- Counselors must empathize with each woman's situation and consider the factors that contributed to the unwanted pregnancy. Counselors can help women find ways to address barriers to successful contraception.
- Women who receive a preferred method, who know they have a choice, and who are able to follow up and use the method correctly and consistently have the best success with contraception.

8. Activity: Provider attitudes for contraceptive counseling skits (30 min)

Introduce the activity by stating that provider attitudes affect what they say, how they say it, and that this affects successful contraceptive use. Ask for two volunteers. Refer them to the Contraceptive Counseling Provider Attitude Skit Scripts in the Participants' Handbook (Appendix M). Allow several minutes for them to prepare.

Ask the volunteers to act out each negative version of the skits. Discuss the activity by asking the group to list attitudes that were negative and how these attitudes were communicated. Write the answers on newsprint paper.

Next, ask the volunteers to act out each positive version of the skits. Record their answers again. Ask the group to discuss the differences between the two skits.

Key points for negative skits discussion:

- **Skit 1**: The counselor did not find out what the woman’s contraceptive preferences are, and she made the decision for her. The counselor also did not respect the woman's privacy and confidentiality. The words and tone the counselor used were judgemental.

- **Skit 2**: The counselor did not find out what the woman’s contraceptive preferences are, and she made the decision for her. This is especially damaging because sterilization is a permanent method. This is an extremely bad example of contraceptive counseling.

- **Skit 3**: The counselor did not give information about each method. She did not find out what the woman’s particular needs are or probe to determine if the method she chose would work for her.

Key points for positive skits discussion:

- **Skit 1**: The counselor ensures that privacy is maintained. The counselor displays an attitude of openness, respect, and concern for the woman. She does not make any assumptions about the woman's reason for seeking an abortion, and asks questions to determine the woman's postabortion contraception needs.

- **Skit 2**: The counselor described a range of methods, which is positive. However, the counselor did not ask why the woman was having trouble deciding between the two methods, which might have helped the woman determine which method would work better.
• **Shit 3:** The counselor is interested and actively helping the woman make her decision by asking her to explain the reasons for her indecision. The counselor gave information about resupply and the benefits and drawbacks of each method for pregnancy versus STI prevention.

9. **Involvement of Partners (10 min)**

Ask participants why involving a woman’s partner in a contraceptive counseling session might be beneficial. Responses may include:

- It sometimes increases the effectiveness of the counseling and the partner’s support of the woman’s contraceptive use
- Male partner’s support of contraception is a strong predictor of contraceptive use
- Being present during counseling may increase her partner’s awareness and use of male contraceptive methods (condom, vasectomy)

Ask participants why involving a woman’s partner in a contraceptive counseling session might be problematic. Responses may include:

- Her partner may influence a woman’s ability to make a choice that is best for her
- Her partner’s discovery of her contraceptive use may lead to negative consequences, including violence

Ask participants what they should do if the woman’s partner does not approve of contraception but the woman still wants to use it. Ensure the following key points are made:

- The provider could help the woman select a method that does not require her partner’s cooperation (injectable, implant, IUCD)
- The provider should discuss any possible consequences, such as violence.
- The provider should provide any appropriate referrals for additional services, if needed.

Emphasize that if the woman’s partner wants to be included in the contraceptive counseling process, the provider should first meet alone with the woman to determine if she wants her partner to be involved.

If the woman does not want her partner involved, she should be counseled and given the method privately and no information from the visit should be shared with her partner.

10. **Counseling Checklist (40 min)**

Show and discuss slide: *Essential Steps for Effective Contraceptive Counseling (GATHER)*

- Greet and establish rapport
- Ask the woman
- Tell the woman about the characteristics of available methods
- Help the woman choose her method
- Explain how each method works
- Return for follow-up care and refer to other resources
Refer participants to the Counseling Checklist in the Participants’ Handbook (Appendix C and D). Explain that following the checklist will ensure that the counselor will complete all of the essential steps for effective contraceptive counseling. Use question and answer to discuss each item on the checklist. For each item, ask participants to describe what the step means regarding provider behaviors.

Key points for the checklist items may include:

1. **Establish rapport**
   a. Greet her in a friendly way, speak directly to her, use appropriate body language.
   b. Assure her of privacy and confidentiality.
   c. Ask her if she feels well enough to discuss contraception.
   d. Ask if she would like her partner to be present during the counseling session.

2. **Assess the woman’s needs**
   a. Discuss factors leading to the abortion.
   b. Ask if she desires to delay pregnancy – do not assume you know what she wants.
   c. Discuss prior use of contraception, method issues, desire and ability to use a method in the future.
   d. Explain human reproduction if necessary (menstrual cycle, contraception, pregnancy).
   e. Consider emergency contraception (EC) and referrals.

3. **Assess the woman’s individual situation**
   a. Consider her clinical condition and help her talk through her personal situation.
   b. Explore which methods are options and how can she achieve correct, continued use.
   c. It may be appropriate to begin with a discussion on partner or family issues. Some issues (e.g., violence, opposition to contraception use) may be very sensitive and should be discussed very gently.

4. **Explain the characteristics of available and effective methods**
   a. Make sure she understands which methods are available and the benefits, risks, and alternatives. Educational materials and models are helpful, if available.

5. **Ask her to choose a method**
   a. Do not choose a method for the woman; help her make her own choice.
   b. Support her in choosing the method that is best for her and her partner.
   c. Discuss potential barriers to successful use of the method (including resupply issues), and ways to overcome those barriers.

6. **Ensure she understands how to use the method.**
   a. Ask questions to confirm understanding, paraphrase her responses, and use visual aids.
7. Refer her to resources
   a. She may need follow-up for a method.
   b. Additional resources may be needed if her method of choice is not available or if she has other reproductive health needs.
   c. It is essential to have a resource list available, so that she can be referred to convenient services, if needed.

11. Activity: Reflecting on the words we use (10 min)

Brainstorm which words or phrases average people are more comfortable using to discuss sexual and reproductive health topics rather than the clinical terms providers often use. For example, people may rather say “slept together” instead of “had sex” or “intercourse”. Make a list of commonly used terms that are more modest, yet understandable, to clients and in particular, rural people and women. Discuss the need to use these terms in counseling women and in including male partners in counseling sessions.

Emphasize that it is important to use language that people are comfortable and familiar with, while still being clear about what is being discussed.

12. Eligibility Criteria for Postabortion Contraception (15 min)

Show and discuss slides: Medical Eligibility for Postabortion Contraceptive Use
   • If no severe complications, all methods can be used immediately after EVA/MVA.
   • Most methods can be started with MA.
   • Screen for any medical precautions for particular methods.
   • All methods require adequate counseling and informed consent.
   • All modern methods can be used by young or nulliparous women.
   • Long-acting reversible contraceptives (LARC) have many advantages and should be offered as an option for women of all ages and regardless of her marital status.
   • Complications that occur during or after an abortion must be taken into consideration. “Bridging” or temporary methods can be used until it is safe to use her desired method.
   • For MA, a follow-up visit is necessary for IUCD or voluntary sterilization (VS). A bridging method can be used until the follow-up visit.

Ask participants to review the Guidelines for Selection of Contraception by Methods table and Use of Contraception in Abortion with Complications section in their Participant's Handbook silently for a few minutes and answer any questions.

13. Activity: Emergency contraception (EC) (10 min)

Tell participants that Emergency contraception (EC) is a particularly important option for preventing pregnancy after unprotected intercourse or contraceptive failure.

Explain to participants that you will read a series of statements about emergency contraception (EC). Each statement will either be true or false.
Instruct the participants to stand up if they believe that statement to be true. Give participants a few moments to decide, then provide the correct response and explanation. Ask them to sit back down for the next questions.

**True or False:**

1. The sooner after unprotected intercourse EC is used, the more effective it is.
   **TRUE:** EC does not cause abortion, and will not work once pregnancy is established.

2. EC pills are 50% effective when used within 5 days after unprotected intercourse.
   **FALSE:** EC pills are 60-95% effective in preventing pregnancy when used within 5 days after unprotected intercourse.

3. IUCD can be used as an EC method
   **TRUE:** When inserted within 5-7 days after unprotected intercourse, a copper IUCD is 99% effective in preventing pregnancy.

4. EC pills can be used as a primary method of contraception
   **FALSE:** EC pills can be used as a back-up method in case of contraceptive failure (for example, condom breakage), if no regular method was used, or when sex was non-consensual (rape). However, it is not meant to be a woman's primary method of preventing pregnancy.

5. If pills packaged specifically for EC are not available, specific doses of oral contraceptives can be used
   **TRUE:** In some settings, pills specifically packaged for EC are available. (Show samples of EC pills if available.) Where packaged ECP's are not available, taking a specific dose of commonly packaged oral contraceptives is acceptable. Oral contraceptive pills used for EC should be initiated within five days (120 hours) after unprotected sex. Recommended dosages depend on the formulation of the particular pills used.

Refer participants to the Emergency Contraception section of the Participants' Manual to review examples of ECP regimens.

**14. Activity: Special considerations for counseling specific populations (20 min)**

Divide participants into 4 groups: women with multiple abortions, women who have experienced violence, young women, and women with cognitive and developmental disabilities and/or mental illness. Ask each group to answer the following questions and record their responses. Ask one member of each group to report to the larger group.

1. What are the special contraceptive needs for this population?
2. What additional barriers may prevent them from having successful contraceptive use?
3. What special challenges might arise in a contraceptive counseling session with these women?
Facilitate a large group discussion ensuring the following points are shared:
- Women in these situations may have very specific contraceptive needs.
- Women in these populations often experience discrimination.
- A woman may face further violence if her abortion or contraception is not kept confidential.
- Sensitivity is important when interacting with women in these populations.
- Personal factors, such as patterns of intercourse or the need to conceal contraceptives may influence method choice.
- Consider recommending dual protection and provide EC.
- Methods not requiring a daily regimen may be a better choice for some populations.
- Women who experience violence regularly often have less power and may need additional skills for convincing partners to use condoms.

15. Activity: Contraceptive Counseling Role Plays (60 min)

Introduce the role plays as an opportunity to apply the content covered in this module and practice counseling skills.

Refer the participants to the Contraceptive Counseling Role Play Scenarios in the Participants’ Manual (Appendix M). Depending upon the group, it may be appropriate not to do ALL of the case studies or it may be appropriate to write a case study more relevant to the local situation of the learners.

Follow the instructions on the Role Play Scenarios handout. Work through the cases, switching roles until all participants have played each of the three roles at least once.

Ask a group to present a role play to the full group.

Discuss the role play. Possible questions include:
- What skills did the providers perform well?
- What counseling skills could be improved?
- In your own role plays, what were the key counseling issues that you discussed?
- How comfortable did you feel during the role plays?
- How did the woman respond to your counseling?
- What are some possible challenges of providing effective counseling to women with special considerations?
- How could you gain additional skills before performing contraceptive counseling with actual clients?

16. Summary (10 min)

- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 4: YOUNG WOMEN AND ABORTION CARE

Estimated Time: 2 hours

Purpose
This module provides guidance for providers and others involved in service delivery on abortion counseling, contraceptive counseling and service provision, and clinical care that is appropriate for young women.

Preparation
- Label three flipcharts "Not at all," "A little," and "A lot," and post them in that order, spaced out along a wall in an open area of the room where there is enough room for the participants to move around.

Step-by-Step

Show and review slide: Module Overview
- Definition of "young women" and the context of young women in Nepal
- Youth-friendly abortion services
- The importance of contraceptive counseling and service provision for young women

1. Introduce module and state objectives (10 min)

Show and discuss slide: Module Objectives

By the end of this module participants should be able to:
- Identify why young women face unique vulnerabilities and barriers to safe abortion-related care
- Define "adolescence," "youth," and "young people"
- Describe the context for young women in Nepal
- Describe how to make abortion-related care appropriate for young women

Ask participants why young women in Nepal resort to unsafe abortion. Answers should include:
- Stigma and negative attitudes
- Fear of negative repercussions
• Lack of access to comprehensive sexuality education
• Limited financial resources
• Cost of care
• Transportation
• Involvement laws
• Concerns over privacy and confidentiality

2. Young Women in Nepal (5 min)

Show and review slide: Who Are Young Women?

Adolescents, youth, and young people are between the onset of puberty and adulthood
• Adolescents are those people aged 10-19
• Youth are people aged 15-24
• Young people encompasses both age ranges (10-24)

3. The Context of Young Women in Nepal (5 min)

Show and discuss slide: What Is It Like to Be a Young Nepali Woman?
• 33% of the total population are adolescents and youth.
• By age 24, more than 2/3 of women have gotten married.
• 18% of all births are among women under the age of 20.

Inform participants that the use of contraceptives among women aged 15-49 years has increased over the last 30 years from 3% to 50%.

4. Activity: Supportive and Non-Judgemental Attitude (30 min)

Explain to participants that the three signs ("Not at all," "A little," and "A lot") on the wall represent a continuum. You will be reading a series of questions about young women. Once a question is read, ask participants to move to the point along the continuum that best represents their feelings.

Encourage participants to be honest about their feelings and to resist being influenced by where other participants are placing themselves.

After participants have arranged themselves, ask volunteers at different points along the continuum to explain why they are standing there. If, based on someone's explanation, participants want to move to another point on the continuum, encourage them to do so.

Continue the process until all questions have been read. Once you have finished reading the questions, ask participants to return to their seats.

Ask two participants to share their feelings about the activity, soliciting a different response from the second person.

Facilitate a brief discussion about the different responses and levels of comfort in the room.
referring to the reasons participants gave about their place on the continuum. Some questions could include:

- What did you learn about your own and other participants’ comfort with young women and abortion?
- What age did you assign to a “young woman” as you thought about the questions? Would your comfort level have been different if she were 19? 17? 15? 13? 11?
- How can your comfort levels and attitudes around young people’s sexuality affect the provision and quality of abortion services for young women?

Key discussion points:
- Young women have a right to make a free, informed decision about their pregnancy and that decision must be respected.
- It is helpful for providers to examine their beliefs and attitudes with regard to gender, age, sexuality, marital status, and abortion. Providers should make an effort to keep these personal beliefs from limiting their ability to give the best care possible to young women.
- Providers can reduce the impact of social barriers and help young women get the care they need by providing a supportive and nonjudgmental environment.

**Comfort Continuum Questions:**

1. How comfortable are you with young women having consensual sex with her husband, with whom she is in love?
2. How comfortable are you with young women having consensual sex with her boyfriend, with whom she is in love?
3. How comfortable are you with an adolescent girl who wants to keep her pregnancy and have a child?
4. How comfortable are you with an unmarried adolescent girl who wants to terminate her pregnancy without her parents’ knowledge?
5. How comfortable are you with the idea of providing contraceptive counseling and methods to unmarried young women?
6. How comfortable are you with the idea of providing abortion/postabortion counseling to young women?
7. How comfortable are you with the idea of performing abortion for young women in the first trimester?

**5. Informed Consent (15 min)**

**ASK:** At what age can a young woman consent for safe abortion services in Nepal?

**ANSWER:** Young women 16 years or older can consent for services.

**Show and discuss slide: Young Women and Informed Consent**

- Right to private medical counseling should not be affected by third party consent requirements
- An adolescent should not be forced against her will to have an abortion
- Evolving capacities and principle of capability
Tell participants that a young women's right to private medical counseling should not be affected by third party consent requirements for medical treatment, as counseling is separate. If an adolescent under the age of 16 years cannot find a support person to provide consent this should not inhibit the provider from providing counseling.

Explain that adolescents and young women have the right to consent (or assent if third party consent is legally required) to services – or not. No adolescent or young woman should be forced against her will to have an abortion even if her parent/caregiver/partner requests it.

Explain that the Convention on the Rights of the Child affirms children’s and young people’s right to independent decisionmaking in accordance with their evolving capacities. To determine capacity of a young person seeking reproductive health care including safe abortion services, a principle of capability can be used.

Show and discuss slide: *Evolving Capacities*
- Young people have a right to independent decision-making in accordance with their capacities
- Capacities are not linked to chronological age. They differ among individuals and are constantly evolving.
- Parents, guardians, and other adults should provide direction only in accordance with a young person’s capacities to make decisions.

Tell participants that while there are no universally accepted definitions of young people’s capacity to make decisions, it is widely recognized that capacity is evolving, and not linked directly to chronological age, but that capacity is developed through diverse life experiences and social contexts.

The Convention on the Rights of the Child recognizes that support and guidance can be helpful for any young person, but parents and guardians should provide direction only “in a manner consistent with” the young person’s capacities. No adult should attempt to direct decision-making if the young person’s capacity has evolved to the point of being able to make the decision her- or himself.

Show and discuss slide: *Principle of Capability*
- “Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight.” (Cook and Dickens, 2000)

Explain that because determining capacity is subjective, a useful principle has been provided by Cook and Dickens (2000): Young people who understand that they need to protect their reproductive health, and who request reproductive health services to that end, can be considered capable of receiving reproductive health counseling and services without parental oversight.

When applied to abortion care for young women, this principle of capability means that a young woman – who identifies that she has an unwanted pregnancy and voluntarily requests a safe
abortion to terminate the pregnancy – is capable to consent to a safe abortion procedure. This principle limits the role of the provider in assessing capacity, and supports the ‘presumption of capacity’ approach. The young woman’s capacity is sufficiently demonstrated by her voluntary action to seek and request safe abortion.

6. Third Party Considerations (5 min)

Explain that some young women bring along a partner, mother, friend, or relative to an abortion care facility. In Nepal, a young woman who is less than 16 years old must be accompanied by someone who can give consent for the procedure. This may be a family member, friend, or her partner.

It is important to ensure that abortion-related care decisions are fully hers when a third party is involved.

Show and discuss slide: Ensuring a Young Woman’s Decisions are Fully Hers

- Meet alone with her first to have a private conversation free from other people’s influence.
- Ask her to carefully explain her decision, paying attention to any personal views or desires she expresses.
- Listen for language that can indicate other people’s influence in her decision making (e.g., “My mother wants me to...”)

Emphasize that a young woman may be influenced by other people’s views and desires, but she needs to understand that her own life will be most directly affected by her decision and that the decision is hers to make.

Explain that decision making on abortion often takes place mostly outside the clinic setting, and a young woman may be particularly susceptible to adults’ influence, especially from a partner or someone who has power over her. Providers should ask questions to ensure that she has not been pressured or coerced by anyone, including a partner, family, community, or friends, to make her decision.

7. Trust and Confidentiality (10 min)

Show and discuss slide: Counseling Considerations for Young Women

- Need for additional counseling time
- Attention to sexual violence
- Importance of dual protection and emergency contraception

Tell participants that an important counseling topic to cover with young women is sexual violence: “Providers should be aware that sexual coercion or violence, which is common among adolescents in many contexts, may be the cause of the unwanted pregnancy and subsequent abortion. In these cases, they should also remember that the younger the adolescent, the higher the chance that the sexual offender is a close relative or a direct family member, which has implications with regard to confidentiality, the client’s overall care, and referral needs (Postabortion Care Consortium, 2006).”
Young women should also be counseled on the importance of dual protection for unwanted pregnancy and STIs, as well as the important role emergency contraception can play in preventing future unwanted pregnancy.

Explain that gaining the trust of a young woman especially if unmarried will allow her to open up to the provider and share her concerns while allowing the provider to ask about sensitive topics such as abuse and other reproductive health needs such as STI protection and contraception.

Ask participants how providers can gain young people's trust in an abortion care setting. Take a few responses before showing the next slide.

**Show and discuss slides: Gaining Trust**

- Respond to questions fully and honestly
- Respect a young woman's decisions even if they are not what the provider wants her make
- Normalize the conversation by letting her know that you have treated many young women (if this is true)
- Give her opportunities to express what she knows and what her opinions are
- Ask her to clarify what terms she uses for words like abortion, sexual intercourse, vagina, vulva, etc.
- Take the time to explain human anatomy and reproduction in a non-condescending way
- Give information multiple times in different ways
- Use clear and understandable language
- Encourage her to ask questions; solicit her opinions before making suggestions
- Use positive body language such as leaning towards her, making appropriate eye contact, and nodding

Ask participants how they could convey to a young woman that her confidentiality would be protected in an abortion care setting. Record answers on a flipchart.

Answers may include:

- Explain the specific ways in which the staff protects confidentiality in the facility
- Begin the counseling and consultation session by reassuring the woman that all the information exchanged and care she receives will not be shared without her permission

**8. First Obstetric Event (10 min)**

Ask participants to imagine what a young woman having her first obstetric event is feeling emotionally. How would they feel? Answers may include:

- Nervous
- Afraid
- Not wanting others to know what is happening

Explain that for many young women, this may be their first gynecological experience and they may be especially nervous, have a lot of questions or need clarification increasing counseling time. The first experience with a provider can influence their future healthcare seeking behavior positively or negatively.
Show and review slide: Pelvic Exam Considerations

- Receive her consent even if an adult has legally consented on her behalf.
- Ensure visual and auditory privacy.
- Explain what she can expect before and during the examination.
- During the examination ask permission before touching her with a hand or speculum.
- Warm the speculum before use. If available, use a smaller speculum.

Ask participants to imagine a young woman who is feeling nervous. What kind of pain might she experience in abortion care?

Show and review slide: Pain Threshold

- Young age and nulliparity are risk factors for experiencing more pain
- Young women may find it hard to imagine the level of expected pain. Provide comparison examples. Pharmacologic pain medications can help
- Non-pharmacological methods may also help

Show and review slide: Cervical Dilation

- A young, nulliparous woman’s cervix may be more difficult to dilate.
- Slower and/or longer dilation process is recommended.
- Start with a smaller dilator than is typically used with women who have had one or more children.

9. Misinformation (15 min)

Ask participants if they have encountered young female patients who have feared that abortion can cause infertility later or other misinformation. What can providers say to counteract misinformation?

Answers may include:

- Give factual evidence-based information.
- Provide complete information about abortion, including possible complications and side effects.
- Offer reassurance and support.

Explain that misinformation can also affect a young woman’s ability to choose a contraceptive method. Young women may not know how pregnancy occurs or is prevented, and they may have heard myths about contraception. Asking a young woman “What are some things your friends say about how you can and can’t get pregnant?” and “What are some some things you have heard about this method?” can help you to identify and counteract misinformation.

Show and discuss slide: Misinformation and Contraception

It is important to:

- Ask rather than assume what a young woman’s reproductive plans are.
- Clearly explain how each contraceptive method works.
• Assess the barriers she may face in using different methods.
• Consider discreet methods or one that does not need regular resupply.
• Inform her about where to obtain a resupply of her method.
• Provide at least one dose of EC if possible in case of unprotected sex or contraceptive failure.

Ask participants to list misinformation they have heard about how pregnancy occurs. Write responses on a flipchart paper. Then, ask participants to list misinformation about various contraceptive methods and write those responses on a separate flipchart paper.

Choose one response from each flipchart paper and ask the participants to brainstorm how to counteract this misinformation for a young woman.

Emphasize that getting a sense of what misinformation she has heard first can help a provider tailor explanations about human reproduction, abortion and contraception.

10. Referrals (5 min)

Explain that because young women may use health-care services less than adult women, providers should seize the opportunity to provide or refer a young woman to other services that may benefit her.

Show and review slide: Referral Services
• Age-appropriate physical and psychological development
• Physical and sexual abuse
• Substance abuse
• Nutritional status
• Vision
• STIs
• Tuberculosis

11. Activity: Positively Framing Sexual and Reproductive Health Information (40 min)

Purpose

This activity helps participants reflect on the importance of explaining sexual and reproductive health information in a positive way. This activity provides an opportunity for participants to practice using language that removes blame and judgment.

Objectives

By the end of this activity, participants will be able to:
• Identify the difference between negatively and positively framed sexual and reproductive health information.
• Frame sexual and reproductive health information in a positive way.

Materials
• Flipchart or board, and pens or chalk
• Copies of Handout: Negatively Framed Sexual and Reproductive Health Information (Appendix S)
• Copies of Counseling Scenario (Appendix S)

Time
10 minutes: Introduction
10 minutes: Reframing statements in pairs
10 minutes: Sharing of reframed statements
10 minutes: Role play and discussion
40 minutes total time

Instructions
1. Introduce the activity by discussing the importance of effective abortion counseling that is tailored to the needs of young women. Refer to the GATHER technique and Gaining Trust slides.

Tell participants that they are going to practice framing sexual and reproductive health information in a positive way. Show slide Reframing Sexual and Reproductive Health Information:

Example #1
- Negatively framed: You neglected to use contraception to prevent this unwanted pregnancy, and now you want us to perform an abortion.

Ask, how do you think this statement would make a young woman feel? After receiving a couple of responses ask, how can this statement be changed to be supportive of the young woman?
- Positively framed: Once you realized you had an unwanted pregnancy, I'm glad you took steps to get safe abortion care with us.

Example #2
- Negatively framed: The procedure is very painful, so we'll give you pain medication.

Ask, how do you think this statement would make a young woman feel? After receiving a couple of responses ask, how can this statement be changed to be supportive of the young woman?
- Positively framed: We'll work with you to help you feel comfortable and safe. Some women feel very little or no discomfort and for others, it's quite painful. We will give you pain medication and take other steps to lower your discomfort, and you can tell us if you need more.

2. Divide participants into pairs and pass out Handout: Negatively Framed Sexual and Reproductive health information. Give pairs 10 minutes to reframe negative statements in a more positive way.
   a. Healthy sexuality is about protecting yourself from diseases and unwanted pregnancy.
   b. You should talk to your parents about this pregnancy, because you're too young to make an important decision about abortion on your own.
   c. Once you have this abortion, you'll see why you need to abstain from sex until you are married and ready to have a baby.
   d. You need to tell your boyfriend that when he wants to have sex with you, he needs to wear a condom so you don't get infected or pregnant.
e. You’ll probably forget to take the pill and get pregnant again; you should get a long-
term contraceptive method instead.

3. Have participants come back together and, for each negative statement, have 1-2 pairs share
their positively-framed statement. The positively framed statement may be similar to:
   a. Healthy sexuality means you are able to express your sexuality in a positive and pleasurable
      way, have opportunities for love and intimacy, and have accurate information and access to
      appropriate healthcare to make good decisions about protecting yourself from health
      problems.
   b. The decision to have an abortion is an important one. Have you considered talking to
      a trusted adult who you think can support you and not impose their own views? I can
      help you practice telling them if you like.
   c. It is difficult to know now how you will feel about having sex after the abortion. Let’s
      talk about how you can protect yourself from another unwanted pregnancy before you
      decide to have sex again.
   d. It can be difficult to talk to a sexual partner about using contraception and preventing
      STIs before you have sex. Would you like to practice having that conversation and
      figuring out how you can make sure you are protected so you can feel secure and enjoy
      yourself?
   e. How well do you remember to do other things on a daily basis? If you think you might
      forget to take a pill every day, you can consider using a long-term or other contraceptive
      method.

4. Tell participants that we will now conduct a counseling role play demonstration. Ask for
two volunteers to play the counselor and patient for 3-5 minutes. The person playing the
 counselor will portray a supportive provider and incorporate positively framed statements
 when counseling the young woman. Ask participants to note the counselor’s effectiveness
 as they observe the role play.

5. At the end of the role play, ask the following questions to the group, noting all responses on
the flipchart:
   - What did you observe about the young woman’s experience in this counseling session?
   - What did you observe about the counselor?

6. Thank everyone for their participation and emphasize the need for careful reflection on the
impact of both verbal and body language has when counseling young women.

Counseling role play scenario

Shriti is a 17-year-old married woman who had a medical abortion (MA) last year. She is pregnant
again. She tells you she doesn’t want to continue the pregnancy and wants an abortion, but is
afraid of having another abortion. She says that she was using the pill when she got pregnant.

12. Summary (5 min)
   - Summarize key points of module, using the objectives and Summary Section of this module
   - Ask if there are any remaining questions. Answer them or add to the Parking Lot.
Purpose
This module describes the knowledge and attitudes health-care workers must have to successfully prevent infection to themselves, clients, coworkers and communities when providing abortion-care services.

Preparation
- Obtain a set of personal protective barriers for an MVA procedure: face protection (mask and eyewear or face shield), arm protection (gown or lab coat), and gloves
- Obtain a hypodermic syringe with cap, samples of acceptable sharps containers (such as empty, well-sealed shipping box), and unacceptable sharps containers (such as drink cans or bottles)
- Obtain materials to demonstrate sterilization and HLD (authentic and placeholders)
- Identify local protocols for, as well as barriers to, processing MVA instruments.
- Adapt this session if the participants supervise instrument processing rather than processing the instruments themselves. Also, consider inviting those who perform instrument processing to attend the session.
- Obtain one Processing the Ipsa MVA Plus® and Ipsa EasyGrip® Cannulae wallchart for each participant site. The wallcharts are available from Ipsa.

Step-by-Step
1. Introduce module and state objectives (5 min)

Show and review slide: Module Overview
- Routes of infection transmission in abortion-related care settings
- Proper infection prevention
- Proper instrument processing and storage

Show and review slides: Module Objectives

By the end of this module, participants should be able to:
1. Explain how infection can be spread in the abortion-care setting.
2. Identify essential elements of infection prevention, including standard precautions.
3. Explain proper procedures for managing occupational exposure to blood and body fluids.
4. Explain how to safely dispose of contaminated wastes including disposal of POC.
5. Describe the options, steps, and common mistakes in processing the Ipas MVA Plus® and Ipas EasyGrip® cannulae.

2. Activity: Self-assessment of infection prevention (5 min)

Refer participants to the Infection Prevention Action Plan Worksheet (Appendix K) in the Participants' Manual. Have them complete the second column of the worksheet, "Do you?" Ask a few participants to share a few responses. Tell them that the rest of the worksheet will be used later in the module.

3. Reasons to use infection prevention (5 min)

Show and discuss slides: Infection Transmission

- Infection prevention practices protect clients, providers, coworkers and our communities against blood-borne pathogens.
- Blood-borne pathogens can cause incurable infections such as HIV and HBV.
- Health care facilities are common settings for transmission.
- Infectious agents are transmitted through cuts or openings in skin and through mucous membranes.
- Most commonly transmission involves: injuries from sharp instruments, such as needle sticks, or splashes of blood on non-intact skin or mucous membranes.

ASK: What is the one body fluid not considered infectious?

ANSWER: Sweat

ASK: Which women have blood-borne diseases?

ANSWER: It is not always possible to tell who is infected, as some diseases have no noticeable signs or symptoms.

Show and discuss slide: Assume Every Person Could Be Infected

- Precautions should be taken with every person!
- Any person could have blood-borne diseases, and neither they nor the provider may realize it.
- Health-care workers may mistakenly assume that some clients are unlikely to be infected.
- Tests can not always detect whether or not a person is currently infected.

