POSTABORTION CARE ON-THE-JOB TRAINING

TRAINERS' GUIDE

Government of Nepal
Ministry of Health and Population
National Health Training Center
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ACKNOWLEDGMENT

Maternity Hospital has made an important contribution to addressing training needs for reproductive health in general and Postabortion care in particular. With the increase in demand for trained PAC providers, there was a need to establish additional training sites, as Maternity Hospital alone was not be able to fulfill government's annual training needs. Further, Department of Health Services, in keeping with the spirit of decentralization of health services, was keen on decentralizing and expanding its training capacity to other hospitals in the country. Considering the low case in training sites outside of Kathmandu valley, alternative training approaches was needed. Therefore, Nepal Family Health Program (NFHP) supported expanding alternative training approach for PAC as PAC On-The-Job-Training.

In this process, Postabortion Care (PAC) on-the-job training package was developed by adopting the training package, which was developed by JHPIEGO Corporation for the implementation of the program in Kenya, which was prepared by Dorothy Andere, KRN, KRM, KRPH; Susheela Engelbrecht, CNM, MPH, MSN; Rick Hughes, MA; Dr. Pamela Lynarn; Dr. Tsigue Pleah; Dr. Rick Sullivan and Wendy Voet. MPH.

On September 24-25, 2002 a workshop was organized in order to review and update the training package in order to amend the course outline according to Nepal specific. The training package consists of the Participant Handbook, Trainer's Guidebook and Supervisor's Guidebook. Ms. Bindu Bajracharya, Senior Program Officer, NFHP was overall responsible for all management, and provide technical support and guidance to review and update the manuals according to *Reproductive Health National Medical Standard Volume I-2001*. During this workshop many trainers had contributed in developing the package. We would like to acknowledge the trainers and individuals who had provided valuable suggestion and technical input. They are Dr. Senendra Upreti, FP Coordinator, NHTC; Ms. Nhucchemaya Prajapati, PHN, NHTC; Ms. Maya Gurung, PHN, FHD; Dr. Kasturi Malla, Deputy Director, Maternity Hospital; Dr. Yamuna Suwal, PAC Coordinator, Western Regional Hospital; Dr. Indira Satyal, PAC Coordinator, Maternity Hospital; Ms. Sajana Ranjit, Assistant Matron, Maternity Hospital; Ms. Maiya Manandhar, Trainer, Maternity Hospital; Ms. Goma Shrestha, Sister, Bharatpur Hospital.

The training package has been used for the conduction of the OJT at Maternity hospital from 2002, Koshi Zonal Hospital from 2004 and Bharatpur Hospital/Seti Zonal Hospital from 2005. All the necessary inputs and feedback, which has been provided by the trainers, have been incorporated in this training package and finalized it. We would also like to acknowledge Ms. Sandhya Limbu, Assistant Program Officer, NFHP for the support in the developing and updating these materials.

Our appreciation especially to Ms. Bindu Bajracharya for her technical support and guidance in developing this manual and taking responsible in all the process to establish the PAC On-the Job Training in the country in 2002 and expansion of the OJT approaches in different level hospitals. Similarly we would like to acknowledge PAC OJT trainers- Dr. Kasturi Malla, Director Maternity Hospital, Ms. Maiya Manandhar, Nurse Trainer, Maternity Hospital and Dr. Indira Satyal, PAC Coordinator, for being a trainer and supervisors in first PAC On the Job Training in the country.

My gratitude towards Dr. Rajendra Bhadra, Team leader and special thanks to NFHP for its funding and technical support in developing training packages and expansion of the approach in different sites. My special thanks to those institutions, where this approach has been implemented and contributed in making this alternate approach successful for future expansion.

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INTRODUCTION

OVERVIEW OF POSTABORTION CARE

Postabortion care (PAC) is a comprehensive approach to managing patients with emergency complications due to either spontaneous or induced abortion. This approach includes the emergency management of abortion complications with manual vacuum aspiration (MVA), the provision of postabortion counselling including family planning, and the referral of the patient to other reproductive health (RH) services. This on-the-job training (OJT) course is based on *Postabortion Care: A Reference Manual for Improving Quality of Care,* which was published by the Postabortion Care Consortium. The background and rationale for PAC can be found in this reference manual.