Remind participants that anyone – elderly women, babies, healthy-looking people – can have a blood-borne disease.
Emphasize that all clients must be treated with the same precautions at all times. Do not make assumptions based on behaviors or appearances.

4. Why infection practices are not used (10 min)

Ask participants to think back to their self-assessment. Ask them to choose one of the infection prevention techniques they do not currently practice and reflect on the worst possible outcome of not practicing it.

Allow participants time to reflect, then ask: What are some possible worst-case outcomes?

Take one to two brief responses. Answers might include:
- Acquiring an incurable disease such as HIV
- Contaminating a community water supply

Tell participants that these sobering reflections give us plenty of reason to consistently practice infection prevention.

5. Standard precautions (5 min)

Show and discuss slide: *Modes of Transmission*

Explain that treating all clients with the same precautions is called “standard precautions.”

Show and discuss slide: *Standard Precautions*
- Properly handle blood and body fluids
- Use appropriate prevention techniques with all clients and staff at all times
- Apply infection-control measures designed to block transmission between the person and potentially infectious bodily fluids.
- Consider all blood and other body fluids from every person to be infectious.

Emphasize that standard precautions should be used at all times, regardless of a person’s actual or perceived health status. There is no reason to treat individuals with known diseases differently.

Show and review slide: *Elements of Infection Prevention*
1. Handwashing
2. Personal protective barriers
3. Aseptic technique.
4. Proper handling and disposal of sharp items.
5. Proper instrument handling and processing.
6. Proper infectious-waste disposal
7. Environment cleanliness.

Now we are going to talk about these infection prevention elements one at a time. The first one is handwashing.
6. Handwashing (5 min)

Hands are a common route for infection transmission. Handwashing is an important, but often neglected, way to prevent infection.

Show slide: *When Should We Wash Our Hands?*
- Before and after each client contact
- After contact with potentially contaminated items, even if wearing gloves
- Many times a day

Show and discuss slide: *How Should We Wash Our Hands?*
- **Wet** your hands with clean, running water.
- **Lather** your hands by rubbing them together with the soap. Be sure to lather the backs of your hands, between your fingers, and under your nails.
- **Scrub** your hands for at least 20 seconds.
- **Rinse** your hands for at least 20 seconds.
- **Dry** your hands using a clean towel or air dry them.

**ASK:** What is a “standing pool of water” compared to “flowing water?”

**ANSWER:** A standing pool of water is a basin or other container of water which does not have flowing water and into which everyone dips their hands. When running water is not available by faucet, spigot or pump, one person can pour fresh water from a container, enabling another person to wash.

**ASK:** Why is this not a good infection prevention practice?

**ANSWER:** Because contamination can spread to everyone who washes their hands in that water. Microorganisms can thrive in a container of water used by multiple people.

Show and discuss slide: *Handwashing*

According to studies of handwashing behavior, when head doctors and other clinic leaders wash their hands regularly, other health-care workers tend to do the same.

Ask participants to think about the handwashing practices of lead clinicians in their own facilities.
- Do these leaders set a good example of handwashing behaviors?
- If they do not, how could they be convinced to do so?

7. Personal Protective Barriers (10 min)

Tell the participants that you will now talk about personal protective barriers, which are used as protection against exposure to infection.

Put on personal protective barriers— cap, mask, eyeglass, gown, gloves, and gum boots. Wear them while you discuss the next few points.

Show and discuss slide: *Personal Protective Barriers for Abortion-related Care*

Barriers must be worn whenever there is the possibility of contact with blood or body fluids.
ASK: When a health-care provider is performing an MVA, what areas of their body might be exposed to blood?

ANSWER: Eyes, face, mouth, arms, hands

ASK: What personal protective barriers should the provider wear during an MVA procedure?

ANSWER: Face protection (shield or mask and eyewear), arm covering (gown or lab coat) and hand protection (gloves).

ASK: Is it necessary to wear all these barriers whenever doing anything in the clinic?

ANSWER: No, only when contact with blood is possible, such as by accidental splashing.

ASK: What barriers should a person wear when cleaning instruments, even if the instruments have been soaked in a chlorine solution?

ANSWER: Face shield or eye and mouth protection, gloves, gown or lab coat.

Explain that sometimes people think that it looks inappropriate for an MVA provider to be wearing a mask if they are not working in an operating theatre.

ASK: Why should a provider always wear mouth covering, such as a surgical mask, when performing MVA?

ANSWER: A surgical mask is to protect the provider, not the client, from infection.

Inform that another barrier to use is gloves.

**Show and review slides: Using Gloves Properly**

- Always change gloves between client contacts.
- Change gloves after contact with a potentially contaminated item.
- Put on new gloves before touching sterile instruments.
- Change gloves between rectal and vaginal examinations.
- Wear gloves when drawing blood or starting an intravenous line.
- Remove gloves and wash hands immediately following a procedure.
- Wear gloves (ideally, utility gloves) while cleaning if there is the potential for hand contact with blood or other body fluids.

8. Aseptic Technique (15 min)

Tell participants that you will now discuss “aseptic technique,” which protects clients against infection after procedures.

**Show and review slide: Three Critical Components of Aseptic Technique**

- Antiseptic preparation
- No-touch technique
- Proper processing and handling of instruments

**Show and review slide: Antiseptic Preparation**
• Woman cleans her vagina using water to remove microorganisms.
• Provider then performs cervical antisepic prep.
• Resident vaginal flora can be introduced when inserting the cannula into the uterus, causing infection.

Show and review slide: No-Touch Technique
• Always handle instruments by the hand that does not come in contact with the woman.
• No instrument contact with a contaminated surface before insertion through the woman’s cervix.
• The tenaculum, cannula or dilator tips should not touch providers’ gloves, woman’s vaginal walls, or unsterile surfaces.

Tell participants that you will now talk about the final component of antisepic technique: how to safely handle sharp items. Explain that handling sharp items is a common way that workers get exposed to blood and body fluids. It is often responsible for disease transmission.

Ask participants to name some sharp items in the clinic. Answers may include: blades, glass, hypodermic needles, tenaculae, suture needles, and scissors.

Explain how handling needles or other sharp items in certain ways can result in injuries and infection. Ask participants if anyone has been stuck or cut while providing clinical services. Have one person briefly say how they were stuck or cut and how it affected their infection-prevention practices afterwards.

Show and discuss slide: How Can We Prevent Injuries from Sharp Items?
• Do not carry hypodermic needles.
• Set aside a specific area for keeping sharps during procedures.
• Announce the passage and presence of sharps to avoid accidentally sticking others.
• Dispose of needles and syringes immediately, in puncture resistant containers, without recapping, removing, cutting or bending them.
• If syringes must be recapped, use the “scoop method.”

Ask participants to propose other ways to prevent injuries from sharp items.

Show and discuss slide: Scoop and Pull Method

If syringes must be recapped during a procedure:
• Scoop cap onto needle without touching cap or needle
• Pull cap onto needle by holding cap near base
• Never put fingers on tip of cap while pushing cap onto needle

Ask a volunteer to come to the front and demonstrate the scoop method.

Emphasize that the last step is to pull the cap over the needle, not to push it from the top of the cap, as the needle can easily pierce through the cap and into the fingertip. Recapping needles is only to be done when necessary during a procedure and never before disposing of a needle.
Show and discuss slide: Safe Needle Disposal

- Immediately drop needles into sharps container.
- Do not recap, remove, cut or bend needles.
- Place sharps containers everywhere that needles are used.

Explain that a sharps container is a container that securely contains the syringe with the needle still attached. The container should not allow the syringe to puncture anything or be easily removed. Sharps containers vary in appearance.

Ask what sharps containers are you using locally?

- For every example, ask if it meets the criteria for safe disposal. Criteria include: container is secure, cannot be punctured, prevents items from being easily removed, allows syringe to be dropped in immediately with the needle still attached.
- If the item does not meet the criteria, then it is not appropriate for use in clinics. For example, drink cans do not allow syringes to be dropped in immediately with needles still attached.

Transition by saying: now we will discuss a few scenarios to apply our knowledge.

Read the following scenarios and, for each one, ask participants whether or not it presents a good solution for proper sharps disposal.

Show slide and read: Sharps Containers Scenario 1

As a way to reduce costs, a clinic decides to put one large container at the centrally located nurses' station. Workers bring their sharps there from all over the clinic.

Is this a good solution?

Correct response: No. Containers should be located every place needles are used, because carrying needles causes accidental injuries.

Show slide and read: Sharps Containers Scenario 2

Another clinic thought a technological solution would help, so they bought a needle cutter that automatically breaks needles before disposal.

Is this a good solution?

Correct response: No. Needles should not be broken, cut or bent before disposal. Breaking, bending or manipulating needles in any way—even with a machine—causes injuries.

Show slide and read: Sharps Containers Scenario 3

One clinic used large, metal cooking-oil containers into which many needles and syringes can easily be dropped. The containers, which can be securely closed when full, were placed everywhere that needles are used.
Is this a good solution?

Correct response: Yes. Staff don’t have to carry the needles anywhere for disposal and the containers are secure, cannot be punctured, prevent items from being easily removed and allow syringes to be dropped in immediately with needles still attached.

Show slide and read: *Sharps Containers Scenario 4*

At one clinic, workers had to take the needle off the syringe and insert both separately into a small drink can.

Is this a good solution?

Correct response: No. Needles should not be handled before disposal, even to detach. A drink can is not an appropriate sharps container. It does not provide enough room for the syringe to be dropped in immediately with the needle still attached.

Summarize content on proper sharps handling by emphasizing how they reduce the risks of injury to providers, clients, coworkers and the community around the clinic.

9. Accidental Exposure (5 min)

Tell participants that, despite best efforts, workers are sometimes accidentally exposed to blood and body fluids. This is one reason why it is important for facilities to develop protocols for accidental exposure, widely disseminate the protocols to staff, and monitor the program periodically.

Show and review slides: *If Exposed*

- If exposure caused bleeding, allow to bleed briefly.
- Immediately flush with clean water.
- Wash wound and skin thoroughly; flush mucous membranes with water or saline only.
- If water isn’t available, use antiseptic solution.
- Determine type of fluid and exposure.
- Give post-exposure prophylaxis, if available.
- Evaluate the exposure source.
- Evaluate the exposed person’s immune status.
- Offer voluntary, confidential HIV, HBV, and HCV counseling and testing, if available.
- Consult an infectious-disease specialist.
- Record the exposure and actions taken. Discuss how to prevent future exposure and share lessons learned with all staff.
- Evaluate acute illness that develop

10. Proper Instrument Handling and Processing (1 hr, 30 min)

Distribute one Processing the Ipas MVA Plus* and Ipas EasyGrip* Cannulae wallchart to each participant site.

Explain that this section of the training covers a lot of content. Refer participants to the
Instrument Processing Checklist in their Participants’ Manual (Appendix E) and follow along.

Emphasize that immediately after use, all reusable surgical instruments used in the abortion procedure should be cleaned and high-level disinfected or sterilized to prevent them from infecting other women during subsequent procedures.

Show and review slide: Instrument Processing Overview
1. Decontamination Soak
2. Cleaning/drying
3. Sterilization or high-level disinfection (HLD)
4. Safe storage

Show and discuss slide: Instrument Processing Process

Show and discuss slide: Why Soak Instruments Before Cleaning?
- Makes cleaning easier by keeping instruments wet
- Use of 0.5% chlorine solution assists disinfection
- Removes some material

Remind participants that items are still not safe to handle with bare hands.

Show and discuss slide: Steps in Decontamination Soak
- Fill a plastic container with solution.
- Can use 0.5% chlorine solution.
- Wearing gloves, submerge instruments completely.
- Then draw solution into cannula and aspirator.
- Soak instruments for 10 minutes.
- Use gloves or forceps to remove instruments.

ASK: what are some possible mistakes you might make in the soaking process?
Answers may include: Gloves not worn; instruments not fully submerged; instruments allowed to dry.

Emphasize that barriers must be worn when handling instruments after soaking, including face protection, gloves, and gown or apron.

Tell participants to keep the container close to the procedure area, and to change the chlorine solution whenever it becomes very bloody.

Show and review slide: Cleaning
- WHO says is the most important step to ensure proper final decontamination of instruments.
- Disassemble the MVA aspirator before cleaning.

Show and discuss slide: MVA Parts Disassembled

Use fully assembled aspirator with cannula attached for the demonstration.
• Ask for a volunteer to come up to disassemble the aspirator.
• Describe the steps for disassembling the instrument, pointing them out on the slide while the volunteer follows your directions.

Show and discuss slides: Disassembling the Aspirator
1. Remove cannula by twisting its base and pulling it out of valve.
2. Pull cylinder and remove from valve.
3. Press cap-release tabs to remove cap.
4. Open hinged valve by pulling open clasp.
5. Remove valve liner.
6. Disengage collar stop by sliding under retaining clip, or remove completely.
7. Pull plunger completely out of cylinder.
8. Displace O-ring by squeezing its sides and roll down into groove below.

Point out that participants should never use a sharp object to remove the O-ring, as that could damage the ring.

Show and discuss slides: Steps to Clean Disassembled Instruments Thoroughly
• Wash all surfaces thoroughly in warm water and detergent.
• Use a cotton-tipped probe or soft cloth to remove trapped material.
• Clean the crevices and interior of the cylinder, valve parts, and plunger using a soft-bristle brush, being careful not to splash.
• Flush water through the cannula repeatedly.
• Clean each item until no tissue or blood is visible upon careful inspection, then rinse.
• Allow items to dry.

ASK: what are some mistakes that commonly occur while cleaning?
Answers may include: Barriers not worn; instrument not fully cleaned; antiseptics used instead of detergent (Disinfectants are strong germicides used to clean equipment. Antiseptics are weak germicides used on people and cannot be used for instruments.)

Show and discuss slides: Sterilization or High-Level Disinfection (HLD)
• Instruments must be high-level disinfected or sterilized between patients.
• Prevents potential blood borne pathogens from being transmitted between patients in case of problems during the procedure where aspirator contents may make contact with a woman's body.
• Cannulae must be sterile or HLD at the time of use.
• MVA does not need to remain HLD or sterilized before the next patient. Keep in a clean place until next use.
• HLD options: glutaraldehyde, 0.5% chlorine soak, boiling
• Sterilization options: steam autoclave, glutaraldehyde

Explain that since the aspirator does not ever touch the woman, it does not have to be sterile or HLD at the time of the procedure as long as it has gone through the HLD/sterilization process between patients.
Explain that sterilization kills all microorganisms, including bacterial endospores such as those that cause tetanus and gas-gangrene. HLD destroys all microorganisms including hepatitis and HIV but does not reliably kill bacterial endospores.

Ask participants to work in five small groups and assign each group one of the following HLD/sterilization methods:

1. Sterilize Using Steam Autoclave
2. Sterilize Using Glutaraldehyde
3. High-Level Disinfectant by Boiling
4. High-Level Disinfectant Using Glutaraldehyde
5. High-Level Disinfectant Using a 0.5% Chlorine Soak

Give groups 20 minutes to review and discuss their assigned process. Tell them that they will be responsible for demonstrating their assigned HLD or sterilization procedure.

Ask each group to nominate two volunteers to demonstrate the steps for their sterilization/HLD method (5 minutes or less for each group). Participant volunteers should explain to the larger group what they are doing for each step and should use a mix of authentic and pretend materials. For example, they can use real MVA aspirators, gloves, forceps, and masks but use a pretend jug of glutaraldehyde solution. They should explain each step as they complete each step of the process (for example, “now we wait for 10 minutes”, or “now the water is boiling.”).

Point out any mistakes or omissions, and answer any questions.

Show and discuss slide: Instrument Processing

<table>
<thead>
<tr>
<th>Method</th>
<th>Agent</th>
<th>Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td>Pressurized steam (autoclave)</td>
<td>30 minutes at 121°C and 106 kPa pressure</td>
<td>Steam must reach all surfaces of item. Instruments should be arranged so that their openings are not obstructed, to permit drainage</td>
</tr>
<tr>
<td></td>
<td>2% glutaraldehyde</td>
<td>10 hrs</td>
<td>Discard 14 days after mixing or sooner if solution becomes cloudy.</td>
</tr>
<tr>
<td>High-level disinfection (HLD)</td>
<td>0.5% Chlorine (sodium hypochlorite)</td>
<td>20 minutes</td>
<td>Change solution daily or sooner if it became cloudy.</td>
</tr>
<tr>
<td></td>
<td>2% glutaraldehyde(Cidex)</td>
<td>20 minutes</td>
<td>Discard 14 days after mixing or sooner if solution becomes cloudy.</td>
</tr>
<tr>
<td>Boiling</td>
<td></td>
<td>20 minutes at a “rolling boil”</td>
<td>Items do not need to be fully immersed. The pot should be covered Cool before use.</td>
</tr>
</tbody>
</table>
Explain that some manufacturers produce aspirators and cannulae made of high-grade plastics that are engineered to be sterilized in an autoclave, while other plastic instruments will crack and melt when exposed high heat for sterilization.

Emphasize to always refer to the instructions for use of all items being disinfected or sterilized, to ensure they are using the appropriate form of disinfection.

**ASK:** What mistakes can be made when steam autoclaving MVA instruments?
**Answers may include:** temperature, pressure, or time not correct; autoclave set on higher settings; items not wrapped or arranged properly for steam contact; cannula opening obstructed; instrument not properly disassembled

**ASK:** What mistakes can be made during sterilization or HLD using chemicals?
**Answers may include:** items not submerged or filled; cannula opening obstructed; instrument not disassembled; solution expired or incorrectly mixed; time not correct; instruments not rinsed

**ASK:** What mistakes can be made when boiling the instruments?
**Answers may include:** Water not actually boiling; insufficient length of boiling time.

Show and discuss slide: *Reassembling the Aspirator*

Explain that aspirators should be reassembled after processing and the plunger O-ring should be lubricated. They must be correctly assembled after processing in order to function properly.

Demonstrate each step of reassembling and lubricating the aspirator as you read them aloud:
1. Place the valve liner in position inside the valve by aligning the internal ridges. Close the valve until it snaps in place.
2. Snap the cap into place on the end of the valve.
3. Push the cylinder into the base of the valve.
4. Place the plunger O-ring in the groove at the end of the plunger and lubricate it by spreading one drop of lubricant around the O-ring with a fingertip. Silicone, which is not sterile, is provided with the aspirator; other non-petroleum-based lubricants can also be used (for example, olive oil). **Caution:** Excessive lubrication can cause the aspirator to lose vacuum. Do not over-lubricate the plunger O-ring. Do not lubricate other parts of the aspirator.
5. When reassembling the aspirator, ensure that the plunger is introduced straight into the cylinder and not introduced at an angle.
6. Squeeze the plunger arms and fully insert the plunger into the cylinder.
7. Move the plunger in and out to lubricate the cylinder.
8. Insert the tabs of the collar stop into the holes in the cylinder so that the plunger cannot be pulled out of the cylinder.
9. Always check that the aspirator retains a vacuum before using it.

Ask a volunteer to demonstrate the same steps as you read them aloud. Troubleshoot as needed. Answer any questions.
Show and discuss slide: Storing MVA Instruments

- Instruments should be kept in dry, covered, containers with tight-fitting lids, protected from dust and other contaminates. Cannulae must be in HLD or sterile containers. Aspirators can be stored in clean, HLD, or sterile containers.
- Cannulae that have been processed by wet methods (HLD) should be used daily, if they are not used in that time period, they should be reprocessed.
- If autoclaved, wrapped cannulae that are safely stored can be used within one week.

Explain that properly storing instruments is as important as the HLD/Sterilization process. Once they are processed, the challenge is to ensure that they are not re-contaminated during the storage or handling.

Tell participants that they must make sure that all items are completely dry. If items are even slightly wet when put in storage this can lead to microbial growth.

11. Environmental Cleanliness (10 min)

Transition by saying: now let's talk about environmental cleanliness. A clinic and everything in it should be kept clean and dry at all times to stop the spread of infection.

Explain that detergents and hot water (or 0.5% chlorine solution) are adequate for the routine cleaning of floors, beds, toilets, walls, and rubber draw sheets.

Explain that following spillage of body fluids, heavy-duty rubber gloves should be worn and as much body fluid as possible removed with an absorbent material. This can then be discarded in a leak proof container and later incinerated or buried in a deep pit.

Show and review slide: When Should the Clinic Be Cleaned?

- At the beginning of each clinic session
- Between clients as needed
- At the end of each day

Show and review slide: At the Beginning of Each Clinic Session

- Wipe all horizontal surfaces with a clean cloth.
- Mop floors with a clean mop to remove any dust.

Show and discuss slide: Between Clients

- Clean any potentially contaminated surfaces with a clean cloth and disinfectant cleaning solution.
- Clean visibly soiled areas of the floor, walls, or ceiling with a disinfectant cleaning solution.
- Check sharps disposal containers and replace them if they are three-quarters full.
- Remove infectious waste.

Show and discuss slide: At the End of Each Day

- Check sharps disposal containers and replace them if they are three-quarters full.
- Remove infectious waste.
- Clean all surfaces with a clean cloth and disinfectant cleaning solution.
- Mop floors with a disinfectant cleaning solution.
- Wash waste containers with a disinfectant cleaning solution.

12. Proper Infectious Waste Disposal (5 min)

Explain that properly disposing of infectious waste is also critical to maintaining environmental cleanliness.

Show slide: Infectious Waste
- All disposable material that has come in contact with body fluids
- Proper waste disposal protects the community

ASK: When infectious waste makes its way from a clinic into the community, what dangers does this pose?

Answers may include: Accidental needle sticks and exposure to infected blood and other body fluids in solid waste or water sources.

Show and discuss slide: Safe Infectious Waste Disposal
- Secured; no open pits or piles
- Ideally, incinerated
- Buried and protected by a fence, away from water source
- Liquid waste (such as POC) buried or poured down a drain.

Ask how participants currently dispose of infectious waste at your facilities?
- Have a few participants respond.
- Identify those who are properly disposing of waste.

Explain that preventing injuries is always best, especially if post-exposure resources are not locally available.

13. Activity: Action Plan (15 min)

Explain to participants that they are now going to work in groups to create an Action Plan that demonstrates their commitment to improving infection prevention practices at their clinic facilities.

Have participants divide into groups of three to four, preferably by facility.

Ask them to take out the Infection Prevention Action Plan worksheet (Appendix K in Participants' Handbook). Have them take 8-10 minutes to fill out the remaining columns as a group.
- Where they answered “yes” in the “Do you?” column, they do not need to do anything further.
- Where they answered “no,” they should fill in the next column, “Could you?” (In other words, could they implement this technique once they return to their facilities?)
• If they could, they should indicate this.

• If they could not, they should indicate in the “Why not?” column the obstacles to implementing that technique. These may include personnel and material shortages, administrative policies, etc.

• In the final column, they should indicate how they plan to solve this problem and overcome the obstacles identified.

Tell participants: This is your Action Plan for implementing proper infection-prevention practices at your facility. What remaining questions do you have about infection prevention?

14. Summary (10 min)

• Summarize key points of module, using the objectives and Summary Section of this module in the Participants’ Manual for reference.

• Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 6: TYPES OF ABORTION PROCEDURES

Estimated Time: 5 hrs 35 min

Purpose

The purpose of this module is to familiarize participants with the use of medication for abortion and the features of the Ipas MVA Plus aspirator and Ipas EasyGrip Cannulae. Participants will also understand how to create an individualized pain management plan, and learn the steps to perform a manual vacuum aspiration (MVA) procedure, all within a woman-centered context.

Please note that this module is divided into the following sections:
Section 1: Medical Abortion
Section 2: MVA Instruments
Section 3: Steps for Performing Uterine Evacuation with MVA Procedure
Instructions for advance preparation are provided at the beginning of each section.

Show and review slide: Module Overview
This module is divided into three sections:
1. Medical Abortion
2. MVA Instruments
3. Steps for Performing Uterine Evacuation with MVA Procedure

Show and review slide: Module Objectives
By the end of this module, participants will be able to:
1. Describe the important role of MA in comprehensive health care for women
2. Describe the process for MA
3. Use the Ipas MVA Plus aspirator and Ipas EasyGrip cannulae properly.
4. Develop an individualized pain management plan.
5. Understand and perform the steps for performing uterine evacuation using MVA.
Section 1: Medical Abortion

Estimated Time: 1 hr 20 min

Preparation
- Prepare/copy the side effects continuum (below)
- Cut the side effects strips and mix them in a basket or bowl

Step-by-Step
Show and review slide: Section One (MA) Objectives
- List the eligibility requirements and contraindications for uterine evacuation with medical methods.
- Describe the essential information to be given to clients having UE with medical methods.
- Discuss regimens for uterine evacuation with medical methods using mifepristone plus misoprostol and misoprostol only.
- Explain the expected effects, side effects and potential complications of uterine evacuation with medical methods.
- List effective pain-management approaches and medication regimens for uterine evacuation with medical methods.

1.1 Mechanism of Action (5 min)
Show and discuss slide: Medical Abortion (MA)
- The combination of mifepristone plus misoprostol is more effective in achieving complete abortion than either drug used alone.
- MA is also effective, acceptable, and safe for adolescent and young women.

Remind participants that the combined MA regimen is more than 95% effective in first trimester pregnancies (in Nepal available up to 9 weeks LMP).

Efficacy and safety of medical abortion with mifepristone and misoprostol or misoprostol only were similar between younger and older women.

Show and review slide: Mifepristone
- First developed and approved for clinical use in 1988 in France (RU-486)
- Blocks progesterone activity in the uterus, leading to detachment of the pregnancy
- Causes the cervix to soften and uterus to contract

Show and review slide: Misoprostol
- Synthetic prostaglandin that stimulates uterine contractions
- Inexpensive, stable at room temperature (25 C) and readily available
- Commonly used for treatment of gastric ulcers
- Can also be used for cervical preparation before MVA, labor induction, prevention and treatment of postpartum hemorrhage, and treatment for missed or incomplete abortion.
Show and discuss slide: Expected Effects.

Show and discuss slides: Vaginal Bleeding
- Often accompanied by passage of clots
- Usually heavier than a menstrual period but sometimes may be lighter
- Bleeding most often starts within three hours after misoprostol administration and tends to decrease after the pregnancy tissue has been expelled
- Number of days of bleeding or spotting varies widely
- Most women bleed between 1-2 weeks
- Approximately 20% of women undergoing MA continued to bleed or spot for 35 to 42 days, which may include start of the first postabortion menses

Emphasize the importance of informing women about how much bleeding to expect and how long it might last.

Show and discuss slide: Cramping
- Most women experience some cramping, wide variation in the level of pain
- Some women do not notice cramping; others say the pain is intense.
- Most women fall somewhere in the middle.
- Cramping usually begins one to three hours after taking misoprostol.

Explain that as the uterus contracts and its contents are expelled through the cervix, women generally feel some degree of cramping, which diminishes soon after expelling passing the pregnancy tissue.

Show and review slide: Risk Factors for Pain
- Older age, having given birth before, and a higher number of previous births are associated with reduced pain.
- Young women and women who have never been pregnant tend to experience increased pain.
- Women with painful periods may also experience increased pain with MA independent of other factors such as age or reproductive history.

1.6 Potential Side Effects (5 min)

Explain that MA medicines may produce a range of relatively minor side effects that usually do not require treatment.

Show and discuss slide: Potential Side Effects

Side effects associated with misoprostol use include:
- Nausea
- Vomiting
- Diarrhea
- Fever, warmth, or chills
• Headache
• Weakness
• Dizziness

Explain that although these side effects are associated with misoprostol, they apply to women using the combination of mifepristone and misoprostol for MA. Some of these symptoms may be caused by the pregnancy itself rather than MA. These pregnancy symptoms can actually decrease after MA begins. Those symptoms that increase after taking misoprostol include transient fever and diarrhea as well as nausea and vomiting.

Show and review slide: Gastrointestinal Effects
• Nausea, vomiting and diarrhea are regularly reported following misoprostol
• Usually mild and last less than 24 hours

Show and review slide: Headache, Weakness, Dizziness
• Some women (about 20%) report headache (treat with analgesics)
• Mild dizziness (managed with hydration, rest)

Show and review slide: Fever, Warmth, Chills
• Short-lived fever (a feeling of warmth, chills, shivering)

1.7 Expulsion of Pregnancy (5 min)

Show and review slide: Expulsion of Pregnancy: Timing

With the mifepristone and misoprostol regimen before 9 weeks LMP, the median time from misoprostol use to expulsion is:
• Three hours with sublingual misoprostol
• Four hours with vaginal misoprostol

Show and discuss slide: Expulsion of Pregnancy: What the Woman Might See
• Most woman will see only blood and clots, some possibly large
• Occasionally women with pregnancies between 8-9 weeks may see a recognizable fetus though it is usually less than two centimeters in length (less than 2.3 cm).

Explain that at home women can flush everything that is expelled in the toilet or can dispose of it by burying it.

1.8 Activity: Side Effects Continuum (30 min)

Explain that women will experience a range of normal or “expected effects” as well as potentially other non-threatening “side effects” that may be bothersome but are not serious. To help women manage any side effects – and seek emergency care when needed – they must know what side effects may be possible, and must be able to distinguish between normal side effects and signs of more serious concerns.

Post the Side Effects Continuum at the front of the room and ask participants to choose a strip from a basket or bowl of the side effects strips.
Ask each volunteer to read their strip aloud and to state whether the woman:

1. Is experiencing a normal side effect – band aide symbol
2. Should call the clinic – phone symbol, or
3. Should visit the emergency room (E.R.) "H" (hospital) symbol

Ask the volunteer to tape the side effect strip on the continuum under the appropriate sign. After each side effect strip is placed on the continuum, ask learners if they agree with where the strip has been placed and correct it if need be.

Discuss a combination of symptoms that could “move” a minor side effect along the continuum of severity (for example, cramping is often a normal effect of MA, but if cramps are severe and pain pills don’t help, the woman should call the clinic)

Note to Trainer: As participants discuss the situations on the strips, take notes on a flipchart, distinguishing between: Expected Effects, Possible Side Effects, and Warning Signs; you can then use the flipchart when further reviewing these items later.

At the end of activity, return to the flipchart and ask participants to add any missing information, using their Participants’ Manual for reference.

Side Effects Continuum

<table>
<thead>
<tr>
<th>Common</th>
<th>Call Clinic</th>
<th>Go to Emergency Room (E.R.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗</td>
<td>✗</td>
<td>H</td>
</tr>
</tbody>
</table>

Side Effect Strips

Instructions: Make one copy of this sheet and cut it into strips, making a separate strip for each side effect situation.

| Cramping and vaginal bleeding like a heavy menstrual period, but less than 2 pads per hour |
| Vomiting and diarrhea 24 hours after taking misoprostol                                    |
| Woman is feeling worried during her MA and thinks she should go to the emergency room     |
| Fever and chills immediately after taking misoprostol                                     |
| One week after taking misoprostol, woman is soaking through 2 pads for 2 hours in a row   |
| Cramping has improved a little with ibuprofen but woman wants something more for pain     |
| Passing of heavy blood clots from her vagina within 4 hours of taking misoprostol        |
| Severe nausea and vomiting 24 hours after taking misoprostol                             |
| Weakness and feeling very sick, unable to easily get out of bed                          |
| Sudden feeling of fainting or already fainted                                            |
| Woman has foul-smelling vaginal odor and discharge with a fever                          |
| Bleeding in small amounts for 3 weeks after the MA                                      |
Answer Key: Side Effects Correct Placements

Cramping and vaginal bleeding like a heavy menstrual period, but less than 2 pads per hour

- Common

Vomiting and diarrhea 24 hours after taking misoprostol

- Call Clinic or Go to E.R.

Woman is feeling worried during her MA and thinks she should go to the emergency room

- Call Clinic

Fever and chills immediately after taking misoprostol

- Common

One week after taking misoprostol, woman is soaking through 2 pads for 2 hours in a row

- Go to E.R.

Cramping has improved a little with ibuprofen but woman wants something more for pain

- Call Clinic

Passing of heavy blood clots from her vagina within 4 hours of taking misoprostol

- Common

Severe nausea and vomiting 24 hours after taking misoprostol

- Call Clinic or Go to E.R.

Weakness and feeling very sick, unable to easily get out of bed

- Go to E.R.

Sudden feeling of fainting or already fainted

- Go to E.R.

Woman has foul-smelling vaginal odor and discharge with a fever

- Go to E.R.

Bleeding in small amounts for 3 weeks after the MA

- Common

1.9 Pain Management for MA (5 min)

Explain that most women find MA-related pain to be manageable, especially if they are prepared for the range of pain that might be experienced and take pain medicines as advised. Women should be provided with pain medication or a prescription at the time of their first visit.

Show and discuss slide: Pain Management for MA

The best regimen for pain control for MA has not been established.
• Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen are more effective than acetaminophen.
• Can be given with misoprostol or once cramping starts.

Ask participants what other methods may help women manage pain during the process. Responses may include:
• Counseling
• Creating a supportive environment
• Applying mild heat to the abdomen or lower back
• Hot bath or shower
• Music may help to manage pain

Emphasize that these methods are complementary but not adequate substitutes for pain management with medications.

1.10 Considerations for Postabortion Care (5 min)

Show and discuss slide: Misoprostol for Postabortion Care
• Eligibility criteria: open cervical os, vaginal bleeding or a history of vaginal bleeding during the pregnancy and uterine size less than 13 weeks
• Contraindications:
  o Previous allergic reaction to misoprostol or other prostaglandin
  o Known or suspected ectopic pregnancy
  o Signs of pelvic infection and/or sepsis
  o Hemodynamic instability or shock

Tell participants that potential side effects of misoprostol use for incomplete abortion are the same as those for induced abortion. Pain management should be offered to women using misoprostol for postabortion care.

Show and discuss slide: Misoprostol Regimen for Incomplete Abortion
• A single dose of 400 mcg sublingually or
• A single dose of 600 mcg orally

Tell participants that if the initial dose fails and the woman is clinically stable, options include expectant management or provision of MVA.

1.11 Summary (5 min)

Explain that this concludes the section on Medical Abortion.
• Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
• Ask if there are any remaining questions. Answer them or add to the Parking Lot.
Tell participants that this next section will focus on MVA instruments.
Section 2- MVA Instruments

Estimated Time: 1 hour 10 minutes

Preparation

- Have enough Ipas MVA Plus* aspirators, Ipas EasyGrip* cannulae, lubricant and product inserts adequate for practice and for sites, if instruments will be distributed.
- If possible, have samples of worn aspirators and cannulae that need replacing

Step-by-Step

Show and discuss slide: Section Two (MVA) Objectives

- Identify parts and features of the Ipas MVA Plus* and Ipas EasyGrip* cannulae.
- Disassemble and reassemble the Ipas MVA Plus* and Ipas EasyGrip* cannulae.
- Solve instrument technical problems.

Explain that information in this section is based on the product labeling for the Ipas MVA Plus aspirator and Ipas Easy Grip cannulae.

2.1 Description of MVA Instruments (10 min)

Show and review slide: MVA Plus*

- MVA aspirators are designed for multiple use
- Must be HLD or sterilized before first use, and after each procedure. Cannula must remain sterile at time of next use.
- Made of steam-autoclavable material

Use your aspirator set to show the participants the instrument parts while presenting the slides below. Point to each part of the aspirator as you mention it.

Show and discuss slide: MVA Parts Assembled

- Plunger with handle creates vacuum
- Valve buttons control release of the vacuum
- 60cc cylinder holds the products of conception (POC)
- Collar stop with retaining clip prevents plunger from coming out

Inform participants that the Ipas MVA Plus aspirator provides the same amount of vacuum as an EVA machine.

Hold up the cannulae and point to each aspect as you mention it.

Show and discuss slide: About the EasyGrip* Cannulae

- Same dimensions, apertures (openings) as Karman cannulae
- Slightly more rigid
- Permanently affixed base with wings
• Sizes 4, 5, 6, 7 and 8mm have two opposing apertures
• Sizes 9, 10, and 12mm have one larger, single-scoop aperture
• Dots on each cannula at 1cm intervals indicate location of main aperture

Explain that Ipas EasyGrip cannulae have permanent bases that act as built-in adapters. The cannulae connect directly to the Ipas MVA Plus aspirator without requiring a separate adapter.

Tell participants that the cannulae are sterilized before packaging and remain sterile until their expiration date as long as the packaging remains intact. Where regulations allow, these cannulae are reusable after they are sterilized or high-level disinfected.

Show and discuss slide: Selection of Cannulae

Depends on uterine size and amount of dilation:
• Uterine size 4–6 weeks LMP: suggest 4–7mm
• Uterine size 7–9 weeks LMP: suggest 5–10mm
• Uterine size 9–12 weeks LMP: suggest 8–12mm

Emphasize that it is important to use a cannula appropriate to the size of the uterus and amount of cervical dilation present. Using a cannula that is too small may result in retained tissue or loss of suction.

2.2 Indications for MVA (5 min)

Show and review slide: Indications for MVA
• Non-viable intrauterine pregnancy, incomplete abortion, or other spontaneous abortion in progress
• Undesired pregnancy of 12 weeks gestation or less
• No clinical evidence of active uterine or cervical infection
• Endometrial biopsy

2.3 Warnings and Precautions for MVA (5 min)

Show and discuss slide: Warnings and Precautions

As with any UE procedure, one or more of the following may occur during or after an MVA procedure:
• Vagal reaction
• Incomplete evacuation
• Uterine or cervical injury or perforation
• Pelvic infection or acute hematometra.

Explain that rarely, some of these conditions can lead to secondary infertility, serious injury, or death.
Ask participants what medical conditions should be addressed immediately before a MVA procedure. Responses may include:

- Shock
- Hemorrhage
- Cervical or pelvic infection
- Sepsis
- Perforation or abdominal injury as may occur with incomplete abortion or with clandestine abortion.

Emphasize that UE is often an important component of definitive management in these cases and once the patient is stabilized, the procedure should not be delayed.

Explain that history of blood dyscrasia may be a factor in the woman's care. In cases where the woman has a history of a blood-clotting disorder, Ipas cannulae and aspirators should be used only with extreme caution and only in facilities where full emergency backup care is available.

Emphasize that the provider should not perform uterine evacuation until the size and position of the uterus and cervix have been determined. Large fibroids or uterine anomalies may make it difficult to determine the size of the uterus and hard to perform intrauterine procedures, including MVA.

Inform participants that endometrial biopsy should not be performed in cases of suspected pregnancy. There are no known contraindications for other clinical indications.

2.4 Functioning of the Ipas MVA Plus Aspirator (5 min)

Remind participants that before a uterine evacuation procedure can take place proper preparation and counseling should be performed and a woman's informed consent should be obtained.

Show and review slide: Overview: The MVA Procedure

- A cannula is inserted through the cervical os
- Cannula is attached to an aspirator with a prepared vacuum
- Valve buttons are released to start the vacuum
- Cannula is used to aspirate the uterus as required
- Suction can be started and stopped as needed

2.5 Preparing a Vacuum and Checking Vacuum Retention (15 min)

Explain that a vacuum should be prepared in the aspirator and the vacuum should be checked before beginning the procedure. Creating a vacuum is sometimes called "charging" the aspirator.

Show and discuss slide: Creating a Vacuum

- Begin with valve buttons open, plunger all the way in and collar stop locked in place.
- Close valve by pushing buttons down and forward until they lock.
• Pull plunger back until plunger arms catch on wide sides of cylinder.
• Ensure that both arms are extended and secured over edge of cylinder.
• Incorrect positioning of plunger arms can allow plunger to slip back into cylinder.

Explain that providers should never grasp the charged aspirator by the plunger arms because it could lose vacuum or eject its contents.

Show and discuss slide: Check Aspirator for Vacuum
• Charge aspirator.
• Leave charged for several moments (let sit).
• Push buttons to release vacuum.
• A rush of air indicates vacuum was retained.

Explain that is the rush of air is not heard, providers should displace the collar stop, withdraw the plunger and check for the following:

Show and discuss slide: Checking Why Vacuum Fails
• Is the instrument properly assembled?
• Is the plunger O-ring intact, rather than nicked or damaged, free of foreign bodies and positioned in the groove?
• Has the O-ring been properly lubricate? Is it over-lubricated or not lubricated at all?
• Is the cylinder firmly placed in the valve?

Create a vacuum and test again. If vacuum is still not retained, use another aspirator.

Explain that now participants will have the opportunity to practice disassembling, assembling and charging the instruments.

Distribute an instrument set to each participant. Point out to participants the Ipas MVA Plus package insert containing product information that comes with every aspirator.
• Allow participants a few minutes to inspect and handle the aspirator and cannulae.
• Circulate around the room, coaching participants on correct disassembly, assembly and charging.
• Tell them to leave their instruments charged and not release the vacuum until they are instructed to do so.

Demonstrate how to release the valve buttons.
• Ask one person at a time to release the vacuum in their aspirators.
• Ensure that everyone has properly tested their aspirators.
• If they did not hear the rush of air indicating vacuum release, determine together why the vacuum failed.
2.6 Stopping and Starting Suction (5 min)

Show and review slide: *Stopping and Starting Suction*
- To start suction, release the valve buttons on the vacuum-charged aspirator.
- To stop suction, push the buttons to close the valve.
- During use, suction is started after the cannula is in place in the uterus.
- It may be stopped and started during the procedure, if needed.

2.7 Disposal and Replacement (5 min)

Explaining that the disposal of contaminated Ipas aspirators and cannulae as infectious waste. If any of the following have occurred, the instruments should be discarded and replaced:

Show and review slide: *Disposal and Replacement: Aspirators*
- Cylinder has become cracked or brittle
- Valve parts have become cracked, bent, or broken
- Buttons have broken
- Plunger arms no longer lock
- Aspirator no longer holds a vacuum
- Mineral deposits inhibit the plunger movement

Show and discuss slide: *Disposal and Replacement: Cannulae*
- Cannula has become brittle
- Cannula has become cracked, twisted or bent, particularly around the aperture
- Tissue cannot be removed during the cleaning process

2.8 Solving Technical Problems (15 min)

**ASK:** What is the most common problem seen with MVA instruments?

**ANSWER:** Loss of vacuum

Ask why a decrease in vacuum might occur before the aspiration is complete. Take a few responses before showing the next slide.

Show and review slide: *Possible Causes for Vacuum Decrease*
- The aspirator is full.
- The cannula is withdrawn past the external os prematurely.
- The cannula is clogged.
- There is a loss of vacuum due to incorrect assembly.

Show and review slides: *What to Do - Aspirator is Full*
- If the cylinder fills up so that suction stops, depress the buttons and detach the aspirator from the cannula.
• The cannula should be left in its current position, inserted through the cervical os.
• Empty the aspirator into a container by releasing the buttons, squeezing the plunger arms and pushing the plunger forward.
• After re-establishing a vacuum in the aspirator, reconnect it to the cannula, release the buttons and resume the aspiration.
• Many providers keep a second aspirator readily available during an MVA procedure and switch aspirators if the first one becomes full.

Show and review slides: *What to do - The Cannula is Withdrawn Past the External Os Prematurely*
• Remove the cannula, being careful not to contaminate it through contact with the vaginal walls or other non-sterile surfaces.
• Detach the aspirator from the cannula, empty it and then reestablish a vacuum in the aspirator.
• If the cannula has not been contaminated, it can be reinserted.
• If contamination has occurred, another sterile or HLD cannula should be inserted using no-touch technique.
• Reconnect the aspirator, release the valve, and continue aspiration.

Explain that if the cannula becomes clogged, a lack of tissue or bubbles flowing into the aspirator will be noted.

Show and discuss slide: *What to do - The Cannula is Clogged*
• Ease the cannula back toward, but not through, the external os of the cervix.
• Alternately, depress the buttons, close the valve on the aspirator and withdraw the cannula from the uterus, taking care to prevent contamination.
• Remove the tissue from the opening in the cannula with sterile or HLD forceps.
• Reinsert the cannula using no-touch technique, reattach the aspirator and continue the procedure.

Emphasize to *never* try to unclog the cannula by pushing the plunger back into the cylinder while the cannula is in the uterus.

Explain that if there is a loss of vacuum due to incorrect assembly reassemble and test the vacuum of the instrument.
2.9 Summary (5 min)

Explain that this concludes the section on MVA Instruments.

- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
Tell participants that the next section will focus on pain management and the MVA procedure.

Section 3 - Steps for Performing an MVA Procedure

Estimated Time: 3 hr, 5 min

Preparation

- Have Ipas MVA Plus® aspirators and EasyGrip® cannulae available.
- Obtain one copy of the wallchart, Steps for Performing MVA Using the Ipas MVA Plus® and Ipas EasyGrip® Cannulae wallchart for each service delivery site represented.
- Set up pelvic model and supply stations for demonstration and simulated practice.

For each station:

- Pelvic model (Some pelvic models can only accommodate size 6mm cannulae and smallest dilators. If not available, pelvic models can be ordered from Ipas.)
- Fabric to cover the model's perineum for "privacy"
- Gloves
- Speculum
- Small metal cup for antiseptic
- Sponge holder for preparing cervix and wiping it at end of procedure
- Gauze X 3 for prep and wiping cervix twice and once at the end of procedure
- 10cc hypodermic syringe
- 23 gauge 1.5" needle
- 1 % Xylocaine for cervical block
- Dilators (a few small ones for simulation purposes)
- Cannulae
- Aspirator
- Medium basin to hold discharged POC

Tissue examination table (Groups of participants can take turns using one table.)

- Lamp
- Glass dish

Sink (or simulated sink) (Groups of participants can take turns using one)

- Strainer
Step-by-Step

Show and discuss slide: Section Three (PM/MVA Steps) Objectives

- Make an appropriate pain management plan to address all sources of pain and taking into account the woman’s preferences.
- Describe the steps for MVA.
- Demonstrate the MVA procedure in simulated practice (using a pelvic model).

3.1 Activity: Reflecting on pain and how to stay comfortable (10 min)

Have participants think back to a specific time in their life when they were afraid of impending pain. Imagine there was someone there to ease his or her fear and apprehension. What would they have wanted the person to say or do to provide comfort?

Ask a few participants to tell about the experience they have remembered. Discuss and summarize points relevant to assisting clients having an abortion.

3.2 Pain management (10 min)

Explain that women who present for uterine evacuation should be offered all pain management options and provided these services without delay.

Explain that many providers underestimate the amount of pain a woman experiences during the procedure.

Show and review slide: Pain Management

- Most women will experience pain
- Goal: help the woman remain as comfortable as possible, while minimizing medication-induced risks and side effects
- Gentle, respectful care along with providing appropriate information can help reduce anxiety and pain

Show and discuss slide: Sources of Pain Associated with MVA

- Anxiety or depression
- Cervical dilation
- Uterine manipulation

ASK: what happens when a woman has high levels of anxiety before and during an MVA procedure?

Answers may include:

- It may become difficult for her to lie still on the table
- Her muscles may tighten making it more difficult and painful

ASK: what can they as providers do to help decrease a woman’s anxiety or nervousness?
Answers may include:
- Counsel the woman about any emotional stress she is feeling about her choice to terminate her pregnancy
- Assure the woman of a gentle clinical technique
- Provide information so she will know what to expect

**ASK**: How can cervical dilation contribute to a woman's experience of pain?

**Answers may include**:
- The network of fibers around the cervix that transmits pain is related to stimulating the os during the dilation process
- Using the smallest dilator possible can help
- Gentle clinical technique can lessen pain

Explain that providers can address pain from cervical dilation through the use of paracervical block and non-steroidal analgesics such as ibuprofen.

Tell participants that that lower abdominal pain with cramping is associated with movement of the uterus, movement of the cannula against the uterine walls, and the spasm of muscles referred to emptying of the uterine cavity that marks the completion of the procedure.

Explain that the uterine pain is transmitted from the fundus of the uterus along major uterine nerves that follow the uterine ligaments.

**ASK**: What can be used to address pain from uterine manipulation?

**ANSWER**: Pain analgesics such as ibuprofen, other NSAIDs or narcotics

**ASK**: Who should create the pain management plan?

**ANSWER**: the provider should create it with the woman through discussion and clinical assessment prior to the procedure.

**Show and review slide**: *Pain Management Methods*

Pain during a MVA procedure can be reduced with a combination of the following:
- Verbal support
- Oral medications
- Paracervical block
- Skilled, gentle clinical technique
- Calming environment

**Show and discuss slide**: *Key Components of Creating a Pain Management Plan*
- Explain the procedure
- Discuss types of pain she might experience
- Discuss pain management options
- Explain risks and benefits
- Ask her about her preferred support measures. Conversation to distract her or silence?
- Together, choose a plan that meets her individual needs

Emphasize that it is important for women to have a sense of control over which options are chosen.

Show and discuss slide: *Example of a Pain Management Plan*

This plan meets the needs of many women receiving abortion care:
- Oral analgesics administered 30 minutes prior to the MVA procedure
- A paracervical block
- Verbal reassurance and gentle clinical technique

Ask participants what factors should be taken into account when creating a pain management plan. Record their responses on a flipchart paper. Ensure the following are discussed:
- The woman’s physical status and medical history: providers should determine if the woman has any medical problems, which medications she uses on a regular basis, and whether she has any allergies
- The degree of cervical dilatation necessary
- Any psychological concerns, such as anxiety
- The skill of staff members and the nature of the procedures they will be performing
- The availability of pain medications, instruments and supplies

### 3.3 Methods for pain management (10 min)

Show and discuss slide: *Pharmacological Methods for Pain Management*

- Analgesics
- Anesthetics
- Anxiolytics

Emphasize that it is important that any medication administered to the woman be in full effect by the time the procedure begins.

Show and discuss slide: *Goal of Pharmacological Methods*

Administer enough medication to last through the procedure, but not so much that the effects last long after the procedure is complete

Review the following key points. Refer participants to their Reference Manual for more information.

**Analgesics**
- Premedication with non-steroidal analgesics such as ibuprofen is effective
- Paracetamol is not effective
Anesthetics
- Paracervical block is recommended for most women undergoing an MVA procedure
- Regional anesthesia or conscious sedation may be used in some cases
- General anesthesia is not recommended

Anxiolytics
- Premedication with anxiolytics such as lorazepam may be of benefit to some women but routine use is not recommended

Emphasize that nonpharmaceutical methods, such as verbal reassurance, are not substitutes for pharmacological methods of pain control, but rather useful supplements to them.

Explain that during a MVA procedure the woman is usually awake. A woman may feel more relaxed if it is a nurse, assistant or companion talks with her during the procedure. It is important to ask the woman what she thinks might be helpful to her, some women prefer silence.

Ask participants what other strategies for verbal and physical reassurance may be helpful. Responses may include:
- Hold her hand, rub her arm
- Distract her with talking about work or family
- Telling her that the cramping she is feeling means the procedure is almost complete

Ask participants what gentle clinical technique means. Responses may include:
- Ensuring all instruments are at a comfortable temperature before they come into contact with her
- Using smooth motions and gentle technique as instruments are inserted and moved
- Informing women that they are going to touch her and explain what she is going to feel before performing the action
- Avoiding jerky or sudden movements

3.4 Activity: Pain management plan case studies (30 min)

Refer participants to Pain Management Case Studies in the Participants’ Handbook (Appendix N). Participants will work in groups of three or four to review ALL of the case studies and develop one possible pain management plan that reflects the concerns expressed by the woman. Plans should address all sources of pain.

Each group reports on one of the case studies. Allow everyone to comment on the cases after each group report.

Trainer’s Note: Refer to the Pain Management Case Studies Answer Key below for possible options of pain management plans.
Pain Management Plan Case Studies Key

Case 1: Shalini

Anxiety:
- Preferred support measures? Provider will be quiet; someone will hold her hand.
- Anxiolytics/sedatives? Does not want to be groggy and wants to go home quickly, so none used.

Pain of Cervical Dilatation: Paracervical block.

Pain of Uterine Manipulation: Oral analgesic, such as ibuprofen, 45 minutes before the MVA procedure.

Case 2: Vasanthi

Anxiety:
- Preferred support measures? An assistant will closely monitor her emotions, constantly encouraging, advising and supporting her.
- Anxiolytics/sedatives? 10 mg Diazepam orally 45 minutes before the MVA procedure; consider additional dose. Be prepared to reconsider pain management plan if nervousness increases.

Pain of Cervical Dilatation: Paracervical block.

Pain of Uterine Manipulation: Oral analgesic, such as ibuprofen, 45 minutes before the MVA procedure.

Case 3: Namita

Anxiety:
- Preferred support measures? An assistant will closely monitor her emotions, constantly encouraging, advising and supporting her.
- Anxiolytics/sedatives? Administer PO or IV anxiolytic, such as Diazepam or sedative; consider slightly higher or additional dosage; closely monitor respirations; reconsider pain management plan if nervousness increases.

Pain of Cervical Dilatation: Paracervical block; consider priming cervix with misoprostol. If stenosis is present or tear is extensive, consider increasing sedation.

Pain of Uterine Manipulation: Oral analgesic, such as ibuprofen, 45 minutes before the MVA procedure.
Case 4: Tārini

Anxiety:
- **Preferred support measures**: An assistant will closely monitor her emotions, constantly encouraging and advising her; her mother and the assistant will stay by closely supporting her until she is anesthetized and once she awakens.
- **Anxiolytics/sedatives**: Will likely need general anesthesia.

**Pain of Cervical Dilatation**: Will not likely administer paracervical block due to use of general anesthesia.

**Pain of Uterine Manipulation**: General anesthesia will address this pain.

### 3.5 Steps of the MVA procedure (40 min)

Show the wallchart Steps for Performing MVA Using the Ipas MVA Plus and Ipas EasyGrip Cannulae and refer participants to Steps for Performing MVA in their Participants’ Manual. Have them follow along.

**ASK**: What is the most important part of the clinical assessment that needs to be confirmed before a uterine evacuation with MVA?

**ANSWER**: Confirming uterine size

**ASK**: What can make an accurate estimation difficult?

**ANSWER**: Large fibroids or uterine abnormalities

***Emphasize that providers should be well trained in determining the length of pregnancy prior to using MVA.***

**Show and discuss slide: Step 1: Prepare Instruments**

- Check that the aspirator retains a vacuum.
- Have more than one aspirator available.

Tell participants to have more than one aspirator available in case of technical problems or in case there are copious POC (i.e., hydatidiform mole).

**Show and discuss slides: Step 2: Prepare the Woman**

- Ensure pain medication is given at the appropriate time.
- Administer antibiotics.
- Ask the woman to empty her bladder.
- Help her onto the table.
- Ask for her permission to start.
- Wash hands and put on appropriate barriers, including gloves.
- Perform a bimanual exam to confirm or update earlier findings.
- Select and insert speculum.
Explain research has shown that routinely providing antibiotics to women undergoing MVA reduces infection. Give prophylactic antibiotics to all women and therapeutic antibiotics if indicated.

Show and discuss slide: *Perform Bimanual Exam*

Tell participant that if there is doubt about the uterine size but the provider must continue with the procedure, the pregnancy should be treated as if it is further advanced than was initially suspected.

Show and discuss slide: *Step 3: Perform Cervical Antiseptic Prep*

- Follow No-Touch Technique.
- Use antiseptic sponges to clean cervical os, cervix and, if desired, vaginal walls.
- With each new sponge, start at the os and spiral outward.
- Continue until the os has been completely covered by antiseptic.
- Do not clean the cervix with the same gauze used for cleaning the vagina.

Remind participants that “No-Touch Technique” means handling instruments so that the part that will enter the sterile uterus does not touch any other surface, including gloved fingertips or vaginal walls.

Emphasize that No-Touch Technique is important because infection can start when vaginal or other flora is introduced into the uterus during the procedure. No-Touch Technique must be used throughout the procedure.

**ASK:** Why is the cervical antiseptic preparation important?

**ANSWER:** During the procedure, microorganisms in and around the vagina are very often transferred through the os into the uterus, or by the block needle to deep cervical tissue, where they can cause infection.

**ASK:** Why is it important not to retrace with the sponge?

**ANSWER:** Retracing with the sponge can cause contamination by carrying microorganisms from unswabbed areas onto already-cleaned areas.

Show and discuss slide: *Step 4: Perform Paracervical Block*

Explain that most women experience pain when the cannula is inserted through the os, as well as when the os contracts after the evacuation. Since paracervical block aids in preventing pain and is unlikely to cause harm, it is recommended that it be administered to all women needing uterine evacuation.

Emphasize that paracervical block is safe and easy to do and may be done by midlevel providers.

Show and discuss slides: *Step 4: Perform Paracervical Block*

1. Load a 10 mL syringe with 1% plain xylocaine (10 ml).
2. Attach the 20-gauge hypodermic needle to the syringe. (Other needles may be used, such as a spinal needle or the needle from an IV insertion set.)
3. Inject 2 mL superficially into the cervix at the site where the vulsellum or tenaculum will be placed (12 o’clock).

4. Grasp the cervix with the vulsellum/tenaculum. Use slight traction to push the cervix inward and to the side firmly to expose the tissue where the cervix meets the vagina, first on one side and then the other. This transition marks the site of further injections around the cervix. Compared to cervical tissue, vaginal mucosa is more elastic and appears folded.

5. Inject the remaining 8 mL in equal amounts at the cervicovaginal junction at 2, 4, 8 and 10 o’clock. The injection is continuous from superficial to deep to superficial to a depth of 3 cm. These superficial tissues can bleed briefly, but it is not serious, and the uterine vessels are several centimeters away. Always aspirate before injecting to prevent injecting into a vein.

6. Wait 3 minutes before dilating the cervix.

Emphasize that it is important to aspirate before injecting to be sure the needle is not in a vessel, which can cause very serious problems.

**Show and discuss slides: Step 5: Dilate the Cervix**
- Dilatation required in most but not all cases.
- Dilatation is not needed when the cervix allows a cannula or appropriate size to fit snugly through the os.
- Cervical dilatation is an essential step if the cervix is closed or is not yet sufficiently dilated.
- Carefully examine the position of the uterus and cervix.
- Use instruments that accommodate the woman's anatomy.
- Cannula should fit snugly in os.
- Dilate gently, never using force.
- Use mechanical dilators or progressively larger cannulae.

Emphasize being careful to not tear the cervix or create a false opening. This is important to keep in mind, as the cervical tissue will be softened with pregnancy.

Explain that the tenaculum or volsellum can be used to straighten the cervical os to allow for easier passage of the dilators.

Warn that uterine perforation can occur, particularly if the provider miscalculates the position, size, and depth of the cervix and uterus or uses force to insert instruments.

Explain that dilatation or cervical preparation may also be accomplished by administering pharmacological agents such as misoprostol, where available.

**Show and discuss slide: Cervical Preparation**
- Recommended before MVA for all women over 12-14 weeks
- Providers may offer cervical preparation before 12-14 weeks but do not need to use it routinely

Explain that deciding if cervical preparation should be used for first trimester abortion is a matter of weighing the various factors, both positive and negative. Ask participants what factors may impact the decision to prepare the cervix. Responses may include:
Negatives

- Side-effects from the medicine or dilators including increased pain, bleeding and nausea.
- Increases the complexity, cost and time needed to perform an abortion.

Positives

- For women at higher risk of complications (young women, nulliparous women, women with cervical abnormalities, or women at later gestational ages) or inexperienced providers, there may be a benefit from cervical preparation even before 12-14 weeks gestation.
- Decreased procedure time and a decreased risk of incomplete abortion compared to women without cervical preparation.

Refer participant to the table “Examples of Dose/Route/Timing of Misoprostol” in their Participants’ Handbook. Explain that the choice depends on availability, expense, convenience and preference.

Show and review slides: Using Misoprostol to Prepare the Cervix

- Vaginal misoprostol has fewer systemic side-effects than sublingual misoprostol.
- Misoprostol should not be given more than three hours before an abortion as it increases the risk that a woman would expel her pregnancy before the procedure can occur.
- Side effects may include chills, fever, nausea, vomiting and diarrhea.
- Side effects may also include bleeding, cramping and risk of expelling the pregnancy prior to vacuum evacuation.
- Increasing the vaginal dose to 600 µg or 800 µg gives similar dilation rates to the 400 µg dose, with more side effects.
- Misoprostol has been shown to be as effective as mechanical (for example, laminaria) dilators.

Show and discuss slide: Step 6: Insert Cannula

- Gently apply traction to the cervix.
- Rotate the cannula while gently applying pressure.
- Insert cannula just past internal os.
- Alternately, insert cannula slowly until it touches the fundus, and then draw it back.

Emphasize for providers to not insert the cannula forcefully through the cervical os into the uterus. Explain that forceful movements may cause damage to the cervix or uterine perforation and damage to pelvic organs and blood vessels.

Tell participants to remain alert to signs that may indicate perforation throughout the procedure, and stop suction immediately if they appear.

ASK: Why is it important to use a cannula that is the appropriate size of the uterus and amount of cervical dilation present?

ANSWER: Using a cannula that is too small may result in retained tissue or loss of suction.
Show and discuss slide: Step 7: Suction Uterine Contents
- Attach charged aspirator to cannula.
- Hold tenaculum and end of cannula in one hand and aspirator in the other.
- Release buttons to start suction.
- Gently rotate cannula 180 degrees in each direction.
- Use a gentle “in and out” motion.
- Do not withdraw cannula opening beyond external os.