To date, emphasis has been on the treatment of the medical emergency using MVA, which is only one aspect of PAC. However, postabortion counselling including family planning, linkages to other RH services, effective pain management, quality of care, and patients' rights are key elements of PAC as well. This OJT course will focus on these elements and MVA equally.

OVERVIEW OF THE PAC OJT COURSE

This clinical training experience is designed to prepare competent PAC providers using an OJT approach. OJT (also referred to as site-based or clinic-based training) is a form of individualised learning that allows the healthcare provider to learn to provide a whole range of PAC services within her or his own work setting. There are several advantages of learning these skills on the job:

- Healthcare providers can be trained without waiting for a scheduled course.
- Clinic and hospital personnel control the training experience.
- Training is designed to meet local needs.
- There is minimal disruption of services which usually occurs when a healthcare provider travels to attend a training course.

THE TRAINING APPROACH

Mastery Learning

The **mastery learning** approach to clinical training assumes that all trainees can master (learn) the required knowledge, attitudes or skills, provided sufficient time is allowed and appropriate learning methods are used. The goal of mastery learning is that 100 percent of those being trained will "master" the knowledge and skills on which the OJT is based.

While some trainees are able to acquire new knowledge or a new skill immediately, others may require additional time or alternative learning methods before they are able to demonstrate mastery. Not only do people vary in their abilities to absorb new material, but individuals learn best in different ways—through written, spoken or visual means. Mastery learning takes these differences into account and uses a variety of teaching and learning methods.

The mastery learning approach also enables the trainee to have a self-directed learning experience. This is achieved by having the clinical trainer serve as facilitator and by changing the concept of testing and how test results are used. In courses that use traditional testing methods, the trainer administers pre- and post-tests to document an increase in the trainees' knowledge, often without regard for how this change affects job performance.

By contrast, the philosophy underlying the mastery learning approach is one of a continual assessment of trainee learning. With this approach, it is essential that the clinical trainer regularly inform trainees of their progress in learning new information and skills, and not allow this to remain the trainer's secret.

With the mastery learning approach, assessment of learning is:

- Competency-based, which means assessment is keyed to the course objectives and emphasises acquiring the essential knowledge, attitudinal concepts and skills needed to perform a job, not simply acquiring new knowledge.

- Dynamic, because it enables clinical trainers to provide trainees with continual feedback on how successful they are in meeting the course objectives and, when appropriate, to adapt the OJT course to meet learning needs.

- Less stressful, because from the outset trainees know what they are expected to learn and where to find the information, and have ample opportunity for discussion with the clinical trainer.

Key Features of Effective Clinical Training

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

- Uses behaviour modeling
- Is competency-based
- Incorporates humanistic training techniques

Social learning theory states that when conditions are ideal, a person learns most rapidly and effectively from watching someone perform (model) a skill or activity. For modelling to be successful, the trainer must clearly demonstrate the skill or activity so that trainees have a clear picture of the performance expected of them.

Learning to perform a skill takes place in three stages. In the first stage, skill acquisition, the trainee sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the trainee attempts to perform the procedure, usually with supervision. Next, the trainee practices until skill competency is achieved and the individual feels confident performing the procedure. The final stage, skill proficiency, only occurs with repeated practice over time.

Skill Acquisition	Knows the steps and their sequence (if necessary) to perform the required skill or activity but **needs assistance**
Skill Competency	Knows the steps and their sequence (if necessary) and **can perform** the required skill or activity
Skill Proficiency	Knows the steps and their sequence (if necessary) and **efficiently performs** the required skill or activity

Competency-Based Training

Competency-based training (CBT) is distinctly different from traditional educational processes. Competency-based training is learning by doing. It focuses on the specific knowledge, attitudes and skills needed to carry out a procedure or activity. How the trainee performs (i.e., a combination of knowledge, attitudes and, most important, skills) is emphasised rather than just what information the trainee has acquired. Moreover, CBT requires that the clinical trainer facilitate and encourage learning rather than serve in the more traditional role of instructor or lecturer. Competency in the new skill or activity is assessed objectively by evaluating overall performance.