Explain that blood and tissue will be visible entering the cylinder of the aspiration device through the cannula.

Explain that if the opening of the cannula is withdrawn beyond the cervical os this will cause the vacuum to be lost. Remind participants that if the vacuum is lost, or if the aspirator is full, detach the cannula from the aspirator and re-establish the vacuum.

Emphasize that care should be used when disconnecting a cannula from the aspirator as the EasyGrip cannulae fit firmly into the valve body.

Remain alert to signs that may indicate perforation throughout the procedure and stop.

Show and review slide: Signs That the Uterus Is Empty
- Red or pink foam without tissue passing through cannula
- Gritty sensation over surface of uterus
- Uterus contracting (grips) around cannula
- Increased uterine cramping or pain

Show and discuss slide: When the Procedure Is Finished
- Depress buttons down, and then disconnect cannula from aspirator.
- OR carefully withdraw cannula and aspirator from uterus together without depressing buttons.
- Keep instruments ready in case re-aspiration is required.

Explain that the wings can aid in disconnecting the cannula from the aspirator.

Show and discuss slide: Step 8: Inspect Tissue
- Empty contents of aspirator into container/strainer
- Remove the cannula, if still connected
- Release the buttons, if not depressed
- Gently push the plunger completely into the cylinder

Emphasize to not push the aspirated contents through the cannula, as it will become contaminated.

Tell participants to keep the instruments ready in case further suction is required.
Show and discuss slide: *Inspect Tissue For:*
- Quantity and presence of POC
- Complete evacuation
- Molar pregnancy

Explain if the visual inspection is not conclusive; the material should be strained, immersed in water or vinegar, and viewed with light from beneath. If indicated, tissue specimen may also be sent to a pathology laboratory.

Explain that villi and decidua should be visible in the tissue and the amount of tissue should correspond to the uterine size.

Explain that in cases of molar pregnancy, grape-like chorionic villi are usually seen.

Ask participants what it might mean if the tissue inspection shows less tissue than expected or tissue sample is inconclusive.

Show and discuss slide: *Possible Reasons for Less than Expected Tissue*
- Incomplete abortion
- Spontaneous abortion
- Failed abortion
- Suspected ectopic pregnancy
- Anatomical anomaly

Refer participants to their manuals for more details on each of these cases.

Explain that if it appears after tissue inspection that tissue may still be present in the uterus, re-evacuate the uterus.

Show and review slide: *Assess Bleeding*
- Wipe the cervix clear with a clean swab to assess the amount of blood still coming from the uterus or any other source before removing the speculum.
- If significant bleeding continues or other issues are identified, intervene as needed.
- Use clinical judgment to determine if a bimanual exam will be necessary to check the size and firmness of the uterus.

Show and discuss slide: *Step 9: Perform Any Concurrent Procedures*
- If tissue inspection results are satisfactory, perform and needed or desired concurrent procedures.

Ask what concurrent procedures might be conducted immediately after the MVA procedure is complete? Responses may include:
- IUCD insertion
- Performing female sterilization
- Repairing of a cervical tear.
- Contraceptive implant insertion
Show and review slides: Step 10: Post-Procedural Steps and Instrument Processing

- Immediately process or discard all instruments, including the aspirator and cannula.
- Remove barriers, such as gloves, and wash hands.
- Reassure the woman that the procedure is finished.
- Help her into a comfortable resting position on the table.
- Assist with moving her to the recovery area.
- Record information about the procedure, according to local protocol.

Refer participants to module 5 for information on instrument processing.

3.6 Considerations for Postabortion Care (5 min)

Show and discuss slide: MVA for Postabortion Care

- Postabortion care can be an emergency situation, and the woman's condition can change quickly at any point during her care.
- Women who are unstable due to hemorrhage or sepsis need to be stabilized and treatment started immediately.
- Cervical dilatation is required in some cases.
- Pain management should be provided, including paracervical block, to address pain due to cervical manipulation.

Tell participants that they should remain alert for changes in the patient's emotions and physiology throughout the procedure, as these changes may indicate complications. If a woman is unstable or becomes unstable, treatment may require immediate uterine evacuation.

3.7 Activity: Practicing MVA Procedure with a Pelvic Model (75 min)

Pelvic Model Demonstration

Explain that now there will be a demonstration with a pelvic model.

Note to Trainer: Pelvic model practice should simulate clinical practice as closely as possible, including infection prevention and client interaction. All participants should achieve simulated competence on a pelvic model before they perform on actual women during the clinical practicum.

Perform a demonstration of the uterine evacuation procedure on a pelvic model for the entire group.
- Refer participants to the Uterine Evacuation Procedure With Ipas MVA Plus Skills Checklist in the Participants' Handbook (Appendix H).
- Ask a volunteer to stand next to you and read each step of the checklist aloud as you demonstrate.
- Ask another volunteer to sit at the head of the procedure table and act the part of the woman.
- Ask participants to follow along on their copy of the checklist as they watch the demonstration.
Note to trainer: Ensure that the demonstration is realistic. As you perform every step of the procedure, use standard precautions and speak to the volunteer "woman" as you would speak to an actual woman.

Following the demonstration, answer questions about the demonstration and incorporate discussion of possible adverse events as they might occur.

Switch roles: Ask the volunteer who played the role of the woman to demonstrate the procedure while you read the checklist out loud. Ask the volunteer who read the checklist to now play the role of the woman.

Simulated practice with pelvic models - for participants

Tell participants that they will now practice the procedure themselves.

Divide participants into groups of four.

Each group is to perform simulated practice of the uterine evacuation procedure at pelvic model stations. Ask one participant to be the provider and perform the procedure while another participant plays the observer, reading the checklist aloud. Another participant should play the role of the woman and the fourth the support person.

At the end of each demonstration, the provider should first give feedback describing their experience. Then the support person, the woman and the observer should give the provider feedback about skills that were performed well and areas for improvement.

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

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

Evaluate each participant's performance using the checklist when they indicate that they are ready. Other participants can continue practicing while you conduct evaluations. All participants must be evaluated as competent with simulated practice on a pelvic model before they can perform on actual women during the clinical practicum.

Make arrangements for participants who fail to reach competency at this time to have additional practice and evaluation.

Answer any final questions that participants have about the MVA procedure.

3.8 Summary (5 min)

Explain that this concludes the section on pain management and the MVA procedure.

- Summarize key points of section, using the objectives and summary section in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 7:
POST-PROCEDURE CARE AND FOLLOW-UP

Estimated Time: 1 hr and 40 min

Purpose
The purpose of this module is to review all services that should be provided after an abortion, identify and address any complications that occur during or immediately after an abortion, and provide women with information about how to identify and seek treatments for any complications that could arise after she has left the facility.

Preparation
- Draw a large table on three newsprints with three columns and seven rows. Label the columns “Problematic Bleeding,” “Description,” and “Treatment.” Label the rows “Persistently Heavy Bleeding,” “Not heavy but prolonged and erratic,” “Erratic bleeding,” “Hemorrhage,” “Delayed bleeding,” and “Ongoing pregnancy.”
- Determine if participants will provide post-procedure care themselves or will supervise other health-care workers and adapt section accordingly.

Step-by-Step

1. Introduce module and state objectives (5 min)

Show and review slide: Module Overview
- Steps and purposes of post-procedure monitoring
- Assessment of physical and emotional state during recovery
- Postabortion contraceptive need
- Follow-up appointment and referrals
- Discharge instructions, including how to monitor for danger signs that may indicate complications

Show and review slide: Module Objectives

By the end of this section, participants should be able to:
1. Explain post-procedure assessment and monitoring.
2. Describe the immediate post-procedure steps and discharge procedures.
3. Provide follow-up care after MVA and MA
2. Immediate care after abortion service (10 min)

Explain that once the MVA procedure is finished, the woman will require high-quality post-procedure care.

Show and discuss slide: Post-Procedure Care
- Care provided after uterine evacuation completed
- Any physical complications addressed
- Woman informed about her condition and self-care
- Woman is provided with contraceptive method, if desired
- Ends when she is discharged

Say: As clinicians, we already know how to provide post-procedure care, sometimes called “after-care,” for women in general. Many of the aspects of care for women who have received abortion-related services are the same as those of post-procedure care in general. What different conditions, physical or emotional, might be particular to women after abortion-related services? Responses may include:
- Women may experience a range of emotions
- She may have abdominal pain, undetected injuries or bleeding that is not visible to the provider.

Show and review slides: Elements of Post-Procedure Care
- Physical monitoring
- Emotional monitoring and support
- Information and follow-up for other health-related issues
- Contraceptive counseling and provision
- Providing discharge instructions
- Scheduling follow-up care if she desires and providing referrals

Refer participants to the Post-Procedure Care Skills Checklist in their Participants’ Manual (Appendix I). Ask participants to follow along with the checklist as you discuss the elements of post-procedure care.

3. Monitors the woman’s physical status (15 min)

Show and discuss slide: Physical Monitoring
- Ensure that the woman is resting comfortably.
- Take her vital signs immediately.
- Review chart for condition, history, baseline vital signs.
- Monitor physiological status, including vital signs.
- Evaluate bleeding and cramping at least twice.
- Continue therapy for any existing problems.
Explain to participants that vital signs should be observed until the woman is ready to be discharged. This will usually occur within 30 minutes after the procedure, but can vary.

**ASK:** Why is it important to evaluate bleeding, cramping, pain, and vital signs at least twice during the post-procedure period?

**ANSWER:** You need a baseline evaluation and then a second evaluation to determine if there has been any change—for better or worse—in her status.

*Show and discuss slide: Physical Monitoring (contd)*

Assess and manage complications, referring if needed:

- Significant physical decline
- Dizziness, shortness of breath, fainting
- Severe vaginal bleeding
- Severe abdominal pain, cramping
- Enlarged and tender uterus

Tell participants that the passage of clots and soakage of more than two pads per hour for two hours indicates ongoing heavy bleeding and should be addressed. Ask what other signs could indicate excessive vaginal bleeding. Responses can include:

- Appear pale
- Increasingly weak
- Diminished consciousness
- Abdominal pain
- Drop in blood pressure
- Increase in heart rate
- Dizziness, shortness of breath, fainting

*Show and discuss slide: Post-Procedure Pain Management*

- Evaluate pain level, patterns.
- Offer choices for pain relief.
- Administer, monitor pain medications.
- Offer empathy and non-pharmacologic support such as warm compresses in addition to pain medications.
- If a woman’s pain increases, she needs attention.

Tell participants that levels of pain, bleeding, and cramping cannot be measured in exactly the same way for all women. Although there are norms, providers must be alert to differences among women.

Explain to participants that although some post-procedure cramping is normal, the severity of cramping should decrease over time. Severe, prolonged cramping may be a sign of uterine perforation or postabortal hematometra, which is a pooling of blood in the uterus that can occur following uterine evacuation.
Postabortal hematometra can present either immediately following the procedure or several days later. Signs of a hematometra include an enlarged, tender uterus.

4. Provides emotional monitoring and support (5 min)

Show and discuss slide: Emotional Monitoring and Support
- Assess and monitor the woman's emotions.
- Respond sensitively to her emotional state.
- Treat a woman gently.
- Offer counseling or referrals.

Emphasize that when health care providers demonstrate empathy and employ effective communication skills, clients are more satisfied with their care.

Explain that a woman's emotional state affects the amount of pain she experiences and her rate of recovery.

5. Provides information and addresses other health-related issues (5 min)

Tell participants that the post-procedure recovery period gives providers an opportunity to provide women with information and education, and address other health-related needs as appropriate.

Show and discuss slides: Post-Procedural Information and Follow-up
- Clear, simple, verbal and written instructions for self-care
- Instructions about how to monitor recovery and signs of normal recovery
- Behaviors and activities that may place her at higher risk of complications
- Warning signs of complications and where to get help
- Information about other health-related issues
- Information about return to sexual activity and contraception (if desired)

Explain to participants that, with the woman's consent, providing information to the woman's partner or other supportive family member or companion can help monitor her health and seek treatment for any problems.

Ask what other health-related issues can be addressed. Responses can include:
- Reproductive tract infections (RTIs)
- STIs, including HIV
- Cancer screening
- Infertility
- Domestic and sexual violence
- Anemia and other nutrition-related issues

ASK: after an uncomplicated abortion, when can a woman begin having vaginal intercourse.
ANSWER: As soon as she desires to do so.
• Emphasize to provide information to women that conception can occur within 8 days after a first trimester abortion.

Encourage the use of an effective form of birth control when having intercourse if she desires to prevent pregnancy.

6. Provides contraceptive counseling (10 min)

Show and discuss slide: Postabortion Contraceptive Counseling and Services
• Should be provided during the recovery period, prior to discharge, if not yet offered

Review key points for postabortion contraceptive counseling and services:
• Sensitively initiate a conversation about the woman’s desire for future childbearing both in the short- and long-term.
• If the woman wants to prevent pregnancy, ensure she receives the method of her choice before leaving the facility (or that she knows where to get her desired method).
• If her desired method is not clinically appropriate at this time, offer a temporary method.
• Inform all women about emergency contraception.
• Provide EC to women who choose to not start a routine method immediately.
• Discuss STI and HIV prevention and condom use with all women, regardless of contraceptive choice.
• Dual protection should be promoted, especially for women at increased risk for STIs/HIV.

7. Provides discharge instructions (10 min)

Show and review slide: Recovery and Discharge

Post-sedation protocols will vary by site. Full recovery generally means:
• The woman is awake, alert and able to walk without assistance
• Normal vitals
• Agrees that she feels ready to leave
• Slowed bleeding, decreased abdominal pain

Show and review slides: Before Discharge

If the woman aborts in the clinic:
• Observe the expelled tissue, if possible, to confirm a complete abortion.
• Review postabortion instructions and provide information on warning signs.
• Encourage the woman to contact or return to the clinic with any problems, questions or concerns.
• Provide a contraceptive method, if desired by the woman.

If the woman leaves the clinic before she aborts:
• Ensure that she has instructions and supplies relevant to aborting in non-clinical setting.
• Provide her with pain medication to take away from clinic.
For all women undergoing MA:

- Follow-up visit can be scheduled within 2 weeks if a woman desires to be followed up. If the women cannot visit the facility she should know where to contact if in case of emergency.
- Review instructions and provide information on warning signs indicating the woman should contact the clinic.
- Provide a contraceptive method if desired.

Show and review slide: *Discharge of Women with Complications*

- May need additional discharge instructions.
- Emphasize the importance of follow-up care.
- Develop protocols for following up with women who are at high risk of delayed complications or adverse sequelae.

8. **Arranges for follow-up care as desired or needed (5 min)**

Show and discuss slide: *Follow-Up Care*

- Not required after a routine MVA procedure.
- Schedule a follow-up appointment according to the woman's desire or need.
- Secure her consent before releasing records to follow-up provider.
- Provides referrals for health services that cannot be provided currently or during the follow-up visit.

Emphasize that referral protocols and resource lists should be in place.

Explain that this concludes the section on Post-Procedure Care. Tell participants that the next section focuses on Follow-up Care for MA.

9. **Follow-up care for MA (30 min)**

Refer participants to Appendix J: Follow-Up Care Skills Checklist in their Participants' Manual as a reference for this next section.

Explain that a follow-up visit after MA or MVA is not recommended by the WHO but if the woman feels she is uncomfortable and wants to follow-up then this can be done at 2 weeks.

In general women who feel that had a successful MA do not need further care. If desired, providers can follow up by phone for MA.

Show and review slide: *When to Follow-Up after MA*

- If a woman takes the medication and has minimal or no bleeding or still feels pregnant
- If a woman is concerned about ongoing bleeding or other problems
- If a woman desires reassurance after the abortion, she may return in approximately two weeks to confirm that she has had a successful abortion, or to receive additional desired services.
Show and review slides: *During a Follow-Up Visit after MA*
- Inquire about the woman's abortion process
- Confirm the success of the abortion
- Perform MVA to complete the process in the case of a continuing pregnancy.
- Stabilize, treat, or refer for any acute problems.
- Review any laboratory test results.
- Provide a contraceptive method, if desired and not already provided.
- Refer for other medical, gynecologic or counseling services where indicated.

Show and review slide: *How to Assess Completion of the MA Process*
- Assess the amount and timing of vaginal bleeding and cramping
- Ask the woman if she is experiencing any pregnancy symptoms
- For MA at home, ask "Tell me how you took the pills."
- Pelvic exam

Show and discuss slide: *Compare Current Pelvic Exam Results to Those of Exam Prior to MA*
- If the woman was up to 7 weeks at the clinical assessment, the uterus should feel non-pregnant at a 2 week follow-up.
- If the woman was 8 weeks or more, the uterus should be smaller than the period of gestation at the 2 week follow-up.

Explain that the MA is most likely completed if:
- Her pregnancy symptoms have stopped
- Her bleeding pattern is normal
- Her uterine size is non-pregnant or smaller than before

Explain that if a provider is still in doubt, conduct an ultrasound to look for a viable pregnancy.

Show and discuss slide: *Common Scenarios at the Follow-Up Visit*
- Normal (most common: at 2 weeks, 60% of women are still having light bleeding or spotting)
- Problematic bleeding

Show and discuss slide: *Various Patterns of Problematic Bleeding*
- Persistently heavy bleeding
- Not heavy but persistent and erratic
- Erratic bleeding
- Hemorrhage
- Delayed bleeding
- Ongoing pregnancy

Divide participants into three groups, and ask them to assign someone to write and some to report. Give each group a prepared table on a flipchart. Ask participants to discuss each pattern of problematic bleeding and explain treatment options and fill in on the table. When they are
done, ask one group to report back. Ask other groups if they got answers that were different. Ensure the following content is shared (use a pre-prepared flipchart with this information as reference if desired):

<table>
<thead>
<tr>
<th>Problematic bleeding</th>
<th>Description</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistently heavy bleeding</td>
<td>Bleeds like a heavy menstrual period continuously since taking misoprostol.</td>
<td>EVA/MVA if blood volume is low due to bleeding (fatigue, weakness upon standing, racing pulse, feeling faint) or if hemoglobin or hemocrit has dropped significantly</td>
</tr>
<tr>
<td>Not heavy but prolonged and erratic</td>
<td>Not heavy but prolonged and erratic</td>
<td>Repeat misoprostol dose if she is stable and feels well but she needs to return in 1-3 days for assessment. Encourage fluid intake and iron-rich foods or iron supplements.</td>
</tr>
<tr>
<td>Erratic bleeding</td>
<td>Days of very little or no bleeding followed by heavy, gushing, bleeding.</td>
<td>EVA/MVA if anemic                                                                             Encourage fluid intake and iron-rich foods or iron supplements.</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>Soaking more than 2 pads per hour for 2 hours</td>
<td>Treat according to severity of presentation.</td>
</tr>
<tr>
<td>Delayed bleeding</td>
<td>Very rare. After several weeks of little to no bleeding she has sudden heavy bleeding.</td>
<td>Will likely need emergency transport to a higher level facility. Treat according to severity of presentation.</td>
</tr>
</tbody>
</table>
| Ongoing pregnancy                     | HCG pregnancy test positive
Physical exam shows pregnancy symptoms (breast tenderness, nausea)
Ultrasound confirms pregnancy     | EVA/MVA if woman chooses to terminate the pregnancy                            |

Explain that problematic bleeding along with a continuing pregnancy is a sign that MA may not have been successful.

Tell participants to review treatment options with the woman including:
- Waiting and watching for several weeks
- EVA/MVA

10. Summary (5 min)
- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 8:
COMPLICATIONS

Estimated Time:
2 hours 55 minutes

Purpose
The purpose of this module is to identify and manage complications seen in abortion services

Preparation
• Talk with colleagues who are knowledgeable about complications to find out what complications are most common in their facility and which ones are their biggest concerns.
• If available, review data on any complications that have been reported at the participants' facilities or in the district or region.
• Be familiar with local referral processes.

Step-by-Step
1. Introduce module and state objectives (5 min)

Show and review slide: Module Overview
• Presenting, procedural, and pregnancy-related complications
• Diagnosis and management of complications

Show and review slide: Module Objectives

By the end of this section, participants should be able to:
1. Identify signs, symptoms, and causes of abortion-related complications.
2. Identify steps to diagnosis, manage, or refer complications.

2. Types of complications (15 min)

Show and discuss slide: Types of Complications
• Presenting
• Procedural
• Pregnancy-related
Tell participants that complications may develop individually or several at the same time.

Explain that:
- Presenting complications are those that a woman has prior to the uterine evacuation procedure.
- Procedural complications can occur during provision of uterine evacuation, during the recovery period, or later.
- Pregnancy-related conditions may be discovered during the clinical assessment or may not become evident until during or after the uterine evacuation.

Show and discuss slide: *Presenting Complications*
- Most common: woman is ambulatory and has vaginal bleeding, pain and fever or chills and needs treatment for incomplete abortion
- Severe: shock, hemorrhage, sepsis, and intra-abdominal injury

Tell participants that severe presenting complications are more likely in settings where unsafe abortion is common.

Show and discuss slide: *Procedural Complications*

“When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure.” – WHO, 2012

Tell participants that procedural complications are rare when uterine evacuation is performed using safe and effective methods. However, even in the most skilled hands, procedural complications can occur.

Inform participants that in most cases, procedural complications can be managed successfully if treatment is initiated promptly. Serious complications are rare, and can usually be treated by a trained clinician providing general emergency medical and surgical care.

Emphasize that safe abortion does not cause future infertility, breast cancer, or severe psychological reactions.

Show and discuss slide: *Pregnancy-Related Complications*
- Molar pregnancy
- Ectopic pregnancy
- Uterine abnormalities

Tell participants that pregnancy-related or gynecological complications may require specific clinical consideration or management.

Explain that undiagnosed ectopic pregnancy is not a complication of the uterine evacuation, but rather a condition that was present beforehand. For this reason, women should be screened for ectopic pregnancy before uterine evacuation with medical methods or vacuum aspiration.

Ask how does ectopic pregnancy complicate abortion-related care? Take a few responses before showing next slide.
Show and discuss slide: *Ectopic Pregnancy*

- Usually detected during clinical assessment
- Can go undiagnosed, especially after UE with medical methods, as POC not examined
- EVA/MVA and MA will not end an ectopic pregnancy
- A ruptured ectopic pregnancy is life-threatening and requires immediate surgical intervention
- Early detection and treatment saves lives and preserves fertility

Explain that a woman with suspected ectopic pregnancy should be treated or transferred as soon as possible to a facility that can confirm diagnosis and begin treatment.

**Show and discuss slides: Possible Signs and Symptoms of Ectopic Pregnancy**

After EVA/MVA: no villi or decidua are seen when POC are examined

After MA:
- Minimal vaginal bleeding
- Uterine size that is smaller than expected
- Sudden, intense and persistent lower abdominal pain or cramping, sometimes with:
  - Irregular vaginal bleeding or spotting
  - Palpable adnexal mass
- Fainting, shoulder pain, rapid heartbeat or lightheadedness (from internal bleeding)

Note that internal bleeding is not necessarily accompanied by vaginal bleeding.

### 3. Complications of vacuum aspiration or medical abortion procedure (30 min)

Inform participants that several types of complications may infrequently occur with either vacuum aspiration or medical abortion. These include:

- Incomplete abortion
- Infection
- Continuing pregnancy
- Hemorrhage
- Ectopic pregnancy

Tell participants that first we will discuss incomplete abortion.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

**Show and discuss slide: Signs and Symptoms of Incomplete Abortion**

- Heavy bleeding
- Signs and symptoms of infection
• Less tissue than expected
• Small amounts of tissue passing spontaneously

**ASK:** What causes the signs and symptoms of incomplete abortion?
**ANSWER:** Retained pregnancy tissue after uterine evacuation

**Show and discuss slide: Treatment of Incomplete Abortion**
• Usually treat with vacuum aspiration
• May use misoprostol or expectant management with close monitoring
• If woman has heavy bleeding or signs and symptoms of infection, use EVA/MVA immediately

Explain that the treatment of incomplete abortion is usually vacuum aspiration, whether the initial uterine evacuation method was vacuum aspiration or medical methods.

Tell participants that another possible complication of EVA/MVA or medical methods is infection.

**Show and discuss slide: Signs and Symptoms of Uterine Infection**
• Lower pelvic or abdominal pain
• Bleeding
• Fever and chills
• Uterine or lower abdominal tenderness on exam
• Cervical motion tenderness

**ASK:** if a woman has signs of infection, what should the provider do?
**ANSWER:** Establish broad-spectrum antibiotic coverage and then perform/re-perform vacuum aspiration for retained tissue if indicated.

Tell participant that routine use of prophylactic antibiotics with EVA/MVA can reduce infection rates, which are already very low.

Tell participants that the next complication we'll discuss is continuing pregnancy. This is rare after uterine evacuation with vacuum aspiration or medical methods when performed by a trained provider.

Ask if any participants have seen a woman experiencing a continuing pregnancy. If so, ask that volunteer to tell the other participants about her signs and symptoms.

**Show and review slide: Signs and Symptoms of Continuing Pregnancy**
• During MVA, smaller amount of POC than expected
• Persistent pregnancy symptoms a week after UE
• Less vaginal bleeding than expected
• Uterine size increasing after UE
Show and discuss slide: Risk Factors for Continuing Pregnancy

- Early gestational age (less than 6 weeks LMP)
- Provider inexperience
- Uterine anomalies such as bicornuate uterus
- Extrauterine pregnancy

Review the following points:

- Examine the POC immediately after uterine evacuation to decrease the risk of failed vacuum aspiration.
- MVA is the recommended treatment for continuing pregnancy.
- A second dose of misoprostol is an option where MVA is not available and the woman initially had medical abortion with mifepristone and misoprostol.

Tell participants: we will now talk about hemorrhage.

Show and discuss slide: Hemorrhage

- Rare after safe abortion
- May occur because of incomplete abortion, infection, or uterine atony

Ask for a participant who has treated a woman with a hemorrhage to describe the woman’s signs and symptoms.

Answers may include: very heavy, prolonged bleeding; pallor and weakness, agitation, or disorientation; drop in blood pressure, feeling dizzy or faint; rapid pulse; decreased urine output

Show and review slide: Signs and Symptoms of Uterine Atony

- Copious vaginal bleeding
- Large, boggy, softened uterus

ASK: What factors contribute to uterine atony?

ANSWER: Uterus loses muscle tone, cannot stop bleeding. Uterine atony is more common in multiparous and later pregnancies.

ASK: What are some methods for managing hemorrhage?

ANSWER: Vacuum aspiration; fluid and blood replacement and oxygen administration; uterotonics or intrauterine tamponade may also be used. When uterine atony is the cause of hemorrhage, bimanual uterine massage may be effective.

Show and discuss slide: Steps for Management of Hemorrhage

- Conduct bimanual massage
- Give uterotonics therapies
- Proceed with uterine aspiration
- Perform intrauterine tamponade
- Perform hysterectomy if bleeding cannot be stopped by other measures
Explain that management should be done step by step to control bleeding. Providers should move quickly to the next step if bleeding is not controlled. Hysterectomy should be done only as a last resort.

**Show and discuss slide: Uterotonic for Bleeding or Stabilization**

After uterine aspiration:
- Methylergonovine 0.2 mg intramuscularly or intracervically, not for women with hypertension/heart disease
- Oxytocin 20 units in 1L IV at a rate of 60 drops per minute
- Misoprostol 200-800mcg orally, rectally or sublingually
- Intrauterine tamponade

Explain that these therapies may be given for bleeding or to stabilize a patient for transfer after vacuum aspiration or postpartum hemorrhage. They may also be effective after a medical abortion. Refer participants to their manual for more details on dosage and method.

**4. Complications of vacuum aspiration (30 min)**

Explain that cervical, uterine, or abdominal injuries may occur during vacuum aspiration procedures, although they are (very) rare.

**Show and discuss slide: Complications of Vacuum Aspiration**
- Cervical, uterine and abdominal injuries
- Medication-related complications
- Hematometra
- Vasovagal reaction
- Asherman Syndrome

Ask participants to list some of the signs and symptoms of cervical, uterine and abdominal injuries during a vacuum aspiration procedure. Take a few responses, then show slide.

**Show slide: Signs and Symptoms of Cervical, Uterine, or Abdominal Injury**

During procedure:
- Excessive vaginal bleeding
- Sudden excessive pain
- Instrument passes further than expected
- Aspirator vacuum decreases
- Fat or bowel in aspirate

Ask participants to list the signs and symptoms post-procedure. Take a few responses, then show slide.
Show and discuss slide: *Signs and Symptoms of Cervical, Uterine or Abdominal Injury (contd)*

Post-procedure:
- Persistent abdominal pain
- Rapid heart rate
- Falling blood pressure
- Pelvic tenderness
- Fever, elevated white blood cell count

**ASK** what might cause such injuries?

**ANSWER:** Minor cervical lacerations from tenaculum or dilator, or anything inserted in the vagina during an unsafe abortion. Uterine perforation caused by excessive force used to dilate (such as with stenotic cervix); unusual uterine position (for example, very retroverted); actual uterine size different than expected.

Show and review slides: *Management of Cervical or Vaginal Laceration*

- Ensure adequate pain control and proper positioning and lighting.
- Apply antiseptic solution to the cervix and vagina.
- Check for more than one laceration.
- Stop the bleeding by:
  - Clamping a Sponge holding/ring forceps over the tear
  - Applying silver nitrate, or
  - Suturing with continuous absorbable suture
- Repair with laparotomy any deep tears or sutured lacerations that continue bleeding.
- Vaginal packing may be used for emergent treatment of bleeding.

Show and discuss slide: *Management of Uterine Perforation*

If:
- Perforation occurred during aspiration,
- Woman is stable,
- No other signs of intra-abdominal injury, and
- Evacuation is complete

Then you may admit her and closely observe for signs and symptoms of intra-abdominal injury or hemorrhage.

Explain that this is appropriate only if the perforation occurred during the uterine aspiration and the provider feels confident that there were no other injuries.

Inform participants that if laparotomy or laparoscopy is necessary but not possible, transfer the woman to a higher-level facility.

Tell participants that you will now turn to medication-related complications. Explain that
during vacuum-aspiration procedures, women will occasionally experience medication-related complications.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

Show and discuss slide: *Signs and Symptoms of Medication-Related Complications*
- Dizziness
- Muscular twitching or seizures
- Loss of consciousness
- Drop in blood pressure or pulse
- Respiratory depression

ASK: What are the causes of or factors that contribute to medication-related complications?
ANSWER: Overdose, intravascular injection, hypersensitivity reaction, general anesthesia

Show and review slide: *Management of Medication-Related Complications*
- Reversal agents
- Treating respiratory and cardiac depression
- Stabilizing convulsions

Tell participants that you will now talk about another complication of vacuum aspiration: hematometra. This is the accumulation of blood clots in the uterine cavity.

Ask for a participant who has treated a woman with this complication to describe the woman's symptoms.

Show and discuss slide: *Signs and Symptoms of Hematometra*
- Enlarged, firm, tender uterus
- Pelvic pressure
- Intense cramps and pain
- Lightheadedness
- Mild fever
- Scant vaginal bleeding

Tell participants that re-evacuation with vacuum aspiration will usually resolve the condition.

Tell participants that you will now discuss vasovagal reaction.

Explain that fainting can occasionally occur during vacuum aspiration. This is a vagal reaction to stimulation during the procedure. It typically lasts about 10 seconds and does not require intervention.

Ask for a participant who has treated a woman with this complication to describe the woman's signs and symptoms.
Show and discuss slide: Signs and Symptoms of a Vasovagal Reaction

- Fainting, loss of consciousness
- Cold or damp skin
- Dizziness
- Nausea
- Moderate drop in blood pressure, pulse

**ASK:** What is the cause of vasovagal reaction?

**ANSWER:** Result of vagal nerve stimulation during vacuum aspiration.

**ASK:** How is a vasovagal reaction treated?

**ANSWER:** Most symptoms pass quickly as the woman regains consciousness and no further treatment is necessary; in very rare cases, atropine injection will be necessary if the reaction is prolonged.

Explain that a vagal reaction is not a true complication, but rather a side effect. Point out, however, that it can be very distressing when a woman experiences a vagal reaction if the staff are not aware of what is going on.

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

**ASK:** How would you describe Asherman’s Syndrome?

Take one or two responses. Ensure that the following points are covered:

- A rare complication of vacuum aspiration in which the inside of the uterus becomes scarred
- More commonly associated with postpartum curettage than with vacuum aspiration
- Signs and symptoms are amenorrhea, cyclical cramping and infertility

Ask for questions about any of the vacuum aspiration complications discussed thus far.

5. Complications of medical abortion (15 min)

Tell participants that you will now move on to discuss possible complications of uterine evacuation with medical methods. Emphasize that the majority of women undergoing MA do not have any problems or complications.

Show and review slide: Complications of MA

- Failure of MA
- Persistent Pain
- Allergic Reactions
Show and discuss slide: *Failure of MA*

- Signs and symptoms can range from persistent vaginal bleeding to hemorrhage
- Treat with repeat uterine evacuation

Explain that a continuing pregnancy occurs in less than 1% of women who take mifepristone and misoprostol and in approximately 4-6% of women who use misoprostol only for gestations up to nine weeks.

Tell participants that another possible complication of uterine evacuation with MA is persistent pain.

Ask for a participant who has treated a woman with persistent pain to describe the woman's symptoms.

Show and discuss slide: *Persistent Pain*

- Intense pain that persists for longer than four to six hours after taking misoprostol, or
- Intense pain unrelieved with ibuprofen and mild narcotics

**ASK:** What can cause persistent pain?

**ANSWER:** Pregnancy tissue trapped in the os; ectopic pregnancy; upper reproductive tract infection

Tell participants that if there is pregnancy tissue in the os, it can sometimes be grasped with an instrument such as ring forceps and gently removed.

Explain that if a woman is experiencing pain and it is not from any of the listed causes, consider low pain tolerance as a possible cause, and manage with counseling, reassurance, and pain medications.

Tell participants that some women have allergic reactions to mifepristone or misoprostol. These reactions are rare, but have been reported occasionally.

Show and discuss slide: *Allergic Reactions*

- Symptoms may include swelling of hands or feet, rashes, or wheezing.
- Manage conventionally, such as with an antihistamine.
- Severe allergic reactions (very rare) should receive emergency treatment.

Women who experience sudden shortness of breath, swelling of the airway, or any other severe or unusual reaction should receive emergency treatment.

6. Complications in women who present for postabortion care (10 min)

Tell participants that you will now look at complications that may be present when a woman comes to the clinic for postabortion care.
Ask participants to turn to the overview of complications in women who present for postabortion care in their Participants’ Handbook. After five minutes, begin the question and answer discussion.

**ASK:** Do the majority of women presenting for postabortion care require emergency treatment? What signs and symptoms are they most likely to have? What treatment is required in this case?

**ANSWER:** Most women have light to moderate bleeding and no complications, and uterine evacuation may be the only treatment required.

**ASK:** What are the causes of the complications that women may present with in postabortion care? Take a few responses, then show slide.

Show and review slide: *Causes of Complications in Postabortion Care*

- Injury from the abortion procedure
- Incomplete uterine evacuation
- Infection

**ASK:** What is the first step in providing care to a woman presenting for postabortion care?

**ANSWER:** Perform a rapid initial assessment and obtain voluntary informed consent if possible.

Note that a clinical assessment should be done as the provider begins to treat the complications.

**ASK:** With which severe complications may women present? Take a few responses, then show slide.

Show and discuss slide: *Possible Presenting Severe Complications in Postabortion Care*

- Shock
- Hemorrhage
- Sepsis
- Intra-abdominal injury

Tell participants that shock can develop in any patient at any time during postabortion care and requires immediate action.

**ASK:** What is usually a key part of treatment for women presenting with signs and symptoms of pelvic infection, sepsis, or hemorrhage due to incomplete abortion?

**ANSWER:** Prompt uterine evacuation, usually with vacuum aspiration.

Ask if there are any questions about complications in postabortion care.

**7. Emergency response (15 min)**

Tell participants that we will now talk about emergency plans and referring women to other facilities.
ASK: How should informed consent be handled if the woman needs emergency care?

ANSWER: When a woman presents with a life-threatening emergency, complete clinical assessment and voluntary informed consent may be deferred until actions have been taken to save the woman's life.

Ask participants if their facilities have an emergency plan, and if so, what it includes. Take a few responses.

Tell participants that facilities should have a plan for emergencies, which may include:
- On-call provider
- Referral
- Information sharing
- Practicing for emergencies
- Supplies
- Links to communities for referral, follow-up and discussion of concerns about how facilities manage complications

Show and discuss slide: *On-Call Provider*

A clinically knowledgeable person should be available 24 hours a day to:
- Answer women's questions and provide reassurance
- Provide or refer for care

Advise participants that not all facilities have to treat all complications that arise. Stabilizing the woman and referring her for treatment is also appropriate. Referral systems are important so facilities can quickly refer women for more care when necessary.

Show and review slide: *Qualities of a Proper Referral System*
- Staff and transport ready 24 hours a day
- Referral plans and protocols established within and between facilities
- Share information (records or verbal reports) about woman's situation and treatment with referral hospital, and then hospital reports back on her care

Show and review slide: *How Communities Can Assist with Referral*
- Consider all resources available for help.
- Police cars, religious or agency vehicles, and taxis can provide transport.
- Plan ahead.
- Local contacts can act as referral agents.

Show and review slide: *Information Sharing*

Providers should call the referral hospital to tell them:
- That the woman is being transported
- Why she is being referred
• Her history
• What measures have already been taken
• Her current condition

Show and discuss slide: Practicing for Emergencies

On a routine basis, facility staff should review and practice how to:
• Treat hemorrhage and shock
• Start intravenous fluids
• Give oxygen (if available)
• Provide cardiopulmonary resuscitation

Explain that facility staff need to know their roles and protocols in an emergency.

Show and discuss slide: Supplies for Emergencies

• Facility should have a container with emergency medicines and supplies
• Check stock and expirations on a monthly basis

Inform participants that the container or cart should only be used in emergencies, so that supplies are there when an emergency arises.

Show and review slide: Links to Communities

Providers and facilities can work with community members and groups to:
• Recognize signs and symptoms of abortion complications
• Know how and where to receive emergency care
• Prevent delays in transporting women to emergency health services
• Refer women to emergency services, follow up after care and link women to other reproductive health services

8. Post-procedure care (5 min)

Tell participants that we will now briefly discuss care after treatment for abortion-related complications.

Show and discuss slide: Care after Treatment for Abortion Complications

The woman must be:
• Physically monitored
• Emotionally supported
• Provided verbal and printed information about:
  ◦ Her condition, including long-term changes
  ◦ Use of medications
  ◦ Contraceptive methods
  ◦ Follow-up care
  ◦ What to expect, and what to do if emergency care is needed
Explain that information on her condition should include counseling about any long-term changes resulting from the complications, such as hysterectomy or bowel perforation repair. Printed information may be written or illustrated depending on her needs.

9. Activity: Diagnosis and management of complications case studies (45 min)

Say: We have discussed the signs, symptoms, causes, and management of complications seen in abortion-related care. Now we will practice recognizing and managing these complications, either by providing definitive treatment or making a referral.

Divide the participants into 5 groups and assign each group a case study.

Refer the participants to Appendix Q: Complications Case Studies of their Participants’ Manuals and instruct them to discuss the case study and respond to the questions listed at the beginning of the appendix.

They will be given 15 minutes to complete their work.

At the end of the 15 minutes, have each group choose a representative to read their case, and present their diagnosis, management plan, and emergency response aspects.

Provide feedback to each group using the case study answer key below, and respond to any questions.

Complications Case Studies Answer Key

Case Study #1

1. Case info – Sita, a young woman, had a vacuum aspiration two days ago. She returned to the clinic because she has heavy vaginal bleeding, some abdominal pain and a fever. The nurse remembers that when her MVA procedure was performed, the amount of tissue evacuated seemed less than expected, but didn’t say anything at the time because the provider performing the MVA seemed to think that the procedure went smoothly. In addition, tissue inspection is not routinely done at this facility.

2. Diagnosis - Incomplete abortion with infection

3. Steps to manage - Administer course of broad-spectrum antibiotics (dosage and route of administration vary depending on the severity of the infection). Then evacuate or re-evacuate uterus.

4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.
Case Study #2

1. Case info – Gita, an older woman who has four children, came to the clinic for a uterine evacuation at 11 weeks LMP. Immediately following the vacuum aspiration procedure, she has copious vaginal bleeding. Her uterus is found upon exam to be large and soft.

2. Diagnosis - Uterine atony

3. Steps to manage - Perform uterine massage. Administer uterotonic. Perform vacuum aspiration. Perform or refer for further intervention (intrauterine tamponade or hysterectomy) as required.

4. Important emergency response aspects - Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.

Case Study #3

1. Case info – Heera, a young woman who had a uterine evacuation with medical methods, has returned urgently to the facility a few weeks later. She has experienced heavy bleeding for the last week. Today her bleeding is abnormally heavy and she is feeling weak and dizzy. She reports no pain and no fever.

2. Diagnosis – Hemorrhage

3. Steps to manage - Provide supportive therapies as needed (oxygen, fluids and/or transfusion). Perform vacuum aspiration. Provide referral and transportation for treatment, if necessary.

4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.

Case Study #4

1. Case info – A week after taking misoprostol for uterine evacuation, Gyanu returned to the clinic feeling very sick, with fever, persistent abdominal pain and vaginal bleeding. It is noted upon exam that her uterus is tender and there is no tissue visible at the os.

2. Diagnosis - Infection from likely retained tissue in the uterus

3. Steps to manage - Start antibiotics. Perform vacuum aspiration if there are signs or symptoms of retained tissue.

4. Important emergency response aspects – Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies,
supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.

Case Study #5

1. Case info – Maya, a 35-year-old woman, approximately eight weeks pregnant as indicated by LMP, was having some spotting. On pelvic exam, the provider found a retroverted uterus approximately six-to-eight-week size and speculum exam showed a closed cervical os with no blood. She had no uterine or pelvic tenderness. She does not want to keep the pregnancy and so went home with the medications and instructions for a medical abortion. She returned to the clinic after three days, having had very little bleeding after taking the medicines, continuing to feel pregnant, and having some sharp left lower abdominal pain, but not like menstrual pain. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at your facility.

2. Diagnosis – Ectopic pregnancy

3. Steps to manage – For suspected ectopic pregnancy, treat or transfer as soon as possible to a facility that can confirm diagnosis and begin treatment. For ruptured ectopic pregnancy, provide or arrange for immediate surgical intervention.

4. Important emergency response aspects - Each facility needs to review its emergency response plan in order to be prepared for serious complications. Aspects to consider include on-call provider, referral systems including transportation, information sharing, practicing for emergencies, supplies and engaging communities for referral, follow-up and discussion of concerns about how facilities manage complications.

10. Summary (5 min)

- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 9:
MONITORING, RECORDING, AND REPORTING

Estimated Time: 1 hr 30 min

Purpose
This module describes the importance of monitoring abortion-care services to ensure they are satisfactory to both clients and health-care workers and reviews the general components of a monitoring system as well as the specific monitoring tools for CAC in Nepal. A special emphasis is placed on reporting and learning from serious adverse events (SAEs).

Preparation

Step-by-Step
1. Introduce module and state objectives (5 min)

Show and review slide: Module Overview
- Definition of monitoring
- Key steps of monitoring
- Recording and reporting in national log book
- Definition of severe adverse event (SAE) and its overview

Show and review slide: Module Objectives

By the end of this module, participants should be able to:
- Describe monitoring, including adverse event monitoring and reporting, and its importance in improving abortion-related services
- Identify characteristics of effective monitoring systems
- Describe indicators, information sources, and methods of information gathering
- Describe the steps for establishing an abortion-care services monitoring system
2. What is monitoring and why is it important (15 min)

ASK: What do you think of when you hear the word "monitoring"? What words or phrases come into your mind?

- Write responses on the flipchart.
- Ask participants what they notice about the responses.
- Affirm that people may not fully understand or appreciate monitoring.

Tell the group that, by the end of this module, you hope they will appreciate the importance of monitoring and feel positive about their role in monitoring services to improve them.

Show and discuss slide: *What Is Monitoring?*

- Examining all aspects of care, including client satisfaction
- Tracking services over time to identify strengths and weaknesses
- Using data to provide feedback and make adjustments to improve quality
- An ongoing process

Ask participants to give examples of a monitoring process in which they have been involved. Take one or two responses.

Show and discuss slide: *Why Is Monitoring Important?*

- Shows if services are effective or need improvement
- Helps improve services for clients and workers
- Assesses if changes achieve desired effects
- Keeps abortion-related services operating at a high standard

Review the following points with participants:

- Monitoring can range from simple and inexpensive to more complex, formalized approaches.
- A simple approach may be for providers to monitor a few of their own service delivery indicators.
- More formalized approaches usually involve assessment and monitoring across a wide range of service delivery components.
- One of the more formal monitoring approaches is an ongoing quality improvement process and set of tools used by health-care staff to proactively and continuously assess and improve the quality of CAC they provide. There are many other effective approaches as well.

Ask participants to give an example of changes they have observed that have resulted from monitoring. Take one example.

Show and discuss slide: *Effective Monitoring*

- Is integrated into routine work
- Uses simple indicators
- Allows providers to participate in the process
- Is honest, fair, and unbiased
• Is not intended to assign blame or to punish
• Involves clients, including young women, in the entire process

Explain that monitoring can be used to reward staff and increase morale. Managers can use creative incentives in monitoring to promote changes in behavior. Monitoring should never be coercive.

Show and discuss slide: Monitoring Is a Continuous Process

Ask participants: what information are you currently collecting about your services that could be used for monitoring? Take two responses.

Ask participants for examples of how they currently monitor services in their facility. Examples may include:
• Gathering information from log books
• Reviewing medical records
• Assessing inventory of supplies and equipment
• Talking with clients

Ask how compiling and assessing this information helps to determine where services are effective and where they need improvement. Take a few responses.

Point out that monitoring is a critical component of high-quality service delivery.

3. Steps of effective monitoring (20 min)

Refer participants to Appendix R: Monitoring Scenario in their Participants’ Manuals. Give the participants a few minutes to read the scenario on their own.

Ask participants to identify the main steps taken to develop the monitoring program. Responses should include:
• Planning the monitoring including creating a checklist of standards
• Information gathering with interviews, checklist, suggestion box, logbook review
• Analysis of results: discuss strengths and weaknesses
• Action planning for solving problems: creating and implementing a performance improvement plan.

Tell participants that we are now going to discuss each step.

Show and discuss slides: Planning
• Monitoring team = staff and recipients of services, including young women
• How team members will be trained
• Aspects of services to be monitored
• Quality standards and indicators to measure them
• Sources of information (service data logbooks and client records)
• Methods for gathering information (interviews, focus groups, observation and records review)
Checklists and other tools to guide observations, interviews and records review

A plan for sharing results with staff and the community, and improving services, if needed

A timeline for the monitoring process, including activities and persons responsible

**ASK:** What planning steps did the clinic director and committee take in the Monitoring Scenario read earlier?

**ANSWER:** Formed a committee; appointed a person to collect information; determined information sources; informed staff and clients; invited suggestions

**Show and discuss slide: Indicators**

- Measurements that help quantify activities and results
- Can help describe the overall quality

Explain to participants that examples of indicators include:

- Number and type of procedures performed
- Number and type of complications
- Percentage of women desiring contraception who receive methods
- Number of women served by age

Explain that it is important to pick indicators that are actually under staff control; otherwise the process can be very demotivating.

**Show and discuss slides: Information Gathering**

- Logbooks, clinical records and supply ledgers, preferably with local analysis
- Periodic observation and client interviews, making sure to seek young women's perspectives
- To measure a change in a specific area of service delivery, use the same indicator over time
- Monitors should always identify themselves, explain what they're doing and ask her permission to continue
- Ensure privacy and confidentiality; never include unique identifying information on data forms

**ASK:** What information-gathering steps did the monitoring committee take in the monitoring scenario?

**ANSWER:** reviewed the clinic logbooks monthly; reviewed a sample of medical charts quarterly; put a suggestion box in the clinic for employees and clients

Explain that another way to gather information is to evaluate performance using checklists. The skills checklists from this curriculum, which can be adapted to reflect local protocols or to emphasize local concerns, can be used by monitoring teams to assess performance on many aspects of abortion-related care.

**Note to trainer:** Hold up the MVA Skills Checklist or a different checklist from the Participants’ Handbook appendices as an example.

Ask if someone can give an example of challenges that might be faced when trying to gather information for monitoring purposes. Take a few answers. Answers might include:
• Lack of buy-in by top officials
• Fear by staff that their jobs might be jeopardized if they voice concerns
• One key person who won’t cooperate
• Gathering feedback from low-literacy clients

Briefly discuss ideas for countering these challenges.

Show and discuss slide: Analysis
• Compile and review findings
• Discuss strengths and weaknesses of services
• Identify problem areas—what factors contributed?
• Develop improvement plans
• Over time, assess progress in improving care

Review the following with participants:
• Poor-quality counseling services might stem from inadequate training of newly hired staff and a client-intake process that leaves insufficient time for counseling.
• Staff review may also identify causes that are more pervasive—for instance, an underlying belief that counseling is not an important part of services.
• Staff should also seek input from clients and community members to determine the root cause of a problem or issue.

**ASK:** What analysis steps did the monitoring committee take in the Monitoring Scenario?

**ANSWER:** Compiled information from logbook, chart review and suggestion box; discussed what the information meant; determined strong and weak aspects of services

Show and review slides: Action Planning
• Community members, including young women, should be part of action planning
• Start with problems that are relatively easy to fix, given available resources
• Discuss a range of approaches before selecting one
• Draft written plan including timeline
• Specify who is responsible for each step
• Discuss plan with staff and community members who may help implement
• Present findings and proposed solutions to staff, get feedback
• Share positive findings and improvements with staff and community, when appropriate
• Staff who have helped improve services should be recognized

Show and discuss slide: Possible Solutions
• On-the-job training
• Reorganization of services
• Changes to hours of operation
• Changes to supplies procurement
• Strengthened referral systems
Explain that in the Monitoring Scenario we read earlier, the monitoring committee made a plan to improve the weaker aspects of services, communicated these plans to the staff and clients, and asked for feedback about how well the improvement plan was working.

Ask participants to consider meeting with their facility manager to discuss how to establish or improve a monitoring system at their facilities.

4. Routine Reporting Activities (15 min)

Explain that as part of the monitoring process, service providers record and report relevant information as a responsibility to help ensure that clients receive high quality, safe abortion services.

Show and discuss slide: **Routine Reporting Activities**

All listed sites must document the first trimester abortion services in the following:
- Client Personal Profile
- HMIS-3.7 register

Tell participants that these two items are the required minimum; providers and facilities are encouraged to conduct additional recording and reporting activities to strengthen their ability to monitor and improve service provision.

Show and review slide: **Client Personal Profile**
- Personal history
- Gynecological information
- General and physical examination
- Pelvic examination
- Eligibility for type of abortion
- Document presence and management of any abortion-related complications

Show and review slide: **Health Management Information System (HMIS 3.7)**

The provider should record accurate information:
- Type of abortion procedure performed
- If any complications occurred during and after the procedure
- Outcomes of of complications treatment

Show participants a copy of the HMIS-3.7 register. Remind participants that this is a monitoring tool for the national level. Then review with participants the other CAC program forms (e.g. client personal profile with consent form, etc.) and how they are to be filled in, by whom, when, and sending the CAC report to the DHO/DPHO/FHD.

The following instructions and forms (in the back of the handbook/trainers manual) should be covered:
- Instructions for maintaining the CAC facility based register
- Personal profile of the client and consent form
5. Severe Complication/Severe Adverse Event Reporting (30 min)

Explain that an adverse event is a condition requiring intervention and management beyond what is normally necessary that is related to:

- A procedure
- Anesthesia, or
- Postabortion contraceptive method.

Show and review slide: Adverse Events

- Complications a woman has during care that are not a result of a disease
- Rare in routine abortion-related care
- Important to monitor because each event offers the opportunity to learn how to improve care

Show and discuss slide: Severe Adverse Events (SAE)

Results in:

- Life threatening injury
- Permanent impairment of body function or permanent damage to body structure
- Or necessitates medical or surgical intervention to prevent permanent impairment
- Death

ASK: What is a near miss?

ANSWER: An event that as potential to harm a patient but does not because chance, prevention, or mitigation.

Refer participants to the Examples of Complications/Serious Adverse Events (SAEs) Table in their Participants’ Reference Manual. Ask participants to read over the examples for 3 minutes.

Ask participants to finish the following statement: “one in every____ patients in the hospital for any reason suffers some adverse event.”

ANSWER: One in 10 patients

Emphasize that the risk of death from abortion is extremely rare.

Show and review slide: Factors that Can Lead to Adverse Events

1. Client factors
2. Human error
3. Institutional errors
Show and review slide: *Client Factors*
- Client may not be able to communicate or disclose information
- Clients may have high-risk medical conditions (increased gestational age)
- Complex medical problems, obesity, altered uterine anatomy

Show and review slide: *Human Error*
- Slips and lapses: improper actions (inattention, fatigue, failure of memory)
- Mistakes: plan of care is improper for a situation (problems with training, experience or knowledge)

Show and discuss slide: *Institutional Error*
- When patient safety is not protected by an institution (i.e.: not having the correct medications on hand to save money)

Ask participants to brainstorm situations, actions, inactions, and other contributing factors that can lead to adverse events or serious adverse events.

On a flipchart, draw three rows and label them #1, #2, and #3 to correspond with the types of factors listed on the PowerPoint slide. As participants provide examples, ask them if it represents a client factor (#1), a human error (#2), or an institutional error (#3). Write the example in the appropriate row. Take a few responses.

Explain that adverse events occur for many reasons and are rarely the result of a single person or an event. They usually result from a combination of multiple factors coming together in a single event.

Explain that after an adverse event has taken place the first priority is to care for the patient.

Tell participants that there are two ways that events can be evaluated: a blame culture and a safety culture.

Show and review slide: *Blame Culture*
- Focus is on individual responsibility

Show and review slide: *Safety Culture*
- Open dialogue with everyone involved
- The goal is to see where the system failed and make improvements

Emphasize that learning can only occur if adverse events are approached from a culture of safety rather than a culture of blame.

Show and review slide: *Safety Depends On*
- Just culture: When an adverse event is reported, human actions are considered within the context of the health care system
- Reporting culture: Staff report safety concerns without fear of punishment, even when it involves human error
- Learning culture: Improvement efforts focus on the health care system as a whole
Show and discuss slide: *Adverse Event Reporting*

SAE must be reported if a woman is hospitalized for one of the following conditions:
- Bleeding requiring blood transfusion
- Infection requiring intravenous antibiotics
- Unintended intra-abdominal surgery
- Death

Explain that once an adverse event is identified, recorded, and reported, the final step is to learn from the event. This is best accomplished through a team discussion with all relevant staff members. Conduct the meeting in “the spirit of learning,” that is, non-punitive and everyone is allowed and encouraged to speak.

Show and discuss slide: *Team Discussion – Spirit of Learning*

As a team, discuss and answer these questions:
- What happened?
- Why did it happen?
- What can be changed to prevent similar events in the future?

Emphasize that implementing the identified needed change(s) is final step.

6. **Summary (5 min)**

- Summarize key points of module, using the objectives and Summary Section of this module in the Reference Manual for reference.
- Ask if there are any remaining questions. Answer them or add to the Parking Lot.
MODULE 10:
SERVICE PROVISION

Purpose
To review the facilities, supplies, personnel, and quality assurance mechanisms factors that all contribute to the provision of high-quality services

Preparation
- Prepare three flipcharts with the following titles: "Medicaton and Supplies for MA," "MVA supplies," and "Other medications"
- Make copies of the Models of Service Delivery Table at the end of this module

Step-by-Step

1. Introduce module and state objectives (5 min)

Show and review slide: Module Overview

Factors required to provide high-quality CAC services, including:
- Physical facilities and health services
- Medication and supply management
- Staff knowledge and skill
- Recording and monitoring processes
- Equipment

Show and review slides: Module Objectives

By the end of this module, participants will be able to:
1. Understand how the quality of the physical facility and the health services offered affects to overall quality of CAC
2. Understand how medication and supply procurement affects service delivery
3. Describe the knowledge, attitudes, and skills staff should possess
4. Describe the importance of monitoring and reporting to identify problems and improve care
5. Design an action plan to establish a CAC center in a setting
2. Physical Facilities and Health Services (10 min)

Ask participants to brainstorm what would a high-quality facility providing abortion services need in terms of (1) physical facilities and (2) health services? Take a few responses before showing the next slide.

Show and review slides: Physical Facilities and Health Services
- Accessible hours and days of available CAC services
- A space for registration and record-keeping
- Private areas for information and counseling
- A separate area for adolescent and young women for waiting and recovery
- Infection prevention practices and supplies
- A procedure room with an adequate light source and equipment for MVA procedures
- Procedure tables, recovery beds, and a table and chairs
- An effective referral system for complications
- Integrated family planning services
- A laboratory

3. Medication and Supply Management (20 min)

Explain that supplies and medications are essential to the provision of CAC services.

Post 3 flip charts around the room titled, “Medication and Supplies for MA”, “MVA supplies,” and “Other medications.” Ask participants to walk around the room and list as many CAC-related supplies and medications under each title. Give participants 10 minutes and then ask them to return to their seats. Compare participants’ responses on the flipcharts to the content on the following slides.

Show and review slide: Medication and Supplies for MA
- Adequate supply of recommended drug regimens
- Sanitary pads or cotton wool

Show and review slide: MVA Supplies
- Sufficient number of aspirators and cannulae on-hand that are properly cleaned, maintained, and stored

Show and review slide: Other Medications/Supplies
- Adequate supply of pain management drugs
- Antibiotics for prophylaxis and/or treatment of infection
- Other emergency drugs
- Contraceptives (should be available at all times)

Point out to participants the use of terms such as adequate, sufficient. Explain that facilities should always have enough medication and supplies to serve their clients. Systems for the procurement of these medications and supplies should be in place to avoid stock-outs.
Explain that supply forms and log books should be utilized in procurement systems.

Ask if participants can think of any other basic facility needs for the provision of high-quality CAC services. Take a few responses and then show the next slide.

Show and review slide: Basic Facility Needs
- Secure, clean, and dry storage space to keep medications and supplies on-hand
- Clean water to maintain cleanliness of the equipment and the facility
- Safe drinking water for staff and patients

4. Activity: Staff Knowledge, Attitudes, and Skills (20 min)

Post a flipchart paper and draw a stick figure image of a female in the middle. Draw a line down the center of the page skipping over the female image.

Tell participants to imagine that your 16 year old family member has come to facility seeking a first trimester abortion. She has been a victim of sexual violence and she is really struggling emotionally.

Ask how would you like her to be treated by the staff? Record their responses on the left side of the flipchart page. Ensure the following characteristics and values are included:
- Positive
- Helpful
- Empathetic
- Non-discriminatory
- Treat with dignity
- Treat with respect

Now ask participants to consider that the woman is their daughter. Ask what knowledge and skill sets would you like for the provider to have. Record their responses on the right side of the flipchart page. Ensure the following knowledge, skills/proficiencies are included:
- Full understanding of the two recommended abortion procedures
- Ability to provide easy to understand information about the expected effects, side effects, risks, and potential complications of each of the two types of abortion procedures.
- Perform a clinical assessment, including gestational dating
- Provide abortion counseling (pre, during, and post) and obtain informed consent
- Provide contraceptive counseling
- Perform high-quality abortion procedures, whether it be MVA or MA
- Conduct follow-up and assessment of abortion complications
- Refer women for emergency care, if needed.

5. Staff Training (5 min)

Explain that additionally, all staff members involved in the provision of CAC services have the appropriate educational background and related experience. They should have a clear understanding of the current Nepal safe abortion law and policy for comprehensive second trimester abortion.
Mention that this includes an understanding of any current policies related to the care of specific populations, such as young women under 16 years of age, or disabled women.

Ask participants once more to think about having a 16 year old daughter in need of an abortion. What training background would you like the staff to have?

Show and review slide: Staff Training
- Providers should attend refresher trainings as needed
- Staff should be trained on new technology, methods of care, or provision of CAC services as they arise

6. Record Keeping (5 min)

Explain that a patient’s medical records contain valuable and sensitive information.

Show and discuss slide: Record Keeping
- Policies should exist regarding which information to collect and record in each client’s records
- Correct and consistent use of referral forms
- Policies should be in place to ensure all individual client records are kept private
- Complete clinic-level records

ASK: What are some examples of clinic-level records?
ANSWER: logbooks, monthly registers

ASK: why is it helpful to consistently complete log books and monthly registers?
ANSWER: They can aid the facility in its monitoring and evaluation of the services provided.

7. Monitoring and Evaluation (5 min)

Explain that when a facility engages in monitoring and evaluation activities, providers and facilities can learn from their experiences and modify their practices to provide the highest quality of care possible.

Show and review slide: Monitoring and Evaluation Plan
- Clear definitions of services to be evaluated
- Sources of information
- Indicators for measurement
- Mechanisms for obtaining feedback from women for improving services

8. Action Plan for Establishing High-Quality CAC Services (20 min)

Refer participants to the Action Plan Activity worksheet in their Participants’ Manuals. Ask them to work with a partner or a small group with professionals from the same health care facility if possible. Together, fill out the worksheet as best as possible using the Service Site Equipment Guidelines listed below the table in the Participants’ Manual.
As a large group process the activity:
- What information did you not have but felt you needed for your plan?
- Was it clear who should be responsible for different activities or do these roles need to be better defined at the facility?
- Looking through the lists of equipment, instruments, consumable supplies, and personnel—what is your facility missing? What are next steps to ensure these are provided?

9. Models of Service Delivery: (OPTIONAL 15 min)

Tell learners they will complete the Models of Service Delivery worksheet (on the next page of the Training Manual).

Ask learners to form groups with those working at the same facility or with other individuals. If all learners are from the same site, complete this worksheet as a large group.

Ask learners to take five minutes to fill out the worksheet below.

After five minutes, ask learners to share one practice they identified as needing change and the action(s) needed to implement that change.

Instruct learners to continue completing the worksheet with the appropriate personnel once they have returned to their sites.

Ask for an answer any last questions about service delivery (e.g. Where will you get the medications? How will you store them? What steps do you need to take to set up a system for managing your medications?). Write your responses below.

10. Summary (10 min)
- Summarize key points of module, using the objectives of this module in the Participants’ Manual for reference.
- Answer any remaining questions. Review and address any questions remaining from the Parking Lot.
## Models of Service Delivery

<table>
<thead>
<tr>
<th>Question</th>
<th>Current Practice at Your Facility</th>
<th>What to Change</th>
<th>What is Needed to Make the Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much time is allotted for counseling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What on-call and/or emergency services are offered?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who provides counseling?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many staff members are trained on MA/MVA?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the counseling services offered?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What supplies and equipment are available (e.g., EV, MVA, ultrasound)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What monitoring and reporting mechanisms are in place?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Knowledge Questionnaire

CAC Pre-Course Questionnaire (PCQ) Answer Key:

Comprehensive Abortion Care (CAC) Services
1. The Nepal Safe Abortion Law allows CAC services to be offered to any woman with a pregnancy of any gestation for any reason. F
2. Only listed, registered clinicians can provide CAC services, but sites offering CAC services do not have to be listed. F
3. A woman is required to accept a method of contraception after an abortion if she has had a previous abortion before. F
4. Comprehensive abortion care means addressing access, choice and quality of care. T

Client Assessment
5. A physical exam is not needed before CAC. F
6. Laboratory tests for provision of abortion care can be helpful if available, but are not routinely required. T
7. Prophylactic antibiotics should be administered at the time of MVA to reduce the risks of post-procedure infection. T
8. Ectopic pregnancy can go undetected even after clinical assessment. T

Counseling, Information and Informed Consent
9. Ovulation can occur as early as 8 days after an abortion. T
10. If there are no complications, nearly all contraceptive methods can be started immediately after an abortion. T
11. Presence of infection at the time of an abortion may affect a woman’s eligibility for insertion of an IUCD after her procedure. T
12. Emergency contraception can prevent pregnancy after unprotected intercourse but medical abortion induces abortion in women who are already pregnant. T

Young Women and Abortion Care
13. A counselling session with a young woman will usually be shorter than with an adult woman. F
14. The provider should help the young woman make her decision based on what the provider knows is best. F

Infection Prevention
15. Blood-borne diseases are more often spread through splashes of blood onto skin rather than from needle sticks. F
16. Providers should wash their hands before putting on gloves for an MVA procedure, but it doesn’t matter if they wear any eye protection or not because nothing will get in their eyes. F

17. The Ipas MVA Plus aspirator and EasyGrip cannulae can withstand all of the following processing options: boiling, soaking in glutaraldehyde, soaking in chlorine, autoclaving. T

18. “No-touch technique” means that only the provider who performs the procedure is allowed to touch the instruments. F

Pain Management
19. No analgesia should be given before the abortion procedure; only after the procedure is complete. F

20. Only verbal analgesia is sufficient for pain management in MVA.

Uterine Evacuation with MVA
21. When no more tissue is seen in the plastic cannula, you can be sure that the uterus is completely evacuated so you don’t need to look at the tissue again. F

22. After an abortion, women should always stay in the facility for at least 4 hours. F

23. The in-and-out motion of the cannula requires care to avoid the possibility of perforating the uterus. T

Medical Abortion
24. It is always necessary to give antibiotics before and after a medical abortion. F

25. According to the Nepali National Strategy, oral or sublingual misoprostol are the recommended routes of taking the misoprostol. F

26. Unlike vacuum abortion, pain management is not at all necessary in medical abortion. F

27. Access to emergency care is required to safely undergo medical abortion. T

Complications
28. Increasing pain in the days following an abortion is no cause for concern. F

29. Retained pregnancy tissue (products of conception—POC) can lead to infection if not treated. T

30. A facility providing abortion services does not have to be equipped to treat all complications that might come up, as long as they can refer women to a facility that can treat complications. T

31. Vaginal bleeding soaking more than two sanitary pads per hour for two consecutive hours after expulsion of POC should be considered normal. F

Post-abortion family planning
32. IUCD does not need to be removed before starting medical abortion in women with IUCD in situ. F

33. Condom is the method that significantly decreases STI. T
Monitoring, Recording and Reporting

34. Recording and reporting of abortion services is the responsibility of the nurse provider and the provider need not fill these forms. F

35. Severe Adverse Event (SAE) following abortion services when managed appropriately need not be recorded and reported. F
MID-COURSE KNOWLEDGE QUESTIONNAIRE (KQ)

COMPREHENSIVE ABORTION CARE (CAC) SERVICES

1. The new abortion law legalizes the termination of pregnancy with the consent of the client (upon request) only up to:
   a. **12 weeks gestation**
   b. 20 weeks gestation
   c. After sex selection
   d. All of the above

2. Which of the following statements is FALSE? The abortion bill legalizes CAC after 12 weeks gestation if the pregnancy is due to:
   a. Incest
   b. Rape
   c. If the pregnant woman's health is at risk
   d. **When the client requests the procedure for sex selection**

3. The client with a gestational date above 12 weeks in cases of rape:
   a. Should be refused CAC services
   b. **Should be referred to a listed specialist service provider**
   c. Requires a less complicated procedure
   d. None of the above

4. Consent of the guardian should be taken when
   a. Client is of 24 years old
   b. **Client is below 16 years old**
   c. Client is below 18 years
   d. For all client

CLINICAL ASSESSMENT

5. The single best way to determine the gestational age of an early pregnancy is:
   a. Looking at the cervix
   b. The length of time since the last menstrual period (LMP)
   c. **Bimanual examination**
   d. None of the above
6. Clients requesting CAC services who have a history of slight bleeding may have:
   a. Threatened abortion
   b. Attempted to cause an abortion, resulting in an incomplete abortion
   c. Ectopic pregnancy
   d. **All of the above**

7. If the uterus is smaller than expected it may indicate
   a. Multiple pregnancies
   b. Molar pregnancy
   c. Uterine abnormalities like fibroids or bicornuate uterus
   d. **Ectopic pregnancy**

8. What is a symptom of ectopic pregnancy?
   a. Feeling cold all over
   b. Persistent fever
   c. **Severe lower abdominal pain**
   d. Foul smelling discharge

**COUNSELING, INFORMATION AND INFORMED CONSENT**

9. Before performing an abortion procedure on a client under 16 years of age, the service provider must first get informed consent from:
   a. The client only
   b. **Client and the guardian.**
   c. Guardian only
   d. No consent is needed.

10. The service provider should inform MVA clients that:
    a. She will be awake during the procedure.
    b. She could become pregnant again soon if she doesn't use contraception.
    c. She needs to come for a follow up exam if needed.
    d. **All of the above**

11. Regarding informed consent the following should be considered
    a. It is not necessary to involve women in the decision making process
    b. Her companion cannot accompany to hear the information on abortion service
    c. **Women should understand the entire process and give consent prior to abortion service**
    d. It is not necessary for the woman or her guardian to sign the appropriate consent form
12. While counseling about medical abortion
   a. **Encourage the woman to ask questions and discuss her condition**
   b. Woman need not understand the information you have provided
   c. If she decides not to have CAC she will not receive other services of her choice
   d. It is appropriate to provide the information on CAC in technical language

**YOUNG WOMEN AND ABORTION CARE**
13. Which of the following may require special consideration for young women?
   a. Pelvic exam
   b. MVA
   c. Pain Management
   d. **All of the above**

14. What should a provider do when a young woman comes in for safe abortion care?
   a. Let her talk before providing more information.
   b. Affirm the positive step she has taken by seeking safe care.
   c. Explain and discuss issues of confidentiality.
   d. **All of the above.**

**INFECTION PREVENTION**
15. Which statement is FALSE?
   a. Hand washing should be done after examining each client.
   b. Hand washing is an important infection prevention procedure.
   c. **Sterile gloves should be used for any pelvic examination.**
   d. Shared towels easily become contaminated.

16. Infection prevention practices to minimize infection from viruses such as HIV and Hepatitis B include:
   a. Use gloves only for clients who are known to have these infections.
   b. Instruments that touch the blood stream should be soaked and stored in Betadine solution.
   c. Instruments that have been soaked in chlorine are safe to handle with bare hands.
   d. **None of the above**

17. After the decontamination soak and cleaning the Ipa's EasyGrip* cannula and MVA plus may then be processed by:
   a. Autoclaving
   b. Boiling for 20 minutes
   c. Soaking in 2% glutaraldehyde solution for 20 minutes
   d. **Any of the above is acceptable.**
18. Simple hand washing is done for:
   a. 3 - 5 minutes.
   b. **10 - 20 seconds.**
   c. 25 - 35 seconds.
   d. 10 - 15 minutes.

**PAIN MANAGEMENT**
19. Which of the following statements is TRUE for MVA:
   a. The analgesic tablet should be given at least 30 minutes before the procedure.
   b. Paracervical block is routinely needed for clients undergoing CAC.
   c. It is extremely rare for CAC clients to need to undergo general anesthesia.
   d. **All of the above**

20. Which statement is FALSE: When using injectable Xylocaine for paracervical block:
   a. The xylocaine should be a 1% solution.
   b. The service provider should ask about drug allergies.
   c. Allow a few minutes before the MVA procedure is started.
   d. **Maximum dose of xylocaine is 6mg/kg of total body weight.**

**MVA PROCEDURE**
21. Which of the following is NOT a sign of complete evacuation of the uterus?
   a. Foam is visible in the cannula.
   b. Gritty sensation from the uterine wall
   c. **Loss of vacuum in the cannula**
   d. Cramping

22. Which of the following method is NOT recommended by WHO for surgical method of abortion?
   a) MVA
   b) EVA
   c) **D and C**
   d) All of the above

23. Which of the following is NOT recommended to perform MVA procedure?
   a) Ibuprofen
   b) Doxycyclin
   c) Diazepam
   d) **Paracetamol**
Medical Abortion
24. In what way does Mifepristone work to terminate pregnancy
   a. Prevents sperms from fertilizing the egg
   b. Inhibits ovulation and uterine contractions
   c. **Causes detachments of the product of conception from the uterine wall, softening of the cervix and uterine contraction**
   d. None of the above

25. In what way does Misoprostol aid in abortion
   a. Causes detachment of the product of conception
   b. **Causes uterine contractions and cervical softening**
   c. Prevents implantation of the egg
   d. Prevents ovulation

26. Recommended protocol for Mifepristone and Misoprostol upto 9 weeks is
   a. 300 mg of Mifepristone orally on day 1 and 400mg Misoprostol Vaginally after 48 hours.
   b. **200mg of Mifepristone orally on day 1 and 800 (microgram) Vaginally/ Sublingual after 24 hours.**
   c. 200mg of Mifepristone orally on day 1 and 800(microgram) Vaginally after 72 hours.
   d. 300mg of Mifepristone orally on day 1 and 400 mg Misoprostol Vaginally after 24 hours.

27. What are the symptoms of side effect of MA?
   a. Diarrhea
   b. Vomiting
   c. Fever
   d. **All of the above**

COMPLICATION
28. A post-MVA client should contact the clinic if she has:
   a. Slight bleeding from the vagina
   b. Mild abdominal cramps that go away with paracetamol
   c. **Increasing lower abdominal pain**
   d. All of the above

29. Signs that may indicate uterine perforation are:
   a. The cannula is inserted deeper into the uterus than the size of the uterus.
   b. Loss of the vacuum in the aspirator
   c. Clients complain of severe low abdominal pain.
   d. **All of the above**
30. If the client comes to the clinic with a suspected post abortion complication you should:
   a. Stabilize client.
   b. Assess and manage the complication.
   c. Refer to another service site that can treat her problems if you cannot.
   d. **All of the above**

31. Which of the following statement is true?
   a) The client should not be told about possible complications because this might upset her.
   b) The client should not worry about vaginal bleeding soaking more than two sanitary pads per hour for two consecutive hours after expulsion of POC.
   c) **Retained pregnancy tissue (POC) can lead to infection if not treated.**
   d) The client should take Ibuprofen if there is persistent and increasing abdominal pain following abortion.

**POST ABORTION FAMILY PLANNING**

32. The IUCD is contraindicated in clients with:
   a. Previous history of Caesarean delivery
   b. Repeated abortion
   c. First pregnancy termination
   d. **None of the above**

33. Which contraceptive method cannot be started on the day of taking mifepristone?
   a. Oral pills
   b. Injectables
   c. IUDs
   d. Implants

**MONITORING, RECORDING AND REPORTING**

34. All listed sites must document the abortion service in the following:
   a) Client personal profile
   b) HIMS – 3.7
   C) Only in HMIS-9.3/9.4/9.5
   d) **All of the above**

35. Which of the following **IS NOT** a severe adverse event (severe complication) needing reporting?
   a. Incomplete abortion requiring MVA
   b. Haemorrhage requiring blood transfusion
   c. Infection requiring IV antibiotics
   d. Uterine perforation requiring laparotomy
Four Corners: Part A

Please read the following statements and circle the answers that are closest to your honest responses. Please do not write your name on this sheet.

1. Women with a history of repeated miscarriages should be able to continue to attempt pregnancy if they want a baby badly enough.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

2. Women should be able to stay with a partner who hits them if they are really in love.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

3. Women should be able to have more than one induced abortion if they have more unwanted pregnancies.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

4. Adolescents should be able to have intercourse if both partners are mature enough.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

5. Women living with HIV who want to become pregnant should be able to refuse contraceptive services.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

6. Women who want emergency contraception after their abortion instead of an ongoing method should receive it before leaving the clinic.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

7. Women who want information about how to properly use misoprostol to induce abortion should be able to receive that information from clinicians.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

8. Women who want a nurse midwife provider to give them comprehensive abortion services, including uterine evacuation with MVA, ought to be able to choose that type of provider.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree
Four Corners: Part B

Please read the following statements and circle the answers that are closest to your honest responses. Please do not write your name on this sheet.

1. I would continue (or support my partner in continuing) to attempt a pregnancy despite a history of repeated miscarriages if I (or she) wanted a baby badly enough.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

2. I would stay with a partner who hit me if I were really in love.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

3. I would have (or support my partner in having) more than one induced abortion if the pregnancies were also unwanted.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

4. I would have intercourse during my adolescent years if I believed my partner and I were mature enough.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

5. If I were living with HIV and wanted to become pregnant, I would refuse contraceptive services.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

6. If I wanted emergency contraception after an abortion instead of an ongoing method of contraception, I should be able to get it before leaving the clinic.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

7. If I wanted information about how to properly use misoprostol to induce abortion, I should be able to receive that information from a clinician.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree

8. If I wanted a nurse midwife provider to provide me comprehensive abortion services, including uterine evacuation with MVA, I ought to be able to choose that type of provider.
   - Strongly Agree
   - Agree
   - Disagree
   - Strongly Disagree
Skill Assessment Checklist

A: Clinical Assessment Skills Checklist

**Instructions for self-assessment:** Check "yes" or "no" as to whether you routinely demonstrate each skill during your clinical assessment, and write comments.

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

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures Visual and Auditory Privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records Client History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about any pregnancy tests or ultrasounds and their results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about any bleeding or spotting during the pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines drug allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric and gynecological history:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live births, miscarriages, abortions, contraceptive use history, ectopic pregnancies, menstrual history, fibroids, infections or recent abortion-related care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about her sexual history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about recent medications taken, including misoprostol or herbs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about HIV and STI status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about her surgical history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates physical or cognitive/mental disabilities or mental illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about any known medical conditions that may affect eligibility for MVA or MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses risk of ectopic pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addresses or refers for: Hypertension, seizure disorder, anemia, bleeding disorders, diabetes, heart disease, asthma, suspected ectopic pregnancy, cervical stenosis, alcohol or drug abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs a Physical Exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates general health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks her vital signs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes general health, weakness, lethargy, anemia, malnourishment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks her abdomen for masses, tenderness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conducts a pelvic examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>Asks the woman to empty her bladder before the pelvic examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains to the woman what to expect, reassures her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses towel, sheet, etc. to ensure her privacy is protected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performs a speculum examination (may be done concurrently with the MVA procedure)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes ulcers or signs of STIs on the external genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gently inserts a warm, appropriate-sized speculum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks amount and source of any vaginal bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes any pus, discharge, lesions of the cervical os</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes culture if infection is suspected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performs a bimanual exam (required for MA and MVA)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses size, consistency, position of the uterus and adnexa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compares size of uterus with history of amenorrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks another provider or uses ultrasound if uncertain of uterine size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orders Laboratory Tests</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains any needed tests without delay of evacuation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers Rh immunoglobulin, if routine protocol, at time of MVA or when administering MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Takes Proper Steps for Suspected Ectopic Pregnancy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates woman's history and physical exam for possible ectopic pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate testing (such as hCG) or ultrasound imaging, if available, when ectopic pregnancy is suspected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treats or refers immediately if ectopic pregnancy is suspected or confirmed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Manages RTIs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers prophylactic antibiotics, if available, to all women before MVA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs MVA even if prophylactic antibiotics are not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses for and treats active infection, regardless of uterine evacuation method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribes a course of antibiotics to take after the uterine evacuation if infection present</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
B: Clinical Assessment for Postabortion Care Skills Checklist

**Instructions for self-assessment:** Check “yes” or “no” as to whether you routinely demonstrate each skill during your clinical assessment, and write comments.

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

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures Visual and Auditory Privacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies Abortion as Possible Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs a Rapid Initial Assessment for Shock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabilizes woman without delay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies causes or refer to a higher facilities if needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records Client History</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines first day of LMP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates signs and symptoms of pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about any pregnancy tests or ultrasounds and their results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines duration and amount of bleeding or spotting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines duration and severity of cramping or pelvic pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines if there is a history of fever, chills or abdominal pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines drug allergies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about recent medications taken, including misoprostol or herbs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetric and gynecological history:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live births, miscarriages, abortions, contraceptive use history, ectopic pregnancies, menstrual history, fibroids, infections or recent abortion-related care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about her sexual history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines HIV and STI status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about her surgical history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates physical or cognitive disabilities or mental illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks about any known medical conditions that may affect eligibility for MVA or MA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses risk of ectopic pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>Addresses or refers for: Hypertension, seizure disorder, anemia, bleeding disorders, diabetes, heart disease, asthma, suspected ectopic pregnancy, cervical stenosis, alcohol or drug abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performs a Physical Exam</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Evaluates general health</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks her vital signs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes signs of general health including weakness, lethargy, anemia or malnourishment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks her abdomen for masses, tenderness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Conducts a pelvic examination</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the woman to empty her bladder before the pelvic examination. If the woman is presenting with heavy bleeding and/or shock, then a catheter may be necessary to empty the bladder.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains to the woman what to expect, reassures her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses towel, sheet, etc. to ensure her privacy is protected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performs a speculum exam</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes ulcers or signs of STIs on the external genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gently inserts a warm, appropriate-sized speculum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks amount and source of any vaginal bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes any pus, discharge, lesions of the cervical os</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gently removes any visible POC from the os with a ring forceps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies traumatic injuries and removes any foreign bodies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes culture if infection is suspected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performs a Bimanual Examination</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses size, consistency and position of the uterus and adnexa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes any uterine or adnexal tenderness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compares size of uterus with history of amenorrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes whether cervical os is open or closed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks another provider or uses ultrasound if uncertain of uterine size and/or for detection of POCs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Makes Diagnosis and Develops Treatment Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines type and stage of abortion eg. (incomplete abortion due to spontaneous or induced abortion/ missed abortion/ complete abortion)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnoses and manages severe complications of abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines whether uterine evacuation is needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>If uterine evacuation is needed, determines eligibility for MVA or misoprostol. Counsels woman on available options</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains informed consent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines appropriate pain management plan (pharmacological/Non-pharmacological) and gives it without delay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orders Laboratory Tests</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains any needed tests without delay of evacuation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers Rh immunoglobulin, if routine protocol, at time of MVA or when administering misoprostol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Takes Proper Steps for Suspected Ectopic Pregnancy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates woman's history and physical examination for possible ectopic pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses appropriate testing (such as βhCG) or ultrasound imaging, if available, when ectopic pregnancy is suspected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treats or refers immediately if ectopic pregnancy is suspected or confirmed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Manages RTIs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers prophylactic antibiotics, if available, to all women before MVA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs MVA even if prophylactic antibiotics are not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not administer prophylactic antibiotics for uterine evacuation with misoprostol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses for and treats active infection, regardless of uterine evacuation method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribes a course of antibiotics to take after the uterine evacuation if infection present</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Counseling Skills Checklist

**Instructions for self-assessment:** Check “yes” or “no” as to whether you routinely demonstrate each skill during your counseling sessions, and write comments.

**Instructions for observation:** Silently observe and evaluate the counseling session. Do not interact verbally or nonverbally with the woman or the counselor during an observation. Check “yes” or “no” as to whether the provider demonstrated each skill during the counseling session, and write comments. Offer your evaluation and comments to the provider in private after the conclusion of the session.

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counseling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsels privately where no one else can see or hear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assures her of confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the woman in private whether she wants to invite anyone else in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structures counseling around each woman's needs and concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considers woman's individual circumstances, including emotional and physical state, medical condition, cultural and religious background and comprehension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrates empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separates personal values and beliefs from those of the woman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Effective Verbal and Non-Verbal Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faces or sits beside woman without physical barriers between them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leans forward slightly and makes appropriate eye contact</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks open-ended questions without judgment or assumptions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answers the woman's questions fully, using simple language</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes appropriate sounds, facial expressions and gestures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens actively by being attentive and focusing on the woman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes into account special considerations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>Discusses pregnancy options with woman, if she desires it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary, Informed Consent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides full information on options</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses benefits, risks, alternatives and what to expect with each procedure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss possible outcome of continuing the pregnancy to term</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures the woman has understood the information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures the woman has given consent without pressure or coercion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains consent before the uterine evacuation, unless the woman is in need of emergency care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Procedure Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains pregnancy and medical information, medical eligibility, available procedure and pain management in clear, simple language</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourages her questions and ensures that she understands the information provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoids inserting own preferences into discussion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains permission to treat the woman in the unlikely event of a complication or emergency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses return to fertility post procedure, contraceptive options and when they can be given</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Referrals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides information and makes referrals if needed about other reproductive health issues, including domestic violence, cancer screening, HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes referrals to services that are accessible and appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Closing a Counseling Session</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks woman to summarize key information discussed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solicits additional questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures the woman understands information and instructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides written or pictorial information or referrals, if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documents services and referrals in logbook</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix D: Contraceptive Counseling Skills Checklist

**Instructions for self-assessment:** Check “yes” or “no” as to whether you routinely demonstrate each skill during your counseling sessions, and write comments.

**Instructions for observation:** Silently observe and evaluate the counseling session. Do not interact verbally or nonverbally with the woman or the counselor during an observation. Check “yes” or “no” as to whether the provider demonstrated each skill during the counseling session, and write comments. Offer your evaluation and comments to the provider in private after the conclusion of the session.

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes Rapport</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greets clients in a friendly way, demonstrating interest and concern</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assures privacy and confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks for permission prior to including others in session</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assesses Woman’s Needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks open-ended questions about woman’s circumstances and needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without judgment, explores factors that led to the need for an abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If she was using contraception, assesses reasons for failure of method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains Human Reproduction (if necessary)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines Desire to Delay or Prevent Pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explores woman’s current desire to delay or prevent pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides information on the health benefits of child spacing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assesses Woman’s Individual Situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses woman’s clinical and personal situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses potential barriers to successful use of contraception and ways to resolve them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explains Characteristics of Available and Effective Methods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses any contraindications and methods for which she is medically eligible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offers a full range of methods available at the facility and where the woman will seek re-supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses when contraceptives can be provided in relation to her uterine evacuation method and process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains, in order from most to least effective, her eligible methods’ effectiveness, characteristics, use and side effects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>If she will need re-supplies, explains where she can access them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows actual methods and uses educational tools, pamphlets, pictures or anatomical models</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Helps the Woman Choose Her Method</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supports the woman in selecting the most effective method for her situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures informed choice of method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ensures Understanding of Chosen Methods</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures woman fully understands the method she has chosen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps her plan for continued use, ensuring she knows where and when to resupply or change her method if necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides chosen method or interim method if chosen method is not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides EC and instructions for use as a back-up method, if available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Refers to Other Resources As Needed</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manages special needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has resource lists available to make referrals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If unable to offer specialized counseling or services or meet woman’s needs, makes referrals to appropriate services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix E: Instrument Processing Skills Checklist: Ipas MVA Plus and Ipas Easy-Grip Cannulae

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Decontamination Soak</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fills a container with 0.5 % chlorine solution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wears gloves and face protection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draws 0.5% Chlorine solution into the aspirator and cannulae</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submerges MVA instruments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses gloves or forceps to remove after 10 min of soaking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Cleaning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wears barriers—gloves, gown, apron, face protection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flushes soapy water through the cannula; uses a cotton-tipped probe, soft brush or soft cloth to gently remove material</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disassembles aspirator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleans all instruments, removes tissue or blood, washes all surfaces in water and detergent if possible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses a small brush to clean crevices and inside</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleans until no material is visible upon careful inspection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dries with a clean cloth if desired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discards the cannula if not possible to remove all matter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. HLD or Sterilize</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Method: Steam Autoclave (Sterilization)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places cannula and disassembled aspirator separately in a cloth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places to allow steam contact to all surfaces, not obstructing openings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilizes at 121°C (250°F) for 30 minutes at 106 kPa (15 lbs/in2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cools before use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Method: Glutaraldehyde (Sterilization)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immerses cannula and aspirator so solution fills them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soaks according to manufacturer's instructions (10 hours for Cidex)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes with sterile forceps or gloves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses with sterile water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes the solution every two weeks or per manufacturer's instructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Method: Glutaraldehyde (HLD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immerges instruments so that solution fills them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soaks according to manufacturer's instructions (20 minutes for Cidex)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes using HLD or sterile gloves or forceps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses with sterile or boiled water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Method: 0.5 percent Chlorine (HLD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immerges so that solution fills instrument</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soaks in 0.5 percent chlorine solution for 20 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes using HLD or sterile gloves or forceps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses with boiled or sterile water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes chlorine solution at least daily</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Method: Boiling (HLD)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures water is at a rolling boil</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boils cannula and aspirator for 20 minutes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cools before removing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes using HLD or sterile gloves or forceps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handles cannula by non-aperture end</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4. Handling, Storage, Reassembly

<table>
<thead>
<tr>
<th>Keeps in covered containers, protected from contaminants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeps aspirators in clean place until next use; keeps cannulae sterile/HLD until and at the time of next use</td>
</tr>
<tr>
<td>Processes cannulae every day if processed using chemicals or boiling</td>
</tr>
<tr>
<td>Keeps only a few instruments in each container</td>
</tr>
<tr>
<td>Uses forceps to remove cannula by the non-aperture end; avoids touching the rest of the cannula</td>
</tr>
<tr>
<td>Reassembles and tests vacuum of aspirator</td>
</tr>
</tbody>
</table>
Appendix F: Uterine Evacuation with Medical Methods Skills Checklist – Mifepristone and Misoprostol

**Instructions for self-assessment:** Check "yes" or "no" as to whether you routinely demonstrate each skill during the session, and write comments.

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

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Clinic Visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the client chooses and is medically eligible for MA, provides more information on it in simple, age-appropriate, non-clinical terms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines whether someone can be with her during the MA process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarifies her feelings on possibility of having heavy bleeding at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains how to take mifepristone and misoprostol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to expect after taking the medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains how to take pain management medications (analgesics) and suggests other methods to reduce pain (e.g., hot water bottle)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures she understands:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The normal, expected effects and common side effects and symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Warning signs indicating the need to return to the clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to do in case of questions or problems at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides contact information if problem or emergency arises</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains that if the MA should fail, further steps will be necessary to terminate the pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solicits and answers questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses with the woman:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information about return to fertility, sexuality and contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contraceptive methods, if desired, with instructions for beginning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has woman swallow the mifepristone pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>If DMPA, implant or hormonal contraceptive chosen for contraception, provides method. If IUCD is chosen, gives instructions for follow-up in 1-2 weeks for insertion. If other methods are chosen, provides methods with instructions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the woman will take the misoprostol pills at home and does not need to return to get them, provide misoprostol pills to take home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advises the woman that follow-up care is available if needed or desired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Possible Second Visit for Misoprostol (if misoprostol was not given on the first visit for home use)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures privacy for counseling session</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greets the woman in a friendly, respectful manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to expect during the follow-up clinic visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides misoprostol for in clinic or to take home (per protocol)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the woman leaves the clinic before she aborts:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gives verbal and written instructions for aborting at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gives supplies (pain medications)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reminds the woman that follow-up care is available if needed or desired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides information and makes referrals if needed about other reproductive health issues, including sexual and gender-based violence, cancer screening and HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If DMPA, implant or hormonal contraceptive chosen for contraception, provides method. If IUCD is chosen, gives instructions for follow-up in 1-2 weeks for insertion. If other methods are chosen, provides methods with instructions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the woman aborts at the clinic:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• POCs may be examined to confirm expulsion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviews after-care instructions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides information on warning signs that indicate the need to return to the clinic or seek medical assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides contact information for emergencies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the woman whether she has additional questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Possible Follow-Up Visit (if needed or desired by the woman)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>Ensures privacy for the visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greets the woman in a friendly, respectful manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to expect during the follow-up clinic visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inquires about the woman’s experience with the abortion process, asking her if she thinks she is no longer pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses status of the abortion by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Asking about current cramping and current amount of bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conducting a physical examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If it is unclear whether the woman is still pregnant, discusses options:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Have another or more experienced clinician do an exam to check</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ask the woman to return in one week and re-check her (provided the pregnancy would not be too advanced to receive MVA if needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Perform MVA now</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the woman is no longer pregnant, provides:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information on how to contact clinic if she has questions/problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information about return to fertility and contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A contraceptive method if desired by the woman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If bleeding is prolonged or heavier than usual discusses treatment options:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Expectant management (depending on how heavy bleeding is)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MVA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the woman is still pregnant, discusses MVA to complete abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides information and makes referrals if needed about other reproductive health issues, including sexual and gender-based violence, cancer screening and HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the woman whether she has additional questions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix G: Misoprostol for Treatment of Incomplete Abortion Skills Checklist

**Instructions for self-assessment:** Check “yes” or “no” as to whether you routinely demonstrate each skill during the session, and write comments.

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

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Clinic Visit</strong></td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>If the woman chooses and is medically eligible for misoprostol, provides more information on the method in simple, age-appropriate, non-clinical terms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Note: If the woman chooses, refer to checklist in Uterine Evacuation Procedure With Ipas MVA Plus module for the remainder of the steps)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines whether someone can be with her during the misoprostol process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarifies the woman’s feelings on the possibility of having the evacuation at home and asks what support she has there</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures that she understands:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Expected effects and common side effects and symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Warning signs indicating the need to return to the clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains how to take the misoprostol and what to expect after taking it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains how to take pain-management medications (analgesics) and suggests other methods to reduce pain (e.g. hot water bottle)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to do in case of questions or problems at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides contact information if problem or emergency arises</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains that if the uterine evacuation with misoprostol should fail, MVA will be necessary to terminate the pregnancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the woman whether she has additional questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses with the woman:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information about return to fertility, sexuality and contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>• Contraceptive methods, if desired, with instructions for beginning. If woman chooses DMPA or implant, these methods may be supplied with the misoprostol. If she desires other hormonal methods, these may be provided and started immediately. If she desires IUCD, she needs follow-up appointment in 1-2 weeks for insertion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If contraceptive method is declined, discuss rapid return to fertility, (as early as 8 days following MA)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides misoprostol in clinic or to take home (per protocol)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advises the woman that follow-up care is available if needed or desired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Possible Follow-Up Visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures privacy for the visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greets the woman in a friendly, respectful manner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explains what to expect during the follow-up clinic visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inquires about the woman’s experience with the evacuation process, asking her if she thinks the process is complete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses the completeness of the uterine evacuation by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Taking a history of the process (amount and duration of bleeding, side effects, cramping)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Conducting a physical examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Performing an ultrasound, if available, if it is still unclear whether the evacuation is complete</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the misoprostol for incomplete abortion is successful, provides:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information on how to contact the clinic if she has questions or problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Contraceptive counseling (if not done earlier)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Information about return to fertility and contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A contraceptive method if desired by the woman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the pregnancy is continuing, discusses need for MVA to terminate it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes sure she has started contraceptive method if desired</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides information and makes referrals if needed about other reproductive health issues, including domestic violence, cancer screening, HIV and AIDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the woman if she has any additional questions</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix H: Uterine Evacuation Procedure with Ipas MVA Plus Skills Checklist

**Instructions for self-assessment:** Check "yes" or "no" as to whether you routinely demonstrate each skill during the UE procedure, and write comments.

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

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates Pain Management Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tailors pain management to the woman's needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses sources of pain, options, potential side effects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes combination of support and pharmacological measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes into account her medical and psychological status, staff skills, nature of the procedure and availability of supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares the Instruments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Checks vacuum retention of aspirator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has more than one instrument available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares the Woman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers pain medication in timely fashion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers prophylactic antibiotics to all women, and therapeutic antibiotics if indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks woman to empty her bladder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks what supportive measures she would like and provides them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks for permission to start</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts on barriers and washes hands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs pelvic exam to confirm assessment findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inserts speculum gently</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs Cervical Antiseptic Prep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows No Touch Technique</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses antiseptic sponges to clean os and, if desired, vagina</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers Paracervical Block</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses 10mL of 1% plain Xylocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirates before injecting 2mL at tenaculum site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places tenaculum/vulsellum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applies slight traction to expose cervico-vaginal junction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirates before slowly injecting the remaining 8mL in equal amounts at the cervicovaginal junction to 3cm depth at 2, 4, 8 and 10 o’clock</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Dilates Cervix if Needed</td>
<td></td>
<td></td>
<td>Dilates cervix until cannula fits snugly</td>
</tr>
<tr>
<td>Inserts Cannula</td>
<td></td>
<td></td>
<td>Applies gentle traction to cervix</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rotates cannula while gently applying pressure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inserts cannula just past internal os into uterus fundus and then pulls back about 1 cm</td>
</tr>
<tr>
<td>Suctions Uterine Contents</td>
<td></td>
<td></td>
<td>Holds volsellum/ tenaculum and end of cannula in one hand</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Attaches charged aspirator</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Releases buttons to start vacuum</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rotates cannula 180 degrees in each direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Uses an “in and out” motion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Does not withdraw aperture beyond os</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Uses gentle operative technique</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Uses positive, respectful, supportive reassurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stops when pink foam without tissue passes through cannula, gritty sensation is felt, uterus contracts around cannula and uterine cramping increases</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Removes the instrument</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Is ready to evacuate again after inspecting tissue if needed</td>
</tr>
<tr>
<td>Inspects Tissue</td>
<td></td>
<td></td>
<td>Empties aspirator into container</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Looks for POC in the light view box</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Evaluates amount based on estimated length of pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Determines all POC have been removed</td>
</tr>
<tr>
<td>Completes Remaining Steps</td>
<td></td>
<td></td>
<td>Wipes cervix to assess bleeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Considers if pelvic exam is advisable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reassures the woman that the uterine evacuation procedure is finished</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Performs any concurrent procedures (such as inserting an IUCD or implant, performing female sterilization or repairing a cervical tear)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>If inserting an IUCD or implant, follows steps in skills checklists</td>
</tr>
<tr>
<td>Performs Post-Procedure Care</td>
<td></td>
<td></td>
<td>Removes barriers and washes hands</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ensures woman is escorted to recovery area</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Processes instruments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Discuss and resolves any problems with the team</td>
</tr>
</tbody>
</table>
Appendix I: Post-Procedure Care Skills Checklist

**Instructions for self-assessment:** Check “yes” or “no” as to whether you routinely demonstrate each skill during your provision of post-procedure care, and write comments.

**Instructions for observer:** Silently observe and evaluate the provider’s provision of post-procedure care. Do not interact with the woman or provider. Check “yes” or “no” depending on whether the provider demonstrated the skill during the post-procedure period, and write comments. Offer your evaluation and comments following provision of care.

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitors the Woman’s Physical Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures the woman is resting comfortably</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes vital signs immediately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviews chart for condition and history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitors physiological status, including vital signs in between</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates bleeding and cramping at least twice before the women leaves the facility.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continues therapy for any pre-existing problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assesses and manages complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manages Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluates pain levels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers and monitors desired options for pain relief</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addresses Other Physical-Health Issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addresses other physical-health needs and provides referrals if needed for: anemia, RTIs/HIV, violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administers Rh-immunoglobulin, as per protocol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides Emotional Monitoring and Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responds sensitively to emotions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitors emotional status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides counseling and referrals for emotional-health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides Contraceptive Counseling <em>(if not done before the procedure, or additional as needed)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determines desire for future pregnancy and reproductive needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes sure that the woman knows how to use the method of contraception she has chosen and answer any of her questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranges for Follow-Up Care as Desired or Needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedules follow-up appointment according to her condition and/or request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges the Woman</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures recovery before discharging according to protocols</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides instructions on: self-monitoring normal recovery; pain relief/medications; behaviors that increase problems; when and how to seek treatment for complications; follow-up care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix J: Comprehensive Abortion Care (CAC) Clinical Skills Evaluation

Instructions for self-assessment: Check “yes” or “no” as to whether you routinely demonstrate each skill during your provision of post-procedure care, and write comments.

Instructions for observer: Silently observe and evaluate the provider’s provision of post-procedure care. Do not interact with the woman or provider. Check “yes” or “no” depending on whether the provider demonstrated the skill during the post-procedure period, and write comments. Offer your evaluation and comments following provision of care.

Instructions

This is a checklist for the essential skills described throughout the training curriculum for abortion service delivery. It is different than the checklists from each module of this course because it is briefer and can be used to evaluate the participant’s competence in abortion-care skills for abortion-care training certification. The trainer evaluates the competence of each participant based on direct observation of the participant’s provision of abortion care with MVA.

Mark an X in the box next to each step that is competently demonstrated by the participant. After completing the form, discuss the results with the participant.

MVA Clinical Skills

☐ 1. Establishes rapport with the woman, helps her feel comfortable, ensures privacy
☐ 2. Assesses the woman’s health: medical history including date of last menstrual period state (LMP), physical examination, including speculum exam and bimanual exam, emotional state, collection of specimens and ordering of lab tests as needed
☐ 3. Provides counseling, or confirms that the woman received counseling, and obtains her informed consent
☐ 4. Communicates and provides support to woman throughout procedure.
☐ 5. Evaluates need for and administers pain management based on the woman’s condition and her desires
☐ 6. Uses infection-prevention practices: handwashing, gloves, face protection
☐ 7. Administers prophylactic antibiotics
☐ 8. Assesses size and position of uterus
☐ 9. Identifies possible reproductive tract infection (RTI) and administers or prescribes therapeutic antibiotics as needed
☐ 10. Ensures that the cannulae are high-level disinfected (HLD) or sterile, rinsed and ready for use
☐ 11. Prepares aspirator and checks vacuum
☐ 12. Selects cannula based on uterine size and dilatation needed; inspects cannula and aspirator
☐ 13. Swabs cervix, and vagina if desired, with antiseptic solution
☐ 14. Administers paracervical block and any other necessary medications
☐ 15. Dilates cervix, inserts cannula and attaches aspirator
☐ 16. Uses no-touch technique
☐ 17. Moves cannula effectively to empty the uterus
18. Stops evacuation when signs of completion are present
19. Examines the products of conception (POC) to confirm completion and to ensure it is consistent with the woman’s length of pregnancy/uterine size
20. Performs and concurrent procedures, such as IUCD insertion, contraceptive implant insertion, contraceptive injection, sterilization, if desired by woman after counseling; or repair of cervical tear, if present
21. Ensures post-procedure care is provided; monitors the woman’s status
22. Ensures contraceptive counseling and a method are provided, if the woman desires one
23. Ensures follow-up care is scheduled with referrals provided as needed or if woman requests or desires follow up

Evaluator

Name

Title

Date

Signature

Participant

Name

Title

Date

Signature

Name of Medical Facility

Recommendations

For skills that were not observed or were not performed to competency, suggest recommendations to be followed. For example: “needs to continue practice under supervision” or “repeat clinical training.”

<table>
<thead>
<tr>
<th>Item</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

Please add any comments you may have about the participant’s ability to perform MVA
**Action Plan Activity Worksheet**

**Instructions:** Using the service site Equipment's Guidelines, prepare a plan for starting high-quality comprehensive second trimester abortion care services at your site.

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Issues/ Gaps</th>
<th>Activity</th>
<th>Date</th>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

204 • COMPREHENSIVE ABORTION CARE (CAC) INTEGRATED TRAINERS’ MANUAL
MVA Service Delivery Site Assessment/Monitoring Checklist

Introduction:

- The MVA (Medical Abortion) program must be conducted according to national standards and protocol. The provider must ensure that the facility is equipped to handle MVA cases.

Method:

- The checklist shall be administered by the Health/Family Planning Team at the facility. The checklist shall be conducted in all facilities and at all levels, including the District Health Office. If the facility does not meet the MVA standards, the District Health Office shall be notified. The District Health Office shall take appropriate actions to improve the facility. If the facility meets the MVA standards, the District Health Office shall be notified. The District Health Office shall take appropriate actions to improve the facility.

Facility Name: 

District: 

1. Site assessment

Name: 

Position: 

Date: 

Signature: 

Comprehensive Abortion Care (CAC) Integrated Trainers' Manual • 205
Minimum Requirements for MVA Service Delivery Site (For 3 cases/day)

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Registration Area</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Space for nursing station</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Table and chairs for the nursing station</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Space and seats for waiting clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IEC Materials about Abortion and Family Planning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Toilet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HMIS-11 log book</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Counseling Room or Area</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partition screen if necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Table and 2 chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• B.P instruments (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Thermometer (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stethoscope (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Flip chart for counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Client Assessment/Examination Room</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reliable source of running water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Examination table (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Goose’ neck Light/ Emergency light /torch (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Table and 2 chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stainless steel tray/ drum with cover for storing the instruments (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical gloves (5 pairs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bivalve speculum (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cheattel’s forceps with jar (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bowel/Bucket with clean Water (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bowel/Bucket with chlorine water (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Procedure Room</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4.1 Equipment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Procedure table (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Instrument Trolley (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stool for Procedure (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Goose’ neck light (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• I.V. Stand and IV sets (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• B.P instrument (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Thermometer (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stethoscope (1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stainless steel drum with cover for storing the instruments (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• One stainless tray with cover for storing the MVA cannula (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cheattel’s forceps with jar-1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MVA Aspirator-3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MVA cannula set No. 4-12 (3 set)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 10 ml syringe for para cervical block (4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgical gloves (5 pairs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hand towels (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bivalve speculum (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dilators (1 set)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sponge holders (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tenaculum or Volsellum (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Grasping Forceps/ Long Artery Forceps (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Bowl for keeping Betadine solution (3)
- Kidney tray (3)
- Steel container for POC collection (1)
- Gauge piece/cotton

4.2 POC Checking
- Sieve (1)
- Magnifying glass/light box (1)

4.3 Life support instruments
- Oxygen cylinder with oxygen and flow meter (1)
- Ambu bag (1)

4.4 Essential drugs
- Ibuprofen (10 tab)
- Diclofenac (10 tab)
- Paracetamol (10 tab)
- Lignocaine 1% (2 bottle)
- Diazepam- Oral (10 tab) and Injectable (2 vial)
- Doxycycline (10 tab)
- Metronidazole/Tinidazole (10 tab)
- Ciprofloxacin (10 tab)
- Oxytocine (4 vial)
- Ergometrine (4 vial)
- Betadine solution (2 bottle)
- 5% Dextrose
- Normal Saline (4 bottle)
- Ringer lactate (4 bottle)
- Water for injection (2 vial)
- IV Cannula (2)

4.5 Life-saving drugs
- Atropine (2 vial)
- Hydrocortisone (2 vial)
- Dexamethsone (2 vial)
- Inj. Adrenaline (2 vial)
- Inj. Aminophylline/Inj. Deriphylline (2 vial)
- Plasma expanders-2

4.6 Contraceptives available
- Implant (3)
- IUCD (3)
- Permanent sterilization service/ referral

4.7 Infection prevention
- Utility Gloves (1 pair)
- Leak proof waste containers for sharp needles (1)
- Bucket for waste collection (1)
- Plastic apron (2)
- Bowel/Bucket with clean Water (1)
- Bowel/Bucket with chlorine water (1)
5. **Recovery Room**
- B.P instrument (1)
- Thermometer (1)
- Stethoscope (1)
- Low bed (2)
- Mattress and pillow wrap by regzin (2)
- I.V. Stand (1)
- FP methods available (Condom, OCP-3 Pkts, Depo-3 vial)
- Emesis Pan (1)
- Bucket for waste collection (1)
- Sink and reliable source of running water
- Toilet

6. **Space for Instrument Processing**
- Reliable source of running water
- Storage space for supplies and instruments
- Autoclave drum (3)
- Plastic aprons (2)
- Utility Gloves (1 pair)
- Detergent powder (2 pkt)
- Soft brush for cleaning instruments (1)
- Plastic Bowl/Bucket for cleaning (2)

7. **Waste Management system**
- Pit/ Incinerator

8. **Personnel**
- CAC Provider (1)
- Assistant Nurse (1)
- Support Staff (1)

9. **Comprehensive Reproductive Health Service**
- BEOC/ CEOC site (please mention the site type under the remarks column)
- Counseling / treatment/ referral for HIV +ve cases
- Treatment for RTI
- Service for Adolescent

10. **Emergency Services available 24 hour OR referral**
- Name of the referral hospital (please mention the name of the hospital under the remarks column)
- Available transport/Fund in case of emergency
यस स्वास्थ्य संस्थामा माध्यमिक मापदण्ड अनुसारको औषधि, उपकरण र पूर्वाञ्चल पाइएको हुनाले सुरक्षित गर्नेतन सेवाका लागि सिफारिस गर्दछ।

नाम:
पद: जिल्ला जनस्वास्थ्य/स्वास्थ्य अधिकृत
सही:
मिति:

नाम:
पद: पञ्चिक हेल्थ नर्स
सही:
मिति:

स्वास्थ्य संस्थाको छाप
# IUCD Insertion Checklist

## Skill/Activity Performed Satisfactorily

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preinsertion and Insertion Steps</strong> (Using aseptic, &quot;no touch&quot; technique throughout)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Provide an overview of the insertion procedure. Remind her to let you know if she feels any pain.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Gently insert the HLD (or sterile) speculum to visualize the cervix (if not already done), and clean the cervical os and vaginal wall with antiseptic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Gently grasp the cervix with an HLD (or sterile) tenaculum vulsulum and apply gentle traction.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Insert the HLD (or sterile) sound using the &quot;no touch&quot; technique.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Load the IUCD in its sterile package.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Set the blue depth-gauge to the measurement of the uterus.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Carefully insert the loaded IUCD, and release it into the uterus using the &quot;withdrawal&quot; technique.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Gently push the insertion tube upward again until you feel a slight resistance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Withdraw the rod, and partially withdraw the insertion tube until the IUCD strings can be seen.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Use HLD (or sterile) sharp Mayo scissors to cut the IUCD strings to 3–4 cm length.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Gently remove the tenaculum and speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Examine the cervix for bleeding.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Ask how the client is feeling and begin performing the postinsertion steps.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Postinsertion Steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.</td>
</tr>
<tr>
<td>2.</td>
<td>Properly dispose of waste materials.</td>
</tr>
<tr>
<td>3.</td>
<td>Process gloves according to recommended IP practices.</td>
</tr>
<tr>
<td>4.</td>
<td>Wash hands thoroughly and dry them.</td>
</tr>
<tr>
<td>5.</td>
<td>Provide postinsertion instructions (key messages for IUCD users):</td>
</tr>
<tr>
<td></td>
<td>- Basic facts about her IUCD (e.g., type, how long effective, when to replace/remove)</td>
</tr>
<tr>
<td></td>
<td>- No protection against STIs; need for condoms if at risk</td>
</tr>
<tr>
<td></td>
<td>- Possible side effects</td>
</tr>
<tr>
<td></td>
<td>- Warning signs (PAINS)</td>
</tr>
<tr>
<td></td>
<td>- Checking for possible IUCD expulsion</td>
</tr>
<tr>
<td></td>
<td>- When to return to clinic</td>
</tr>
</tbody>
</table>
# IUCD REMOVAL CHECKLIST

## Skill/Activity Performed Satisfactorily

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre removal Steps</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Ask the woman her reason for having the IUCD removed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Determine whether she will have another IUCD inserted immediately, start a different method, or neither.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Review the client’s reproductive goals and need for STI protection, and counsel as appropriate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ensure that equipment and supplies are available and ready to use.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have the client empty her bladder and wash her perineal area.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Help the client onto the examination table.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Wash hands thoroughly and dry them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Put new or HLD gloves on both hands.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post removal Steps</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Before removing the gloves, place all used instruments and the IUCD in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Properly dispose of waste materials.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Process gloves according to recommended IP practices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Wash hands thoroughly and dry them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If the woman has had a new IUCD inserted, review key messages for IUCD users. [If the woman is starting a different method, provide the information she needs to use it safely and effectively (and a backup method, if needed).]</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# IMPLANT INSERTION CHECKLIST

<table>
<thead>
<tr>
<th>LEARNING GUIDE FOR <em>IMPLANTS CLINICAL SKILLS: INSERTION</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skill</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td><strong>GETTING READY</strong></td>
</tr>
<tr>
<td>1. Greet client respectfully and with kindness.</td>
</tr>
<tr>
<td>2. Review Client Screening Checklist and further evaluate client, if indicated.</td>
</tr>
<tr>
<td>3. Tell client what is going to be done and encourage her to ask questions.</td>
</tr>
<tr>
<td>4. Ask about allergies to antiseptic solution and local anesthetic agent.</td>
</tr>
<tr>
<td>5. Check to be sure client has thoroughly washed and rinsed her entire arm.</td>
</tr>
<tr>
<td>7. Select and position woman’s arm and place clean, dry cloth under her arm.</td>
</tr>
<tr>
<td>8. Determine insertion area by measuring 6-8 cm above the elbow fold.</td>
</tr>
<tr>
<td>9. Using template, mark position on arm for insertion of each rod (this should form a &quot;V&quot; shape).</td>
</tr>
<tr>
<td>10. Determine that required sterile or high-level disinfected instruments are present.</td>
</tr>
<tr>
<td>11. Open sterile or high-level disinfected instrument pack without touching instruments.</td>
</tr>
<tr>
<td>12. Open sterile implants package by pulling apart sheets of the pouch and dropping rods into a sterile or high-level disinfected bowl or tray.</td>
</tr>
<tr>
<td><strong>PRE-INSERTION TASKS</strong></td>
</tr>
<tr>
<td>1. Wash hands thoroughly with soap and water and dry with sterilized cloth or air dry.</td>
</tr>
<tr>
<td>2. Put sterile or high-level disinfected surgical gloves on both hands.</td>
</tr>
<tr>
<td>• (If gloves are powdered, wipe powder off glove fingers with sterile gauze soaked in sterile or boiled water.)</td>
</tr>
<tr>
<td>3. Arrange instruments and supplies on sterile or high-level disinfected tray.</td>
</tr>
<tr>
<td>4. Count to make sure that there are two rods.</td>
</tr>
<tr>
<td>5. Apply antiseptic solution to the incision area two times using a circular motion for 8 to 13 cm; allow to air dry.</td>
</tr>
<tr>
<td>Skill</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>6. Place sterile or high-level disinfected eye towel over arm.</td>
</tr>
<tr>
<td>7. Using a disposable needle and syringe, inject a small amount of local anesthetic (1% without epinephrine) just under the skin at the incision site to raise a small wheal.</td>
</tr>
<tr>
<td>8. Advance needle about 5 cm and as the needle is withdrawn, slowly inject 1 ml of local anesthetic in between subdermal tracks.</td>
</tr>
<tr>
<td>9. Withdraw needle and place in a safe area to prevent accidental needle sticks.</td>
</tr>
<tr>
<td>10. Massage the skin to spread the anesthetic within the tissues.</td>
</tr>
<tr>
<td>11. Test incision site with tip of forceps for adequate anesthesia. (If patient feels pain, wait 2 to 3 minutes and retest incision site.)</td>
</tr>
</tbody>
</table>

**INSERTION**

1. Make a shallow, 2 mm incision with a scalpel just through the skin at insertion site. (Alternatively, insert trocar directly through the skin without making an incision.)

2. Insert trocar and plunger through the incision at a shallow angle with the bevel facing up.

3. While tenting the skin, slowly and smoothly advance trocar and plunger to mark (1) nearest the hub on the trocar. The tip of the trocar should be under the first mark on the skin nearest the shoulder.

4. Remove plunger.

5. Load first rod into trocar using either the gloved thumb and forefinger of one hand or a forceps, keeping the other hand cupped beneath the trocar in order to catch the implant if it falls.

6. Reinsert plunger and push implant toward tip of trocar just until resistance is felt. Never force the plunger.

7. Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.

8. Withdraw trocar and plunger together until mark (3) nearest the tip just clears incision; do not remove trocar from incision.

9. Move the tip of the trocar laterally away from the end of the implant to be sure it is completely free of the trocar.
<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Avoid damaging the first rod by holding it out of the path of the trocar with the forefinger and middle finger of the free hand.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Redirect trocar about 15° to follow next mark on the skin; then advance trocar and plunger to mark (1) nearest the hub on the trocar.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. The second implant is inserted at the side of first one to form a &quot;V&quot; shape.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Palpate the ends of the implants nearest the shoulder to be sure the implants are placed correctly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. To prevent expulsion, leave a distance of about 5 mm between the incision and the ends of the implants.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Remove trocar from incision.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POST-INSERTION TASKS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Press down on incision with gauzed finger to stop bleeding.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Remove the drape.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Bring edges of incision together and close it with Bandaid® or surgical tape with sterile gauze.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Apply pressure dressing to insertion area and wrap gauze bandage snugly around the arm to ensure hemostasis and minimize bruising.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination, separating the plunger from the trocar.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Dispose of waste materials by placing in a leak proof container or plastic bag.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 8. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out.  
• If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination. | | | |
| 9. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry. | | | |
| 10. Complete client record, including drawing position of capsules. | | | |
| 11. Observe the client for at least 15-20 minutes and ask her how she feels before sending her home. | | | |
## IMPLANT REMOVAL CHECKLIST

### LEARNING GUIDE FOR IMPLANTS CLINICAL SKILLS: REMOVAL

<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GETTING READY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Greet client respectfully and with kindness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ask client her reason for removal and review her reproductive goals.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If she wants to continue family planning, ask if she wants another set of implants.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tell client what is going to be done and encourage her to ask questions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ask about allergies to antiseptic solution and local anesthetic agent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Check to be sure client has thoroughly washed and rinsed her entire arm.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Position woman’s arm and place clean, dry cloth under her arm.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Palpate implants and mark their position, area for anesthesia and incision site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Determine that required sterile or high-level disinfected instruments are present.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Open sterile or high-level disinfected instrument pack without touching instruments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PRE-REMOVAL TASKS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Wash hands thoroughly with soap and water and dry with sterile cloth or air dry.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Put sterile or high-level disinfected surgical gloves on both hands. (If gloves are powdered, wipe powder off glove fingers with gauze soaked in sterile or boiled water.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Arrange instruments and supplies on sterile or high-level disinfected tray.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Apply antiseptic solution to the incision area two times using a circular motion for 8 to 13 cm; allow to air dry.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Place sterile or high-level disinfected surgical drape over arm (optional).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Using a sterile needle and syringe, inject a small amount of local anesthetic (1% without epinephrine) to raise a small wheal just under the skin, at a point just below the ends of the rods.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skill</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>7. Place needle about 1 cm under the rod ends nearest the original incision site.</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>8. Inject 1 ml of local anesthetic under the ends of the rods while slowly withdrawing the needle.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Withdraw needle and place in a safe area to prevent accidental needle sticks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Massage the skin to spread the anesthetic within the tissues.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Test the incision site with tip of forceps for adequate anesthesia. (If client feels pain, wait 2 to 3 minutes and retest incision site.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>REMOVAL: “U” TECHNIQUE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Make a small (4 mm) skin incision vertically between implants about 5 mm above the implant end nearest the elbow fold.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Insert tip of implants-holding forceps at a right angle to long axis of the nearest rod.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. While stabilizing the implant with the index finger of the free hand, advance tip of forceps until it touches the implant.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Grasp implant at a right angle and gently pull implant toward the incision. If the implant cannot be easily pulled into the incision, flip handles 180° to expose the implant.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Clean off and open fibrous tissue sheath with sterile gauze (or scalpel if necessary).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Grasp exposed end of implant with curved forceps, gently remove implant and place in bowl containing 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Remove the next implant that appears easiest to retrieve on either side of the incision.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Remove the remaining implant using the same technique (steps 2–6). Inject more local anesthetic only if required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Make sure that both rods have been removed. It is important to show 2 rods to the client after removal.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>POST-REMOVAL TASKS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Press down on incision with gauzed finger to stop bleeding and remove the drape, if used.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Wipe client's arm with alcohol to remove any Betadine or markings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skill</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>3. Bring edges of incision together and close it with Bandaid or surgical tape with sterile cotton.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Apply pressure dressing to removal area and wrap gauze bandage snugly around the arm to ensure hemostasis and minimize bruising.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Dispose of waste materials, including Norplant capsules, by placing in leak proof container or plastic bag.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. • If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post removal Counseling**

10. Instruct client regarding wound care and make return visit appointment, if needed.
11. Discuss what to do if client experiences any problems.
12. Make return visit appointment if both rods could not be removed.
13. Ask client to repeat instructions.
14. Answer client’s questions.
15. If client wants to continue spacing or limiting births using another method, review general and method-specific information about family planning methods.
16. Help client obtain new contraceptive method or provide temporary (barrier) method until method of choice can be started.
17. Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.

**REMOVAL OF HARD-TO-REMOVE CAPSULES**

1. If implant cannot be easily moved into the incision, insert curved forceps through incision until forceps jaws are under the end of the implants.
2. Break up scar tissue surrounding ends of the implants.
3. Push end of one implant as close to incision as possible.
<table>
<thead>
<tr>
<th>Skill</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Grasp end of implant with curved (mosquito or Crile) forceps and gently bring it into the incision.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If implant cannot be pulled gently into the incision, insert opened curved forceps with jaws curving up; catch the implant from below between tips of forceps jaws.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Close forceps on implant and flip handle of forceps 180° towards client’s shoulder.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. After flipping forceps, clean off fibrous tissue sheath from exposed end of implant with sterile gauze (or scalpel if necessary).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. If implant <strong>not</strong> visible after “flipping,” twist forceps 180° degrees around its main axis to reveal implant end.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. With the sheath opened, gently squeeze the tissue surrounding the end of the implant with both thumbs to bring the end into view and grasp with second forceps.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Slowly and gently remove implant and place it in a bowl containing 0.5% chlorine solution for 10 minutes for decontamination.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Client Personal Profile**

**Comprehensive Abortion Services**

<table>
<thead>
<tr>
<th>HMIS (3.7) No.</th>
<th>Date of visit: <strong>/</strong>/__</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
<td>District: ___________________</td>
</tr>
</tbody>
</table>

### 1. Personal History

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Last Name:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District:</th>
<th>Municipality</th>
<th>Ward No:</th>
<th>Contact Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LMP Date:</th>
<th>Gestation Week:</th>
<th>Gravida:</th>
<th>Para:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Menstrual cycle:</th>
<th>Regular</th>
<th>Irregular</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug Allergy:</th>
<th>Yes</th>
<th>No</th>
<th>If yes, name of drugs: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client using steroid:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous history of Ectopic Pregnancy:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous surgical history:</th>
<th>Yes</th>
<th>No</th>
<th>If yes, type of surgery: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any contraceptives used for last six months (If yes mention the type):

### 2. Examination/ Investigation

<table>
<thead>
<tr>
<th>Temp:</th>
<th>Pulse:</th>
<th>Blood pressure:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pallor:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jaundice:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart:</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs:</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Abdominal:</th>
<th>Mass palpable:</th>
<th>Abdominal tenderness:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Uterus palpable:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P/S examination: Cervix:</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cervical erosion:</th>
<th>Yes</th>
<th>Foul smelling discharge:</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P/V examination: Uterine size (weeks):</th>
<th>Position:</th>
<th>Adnexa:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigation (If relevant):</th>
<th>Pregnancy test:</th>
<th>Ultrasonography:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hemoglobin:</th>
<th>Blood group and RH type:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Assessment

<table>
<thead>
<tr>
<th>She is fit to undergo safe abortion service:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure chosen by the client:</th>
<th>&lt;63 days</th>
<th>MA</th>
<th>MVA</th>
<th>63 days-12 week</th>
<th>MVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 4. Client Record (Medical Abortion)

<table>
<thead>
<tr>
<th>Drug Provided</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mifepristone (200 mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misoprostol (200 mcg X 4 tablets)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Pain management given (400 mg Ibuprofen X 4 tablets) | Yes | No |

<table>
<thead>
<tr>
<th>Contraceptive Provided (day of Mifepristone):</th>
<th>Condom</th>
<th>Pills</th>
<th>Depo Provera</th>
<th>Implant</th>
<th>None</th>
<th>NA</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Follow up done</th>
<th>In-person</th>
<th>Telephone</th>
<th>Not done</th>
<th>Date of Follow up:</th>
</tr>
</thead>
</table>

| Status on follow up | complete | incomplete | ongoing pregnancy |

<table>
<thead>
<tr>
<th>Contraceptive provided (day of follow up):</th>
<th>Condom</th>
<th>Pills</th>
<th>Depo Provera</th>
<th>Implant</th>
<th>IUCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minilap</td>
<td>NSV</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Any complication | No | Yes (If yes, mention the type) | Heavy bleeding requiring Blood transfusion | Infection requiring hospitalization with IV Antibiotics | On-going pregnancy |

| Reason for Referral | Complication management | More than 12 weeks |

Name of the referral site: ..............................................

Name of Service Provider: ..............................................

Signature: ..............................................

listed Number: ..............................................

### 5. Client Record (MVA)

<table>
<thead>
<tr>
<th>Date of procedure</th>
<th>Time of procedure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medication given</th>
<th>Diazepam 10 mg</th>
<th>Doxycycline (100mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ibuprofen 400 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Para cervical block (1 % Xylocaine)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of cannula used</th>
<th>Amount of blood loss (ml.):</th>
</tr>
</thead>
<tbody>
<tr>
<td>POC findings</td>
<td>Villi seen:</td>
</tr>
<tr>
<td>Fetal parts seen:</td>
<td>Yes</td>
</tr>
<tr>
<td>Scanty POC Seen:</td>
<td>Yes</td>
</tr>
<tr>
<td>POC consists with............Weeks</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post procedural findings</th>
<th>Pulse</th>
<th>Blood pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp:</td>
<td>Non-tender</td>
<td>Non-guarding</td>
</tr>
<tr>
<td>Abdomen:</td>
<td>Tender</td>
<td>Guarding</td>
</tr>
<tr>
<td>Vaginal bleeding:</td>
<td>scanty</td>
<td>Heavy</td>
</tr>
<tr>
<td>moderate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


**Client Personal Profile**

**Comprehensive Abortion Services**

<table>
<thead>
<tr>
<th>HMIS (3.7) No.</th>
<th>Date of visit: ___ / ___ / ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
<td>District:</td>
</tr>
</tbody>
</table>

### 1. Personal History

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District:</th>
<th>Municipality</th>
<th>Ward No:</th>
<th>Contact Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LMP Date:</th>
<th>Gestation Week:</th>
<th>Gravida:</th>
<th>Para:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Menstrual cycle:</th>
<th>□ Regular</th>
<th>□ Irregular</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Allergy:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>If yes, name of drugs:</td>
<td>.................</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client using steroid:</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Previous history of Ectopic Pregnancy:</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

| Previous surgical history: | □ Yes | □ No |
| If yes, type of surgery: | ................. |

Any contraceptives used for last six months (If yes mention the type):

### 2. Examination/Investigation

<table>
<thead>
<tr>
<th>Temp:</th>
<th>Pulse:</th>
<th>Blood pressure:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pallor:</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaundice:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart:</th>
<th>□ Normal</th>
<th>□ Abnormal</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lungs:</th>
<th>□ Normal</th>
<th>□ Abnormal</th>
</tr>
</thead>
</table>

**Abdominal:** Mass palpable: □ Yes □ No

<table>
<thead>
<tr>
<th>Abdominal tenderness:</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterus palpable:</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

**P/S examination:**

<table>
<thead>
<tr>
<th>Cervix:</th>
<th>□ Normal</th>
<th>□ Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical erosion:</td>
<td>□ Yes</td>
<td></td>
</tr>
<tr>
<td>Foul smelling discharge:</td>
<td>□ Yes</td>
<td></td>
</tr>
</tbody>
</table>

**P/V examination:**

<table>
<thead>
<tr>
<th>Uterine size (weeks):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
<td></td>
</tr>
<tr>
<td>Adnexa:</td>
<td></td>
</tr>
</tbody>
</table>

**Investigation (If relevant):**

<table>
<thead>
<tr>
<th>Pregnancy test:</th>
<th>Ultrasoundography:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Blood group and RH type:</td>
</tr>
<tr>
<td>Hemoglobin:</td>
<td></td>
</tr>
</tbody>
</table>

### 3. Assessment

<table>
<thead>
<tr>
<th>She is fit to undergo safe abortion service:</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Procedure chosen by the client:</th>
<th>&lt;63 days</th>
<th>□ MA</th>
<th>□ MVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>63 days-12 weeks</td>
<td>□ MVA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

COMPREHENSIVE ABORTION CARE (CAC) INTEGRATED TRAINERS' MANUAL • 219
### 4. Client Record (Medical Abortion)

**Drug Provided:** Mifepristone (200 mg): Date: __/__/___  Time:  
Miso prostol (200 mcg X 4 tablets): Date: __/__/___  Time:  

- Pain management given (400 mg Ibuprofen X 4 tablets): □ Yes  □ No

**Contraceptive Provided (day of Mifepristone):**

- □ Condom  □ Pills  □ Depo Provera  □ Implant  □ None  □ NA

**Follow up done:**

- □ In-person  □ Telephone  □ Not done  Date of follow up: ..........................................................

**Status on follow up:**

- □ complete  □ incomplete  □ ongoing pregnancy

**Contraceptive provided (day of follow up):**

- □ Condom  □ Pills  □ Depo Provera  □ Implant  □ IUCD
- □ Minilap  □ NSV  □ NA

**Any complication:**

- □ No  □ Yes (If yes, mention the type)  □ Heavy bleeding requiring Blood transfusion
- □ Infection requiring hospitalization with IV Antibiotics  □ On-going pregnancy

**Reason for Referral:**

- □ Complication management  □ More than 12 weeks

Name of the referral site: ..........................................................

Name of Service Provider:  Signature:  listed Number:

### 5. Client Record (MVA)

**Date of procedure:** __/__/___  
**Time of procedure:**  

**Medication given:**

- □ Ibuprofen 400 mg  □ Diazepam 10 mg  □ Doxycycline (100mg)
- □ Para cervical block (1% XylLocaine)

**Number of cannula used:**

- POC findings: Villi seen: □ Yes □ No
- Fetal parts seen: □ Yes □ No

**Amount of blood loss (mL):**

- Scanty POC Seen: □ Yes □ No
- POC consists with .......... Weeks

**Post procedural findings:**

- Temp:  
- Pulse:  
- Abdomen: □ Non-tender □ Tender  
- Vaginal bleeding: □ scanty □ moderate  
- Blood pressure: □ Non-guarding □ Guarding  
- □ Heavy
**Contraceptive Received:**
- [ ] Condom
- [ ] Pills
- [ ] Depo Provera
- [ ] Implant
- [ ] IUCD
- [ ] Minilap
- [ ] NSV
- [ ] None

**Any Complication:**
- [ ] No
- [ ] Yes

(If yes, mention the type)
- [ ] Heavy bleeding requiring Blood transfusion
- [ ] Infection requiring hospitalization with Antibiotics
- [ ] Uterine/ abdominal injury requiring laparotomy
- [ ] Ongoing pregnancy

**Outcome of Complication:**
- [ ] Treated and discharged
- [ ] Referred out

(Name of the referred facility)

**Referral made for 12 weeks:**
- [ ] No
- [ ] Yes

(If yes, Mention the name of the facility)

**Time of discharge after the service:**

<table>
<thead>
<tr>
<th>Name of Service Provider:</th>
<th>Signature:</th>
<th>listed Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Assistant:</td>
<td>Signature:</td>
<td></td>
</tr>
</tbody>
</table>


6. Client consent Form

अनुसूची-५

(दफा १० को उपदफा (१) र (२) संग सम्बन्धित)

सुरक्षित गर्भपत्तन सेवाको लागि स्वय वा नजिकको नातेदारको दिने मन्दूरीनामा

सुरक्षित गर्भपत्तन सेवाको आवश्यकता, गर्भपत्तनका विविध प्रशिक्षित गर्भपत्तन सेवामा अन्तर्निहित जोखिम, ल्यसका विकसितररु र वस्त्रात रुने फाइडा वेकाइवा लगायतका प्राथिक एवं स्वावलंभिक प्रकारमा पूर्ण परामर्श प्राप्त भएकोले सेवा प्राप्त गर्न सुरक्षित गर्भपत्तन सेवा प्राप्त, २०६० को दफा १० को उपदफा (१) म ल्याउँदै बा (२) वमोजिम निज गर्भवती महिलाको नजिकको नातेदारको हैँसिद्धतिने यो मन्दूरीनामा लेखी तपाईं चिनितको स्वावलंभिक/गर्भपत्तनको घोषणा लाई विचारिएको छ।

ल्याउँदै (हस्ताक्षर गर्न नजाराणेको हकमा)

स्वावलंभिक मन्दूरीनामा दिलेको :-
हस्ताक्षर :-
नाम धर :-
क) सेवा लिने व्यक्तिको :-
ख) नजिकको नातेदारको :-

उम्र :-
क) सेवा लिने व्यक्तिको :-
ख) नजिकको नातेदारको :-
ठेगाना :-
जिल्ला :-
गाउँ/नगर :-
ब्या न. :-
टोल :-
मिति :-
## MONTHLY REPORTING FORMAT 9.3/9.4/9.5 (HOSPITAL/ PHC/ HP)

| नेपाल सरकार | प्रविधि प्रादेशिक स्वास्थ्य उप स्वास्थ्य कार्यालय,  
| स्वास्थ्य तथा जनस्वास्थ्य मन्त्रालय, स्वास्थ्य मंत्रालय विभाग | जिल्ला जन/स्वास्थ्य कार्यालय,  
| प्र.स्वा.के./स्वा.चौ./उप स्वा.चौ. | मासिक प्रगति प्रतिवेदन फारम  
| प्र.स्वा.तिक | प्रादेशिक मासिक प्रगति प्रतिवेदन फारम  
| स्वास्थ्य संस्था कोड  |

| श्री जिल्ला जन स्वास्थ्य कार्यालय, |

<table>
<thead>
<tr>
<th>सर्विस क्षेत्र</th>
<th>Medical</th>
<th>Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 सर्विस क्षेत्र (SAS) पर्याप्त जोखिम नियोजन साधन प्रदेश की महत्वपूर्ण संख्या</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 सर्विस क्षेत्र (SAS) पर्याप्त जोखिम नियोजन साधन प्रदेश की महत्वपूर्ण संख्या</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 सर्विस क्षेत्र (SAS) पर्याप्त जोखिम नियोजन साधन प्रदेश की महत्वपूर्ण संख्या</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 सर्विस क्षेत्र (SAS) long-term पर्याप्त जोखिम नियोजन साधन प्रदेश की महत्वपूर्ण संख्या</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**COMPREHENSIVE ABORTION CARE (CAC) INTEGRATED TRAINERS' MANUAL** • 223
End-of-Course Evaluation

Date __________________________ Location __________________________

Name of Trainers __________________________________________

Please rate the course on each item below using the following scale. Please use the comments section to provide more information about the rating and suggestions for improvement.

4 = strongly agree  3 = agree  2 = disagree  1 = strongly disagree  N/A = neither agree or disagree

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The course fulfilled its goal and objectives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The course was well-organized.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The trainers were responsive to participants' needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The trainers used effective training methods.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The training materials (participant manual, slides,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>worksheets, tests, etc.) were effective.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There were adequate opportunities for discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The physical facilities were conducive to learning and sharing.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The travel, lodging and other logistical arrangements were</td>
<td></td>
<td></td>
</tr>
<tr>
<td>satisfactory.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Because of this course, I have a better understanding of and ability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to provide high quality, women centered comprehensive abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>care (CAC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall rating of this course on a scale of 1-5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1=not good, 5=great)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Instructions: Please answer the questions below in a few sentences.

1. Which module topics were most useful to your work?
2. What topics would you have liked us to cover in more detail?

3. What topics would you have liked to remove from the course?

4. What was the most important concept that you took away from the course?

5. What suggestions can you offer to improve this course in the future?

**Instructions: Please complete the following phrases.**

1. The trainers were ________________________________

2. The training atmosphere can be described as ________________________________

3. The sequence or flow of activities was ________________________________

4. If I were leading the course, I would have done differently. General comments and suggestions:
TRAINING FORMS FORMAT
Government of Nepal
Ministry of Health and Population
National Health Training Center
TRAINING REGISTRATION FORM

Training Name: ............................................................... □ Participant □ Trainer / Co-
Trainer/co-coordinator

Training Site: ............................................................... Region: -

Starting Date: ............................................................... Ending Date: ....................................... Fiscal Year: -

PERSONAL INFORMATION
Name (in Block Letter): -

नेपालीमा:

Sex: - □ Male □ Female □ Other

Date Of Birth (yyyy/mm/dd)(BS): -

<table>
<thead>
<tr>
<th>CURRENT HOME ADDRESS</th>
<th>CASTE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>District: -</td>
<td>□ Dalit</td>
</tr>
<tr>
<td>VDC/Municipality: - Ward No: -</td>
<td>□ Disadvantaged Janjati</td>
</tr>
<tr>
<td>Phone No: -</td>
<td>□ Disadvantaged Non Dalit Teral Caste Group</td>
</tr>
<tr>
<td>Email: -</td>
<td>□ Religious Minorities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cadre</th>
<th>Sponsors:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical: -</td>
<td>□ Government</td>
</tr>
<tr>
<td>2. Nursing: -</td>
<td>□ Non Government (Specify): -</td>
</tr>
<tr>
<td>3. Public Health: -</td>
<td>□ Semi Government (Specify): -</td>
</tr>
<tr>
<td>4. Paramedics: -</td>
<td>□ Self: -</td>
</tr>
<tr>
<td>5. AHW/ANM: -</td>
<td>□ Others (Specify): -</td>
</tr>
<tr>
<td>6. Others: -</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WORKING PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working Organization: -</td>
</tr>
<tr>
<td>District: - VDC/Municipality: - Ward No: -</td>
</tr>
<tr>
<td>Phone No: - Fax: - Post: - Level: -</td>
</tr>
<tr>
<td>Civil S. Reg No(लोक स. क्रम): - HuRIC No: - Citizenship No: - Council Reg. No: -</td>
</tr>
</tbody>
</table>

Participant Sign. Trainer Name & Sign.
Training Report (तालीम प्रतिवेदन)

1. तालीमको नाम :  

2. तालीम संचालन मिति : २०लाई .../..../20लाई ..../...../..../..../..../..../..../....

3. तालीम संचालन केन्द्र/जिल्ला/अस्पताल/अन्य :  

4. तालीम संचालन स्थान :  

5. सहभागी तथा प्रशिक्षकहरूको विवरण : (व्याच ने.........)

<table>
<thead>
<tr>
<th>अपेक्षित सहभागीको संख्या</th>
<th>जम्मा सहभागीको संख्या</th>
<th>प्रशिक्षकहरू</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>म.   पु. अन्य</td>
<td>म.   पु. अन्य</td>
</tr>
</tbody>
</table>

6. तालीम संचालन गद्दी परेका समस्याहरू तथा समाधानका प्रयासहरू उल्लेख गर्नुहोस्।

<table>
<thead>
<tr>
<th>समस्याहरू</th>
<th>समाधानका प्रयासहरू</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. तालिमलाई प्रभावकारी बनाउन सहभागी बाट आएका सुभावहरू।

क. तालीमको व्यवस्थापन पक्ष (सुभाव) :  

ख. तालीम सामाप्री पक्ष (सुभाव) :  

ग. तालीम संचालन पक्ष(सुभाव) :  

COMPREHENSIVE ABORTION CARE (CAC) INTEGRATED TRAINERS' MANUAL • 229
8. प्रशिक्षक/सह-प्रशिक्षक/कोचहरूको नाम:

<table>
<thead>
<tr>
<th>क.सं.</th>
<th>प्रशिक्षक नाम</th>
<th>पद</th>
<th>कार्यरत स्थान</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

क.सं. सह-प्रशिक्षक/कोच/विशेषज्ञ प्रशिक्षक

<table>
<thead>
<tr>
<th>पद</th>
<th>कार्यरत स्थान</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. सहभागिहरूको आँपत प्राप्ताइँ (विशेष तथा लिंकिनक तालीम भएका मात्र)

<table>
<thead>
<tr>
<th>क्षेत्र</th>
<th>पूर्व परीक्षा आँपत प्राप्ताइँक (प्रतिशतमा %)</th>
<th>मध्य परीक्षा आँपत प्राप्ताइँक (प्रतिशतमा %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ज्ञान भूमिज्ञान (प्रतिशतमा %)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>सीप दक्षताको मुख्याइक (सबै सहभागी सिमप्रा देख भए नभएको साक्ष्य जानकारी)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. सहभागिहरूको विवरण:

<table>
<thead>
<tr>
<th>क.सं.</th>
<th>नाम धर</th>
<th>पद</th>
<th>कार्यरत स्थान</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

91. तालीमलाई अभ्यास गर्नेको, सम्मलित तथा उपयोगी बनाउन प्रशिक्षक तथा व्यवस्थापकको तर्फबाट सुझाव लेख्नुहुनै।

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

92. प्रतिवेदन तयार गर्नेको नाम: ........................................ पद: ....................................... सहित: ..................................

93. प्रमाणित गर्नेको नाम: ........................................ पद: ....................................... सहित: ..................................

94. कार्यालयको नाम: ........................................

95. प्रतिवेदन पटक में मिलेको: 20../.../...

96. नोट: यस प्रतिवेदनको साथ अन्वेषण उपलब्ध हुन र पर्ने कामात्मक:
   
   - क: तालिम रिजर्वेशन फाराम्बको प्रतिलिपि।
   - ख: सहभागीहरुको हाजिरी (फोटो कपि।)
   - e: Trainer Registration Form
Co-Trainer/Facilitators Record

Name of Training: ___________________  Region: ___________________  Training Site: ___________________

Starting Date: ___________________  Ending Date: ___________________  Fyear: ___________________

Supported By:  □ Government  □ Non Government  □ Private  Specify: ___________________

<table>
<thead>
<tr>
<th>S. No</th>
<th>Trainer Name</th>
<th>Sex (M/F)</th>
<th>Cast (Ethnic) Group</th>
<th>Date of Birth BS</th>
<th>Address With District</th>
<th>Contact No.</th>
<th>Qualification</th>
<th>Working Place With District</th>
<th>Post</th>
<th>A. Siltol No</th>
<th>B. Hurick No</th>
<th>C. Coun reg No</th>
<th>Emp. Type</th>
<th>A. Gov.</th>
<th>B. Non Gov</th>
<th>C. Private</th>
<th>Citizen Ship No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Trainee Record

<table>
<thead>
<tr>
<th>S. No</th>
<th>Trainee Name</th>
<th>Sex (M/F)</th>
<th>Cast (Ethnic) Group</th>
<th>Date of Birth BS</th>
<th>Address With District</th>
<th>Contact No.</th>
<th>Qualification</th>
<th>Working Place With District</th>
<th>Post</th>
<th>A. Sitrol No</th>
<th>B. Hurick No</th>
<th>C. Coun reg No</th>
<th>D. CitizenShip No</th>
<th>Emp. Type</th>
<th>A. Gov.</th>
<th>B. Non Gov</th>
<th>C. Private</th>
<th>A. Pre Test</th>
<th>B. Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Trainer Record

- **Name of Training:** [ ]
- **Region:** [ ]
- **Training Site:** [ ]
- **Starting Date:** [ ]
- **Ending Date:** [ ]
- **Fyear:** [ ]
- Supported By:
  - [ ] Government
  - [ ] Non Government
  - [ ] Private
  - Specify: [ ]

<table>
<thead>
<tr>
<th>S. No</th>
<th>Trainer Name</th>
<th>Sex (M/F)</th>
<th>Cast (Ethnic) Group</th>
<th>Date of Birth BS</th>
<th>Address With District</th>
<th>Contact No.</th>
<th>Qualification</th>
<th>Working Place With District</th>
<th>Post</th>
<th>A. Sitrol No</th>
<th>B. Hurick No</th>
<th>C. Coun reg No</th>
<th>Emp. Type</th>
<th>Citizen Ship No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.  

A.  
B.  
C.
# Trainer Registration Form

**Government of Nepal**  
**Ministry of Health and Population**  
**National Health Training Center**  
**Training Registration Form**

## Personal Information
Name (in Block Letter):  
Nepali Name:  
Sex:  
- Male  
- Female  
- Other  
Date of Birth (yyyy/mm/dd) (BS):  

## Home Address
- District:  
- VDC/Municipality:  
- Ward No.:  
- Phone No.:  
- Email:  

## Qualification
A.  
B.  
C.  
D.  

## Training Experience & Expertise

## Working Place & Experience
- Specialization Area:  
- Current Designation:  
- Duration:  
- Current Organization:  
- District:  
- VDC/Municipality:  
- Ward No.:  
- Phone No.:  
- Fax:  
- Post:  
- Level:  
- Sitrol No.:  
- Huric No.:  
- Citizenship No.:  
- Council Reg. No.:  

**Professional Experience**
A.  
B.  
C.  

*Enclose the Copy of Specialized Training Certificate.*

Authorized Signature.
Application Form for provider listing

अनुसूची-१
(दफा ३ को उपदफा (२) सङ्ग सम्बन्धित
चिकित्सक वा स्वास्थ्यकर्मीको नाम सूचिकृत गर्नको लागि दिइने निवेदन

श्री मान् महानिदेयक जू / श्री मान् प्रमुखजू
स्वास्थ्य सेवा विभाग / जिल्ला स्वास्थ्य कार्यालय।

विषय: नाम सूचिकृत गरी पाउँ

सुरक्षित गर्भपत्तन सेवा प्रदान गर्ने प्रयोजनको लागि खंडा गरिएको सूचीमा मेरो नाम समावेश गर्न
देखाउँ हे विवरण बुलाइएको सुरक्षित गर्भपत्तन सेवा प्रक्रिया, २०६० को दफा ३ को उपदफा (२) बमो
जिम यो निवेदन दिएको हुँ।

विवरण

१ निवेदन दिनेको नाम र ठेगाना:–
२ आफ्नो नाम दर्ता भएको व्यावसायिक परिपत्रको नाम:–
३ व्यावसायिक परिपत्रको दर्ता नं. र दर्ता मिति:–
४ शैक्षिक योग्यता:–
(क)
(ख)
(ग)
५ तालीम:–
(क)
(ख)
(ग)
६ सुरक्षित गर्भपत्तन सेवा प्रदान गर्न मुल्की ऐन ज्यान सम्बन्धीको महत्त्व, यो प्रक्रियामा उल्ले
ख भए बमोजिमको व्यवस्था र पेशागत आचरणको पालना गर्नेछ।
७ सुरक्षित गर्भपत्तन सेवा प्रक्रिया, २०६० बमोजिम सूचिकृत स्वास्थ्य संस्था माफिक सेवा
प्रदान गरेछ।

मिति
आवेदकको,-
हस्ताक्षर
नाम
मैथिली सरकार
स्वास्थ्य मन्त्रालय
स्वास्थ्य सेवा विभाग

चिकित्सक वा स्वास्थ्यकर्मी सूचिकृत प्रमाणपत्र

भी:

सूचिकृत प्रमाण-पत्र

सूचिकृत संयोजनमा सेवा प्रदान गर्ने चिकित्सक वा स्वास्थ्यकर्मीको सुचिकृत नाम समावेश गर्नुहोस् लागि विद्यु भाषा क्विलिट्यम चिकित्सक गर्नुको खोला १६५० ति खोला १६५३ ति उपकरण (२) योजनामा नगराधिकारी को नाम सूचिकृत गरिएकोले पाइ प्रमाणपत्र दिइएको हो।

१. सेवा उपलब्ध गराउँदा सूचिकृत संगठन सेवा प्रविधि, १६५२ योजनामा शुक्रिकृत स्वास्थ्य संगठन माध्यम सेवा प्रदान गर्नु पर्ने।

२. सेवा उपलब्ध गराउँदा मूल्यको ऐतिहासिक योजना तथा क्विलिट्यमको महत्त्व २० ख, च. र यस प्रतियोगिता उन्नतिको व्यवस्था तथा पेशेवरीय आवश्यकात्मक सहयोग पर्ने।

३. सूचिकृत संगठनमा सेवा उपलब्ध गराउँदा क्रममा उल्लिखित योजनामा नगराधिकारीको सेवा उपलब्ध गराउने पाइँ: क-९ हजारामायत गर्नुको सेवा, एम.ए. एम. बि.ए.
ख-१४ हजारा मायत गर्नुको सेवा
०-१० हजारा साप्ताहिक गर्नुको सेवा
ग-बुनी पतन अवधिको गर्नुको सेवा

मिति:-

सूचिकृत प्रमाणपत्र हिने अधिकारीको-

साहित:

नाम:

हर्षि:
Application form for site listing

अनुसूची-४
(दफा ५ को उपदफा (२) संग सम्बन्धित)
स्वास्थ्य संस्थाको नाम सूचीकृत गराउन दिइने निर्देशन

श्रीमान् महानिदेशकज्य श्रीमान् प्रमुख ज्य,
स्वास्थ्य सेवाबिभाग/............स्वास्थ्यकार्यालय,

विशेष: स्वास्थ्य संस्थाको नाम सूचीकृत गराइएको

सूचित गर्नेपन सेवा उपलब्ध गराउनको लागि यस संस्थाको नाम सूचीकृत गराउँ देखाउँको विवरण खुलाई सूचित गर्नेपन सेवाप्रक्रिया, २०६० का दफा ५ को उप दफा (२) वमोजिम को योग्य सदस्यलिपिको हो/हो ।

१ स्वास्थ्य संस्थाको नाम रद्दमा गर्नुहोस्—
२ स्वास्थ्य संस्था दलाई भएको कार्यालय—
३ स्वास्थ्य संस्थाको दलाई न. र मिति—
४ स्वास्थ्य संस्थाले सल्लाला गर्न गरेको अन्य सेवा—
५ स्वास्थ्य संस्थाको प्रमुख पदाधिकारीको नाम र धर—

- स्वास्थ्यसंस्थाला सूचित गर्नेपन सल्लाला गर्ने मुलुकी ऐन उपलब्ध सम्बन्धीको महत्त्वको २८ ख. लेख पनि यस प्रक्रियासँग उल्लेख भएको वमोजिमको यस्ता स्थान पाएका गरेका छ छ।
- स्वास्थ्य संस्थाला अन्य सेवा सल्लाला गर्न दिइएको पत्र संयुक्त र मिति—
  स्वास्थ्य संस्थाला पत्रहरूलो पत्र सँस्थाको अनुगमन भएको मिति—

मिति—
स्वास्थ्य संस्थाको छाप—
निर्देशक—
सहित—
नाम—
दर्जा—
स्वास्थ्य संस्था सूचिकृत प्रमाणपत्र

निरपेक्ष: सूचिकृत प्रमाणपत्र प्रदान गरिएको

सुरक्षित गर्भपतन सेवा सम्पादन गर्नको लागि सूचिकृत गराई पाउन तथा संस्थापन तथा उपबन्द उपर गराउने हुन्दा गर्भपतन सेवा प्रमाण, २०६० को एका अंक मात्र उपदेशक (३) बमीमी लगाई स्वास्थ्य संस्थाको नाम सूचिकृत गर्न मिलित हुनुहोस्।

1. स्वास्थ्य संस्थापन सुरक्षित गर्भपतन सेवा प्रदान वि तर्क र मुख्य अन्य ज्ञान सम्बन्धी सहरको २५ खोले नै तथा यस फ्रेमार्क उल्लेख गरिएको बमीमीको कृतिकाविश्वास को विषयमा पत्र पान गरिएको छ।

2. सुरक्षित गर्भपतन सेवा उपलब्ध गराउने क्षमा देखि बमीमीको सेवा उपलब्ध गराउन पाइनेको:
   (क) ९ विधातामको सम्पर्क सेवा एस.ए. एस.सी.ए.
   (ख) १२ विधातामको सम्पर्क सेवा
   (ग) १६ विधातामको सम्पर्क सेवा
   (घ) कुल पत्र बमीमीको गर्भपतन सेवा

प्रमिति: सूचिकृत प्रमाणपत्र जाती गर्नेको-
सहि: -
नाम: -
दर्जा: -

नवीकरण विवरण

<table>
<thead>
<tr>
<th>क्र.सः</th>
<th>नबिनभाषा पत्र रहने मिलित</th>
<th>नवीकरण गर्न अधिकारीको नाम</th>
<th>हस्ताक्षर र मिलित</th>
</tr>
</thead>
<tbody>
<tr>
<td>१</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>२</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>३</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>४</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>५</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>