For CBT to occur, the clinical skill or activity to be taught first must be broken down into its essential steps. Each step is then analysed to determine the most efficient and safe way to perform and learn it. This process is called standardisation. Once a procedure, such as MVA, has been standardised, competency-based skill development (learning guides) and assessment (checklists) instruments can be designed. These instruments make learning the necessary steps or tasks easier and evaluating the trainee's performance more objective.

An essential component of CBT is coaching, which uses positive feedback, active listening, questioning and problem-solving skills to encourage a positive learning climate. To use coaching, the clinical trainer should first explain the skill or activity and then demonstrate it using an anatomic model or other training aid such as a videotape. Once the procedure has been demonstrated and discussed, the trainer/coach then observes and interacts with the trainee to provide guidance in learning the skill or activity, monitors progress and helps the trainee overcome problems.

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

- **Before practice**: The clinical trainer and trainee should meet briefly before each practice session to review the skill/activity, including the steps/tasks which will be emphasised during the session.

- **During practice**: The clinical trainer observes, coaches and provides feedback as the trainee performs the steps/tasks outlined in the learning guide.

- **After practice**: This feedback session should take place immediately after practice. Using the learning guide, the clinical trainer discusses the strengths of the trainee’s performance and also offers specific suggestions for improvement.

Humanistic Training Techniques

The use of more humane (humanistic) techniques also contributes to better clinical training. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids such as videotapes. The effective use of models facilitates learning, shortens training time and minimises risks to patients. For example, by using anatomic models initially, trainees more easily reach the performance levels of skill competency and beginning skill proficiency before they begin working in the clinic setting with patients.

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Before a trainee attempts a clinical procedure with a patient, two learning activities should occur:

- The clinical trainer should demonstrate the required skills and patient interactions several times using an anatomic model and appropriate audiovisual aids (e.g., videotape).

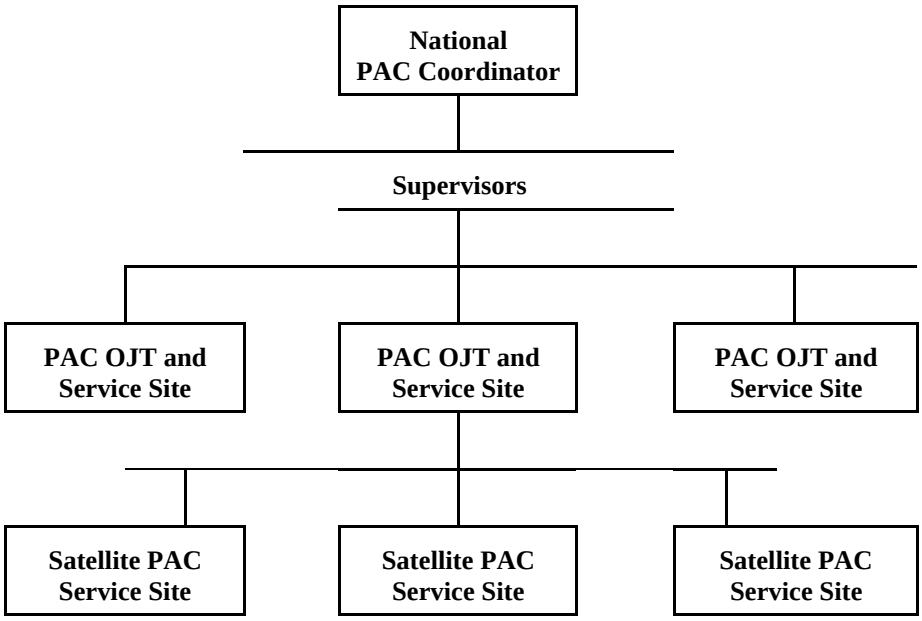
- While being supervised, the trainee should practice the required skills and patient interactions using the model and actual instruments in a simulated setting that is as similar as possible to the real situation.

- Only when skill competency and some degree of skill proficiency have been demonstrated with models, however, should trainees have their first contacts with patients.

When mastery learning, which is based on adult learning principles and behaviour modeling, is integrated with CBT, the result is a powerful and extremely effective method for providing clinical training. And when humanistic training techniques, such as using anatomic models and other learning aids, are incorporated, training time and costs can be reduced significantly.

STRUCTURE OF PAC OJT PROGRAMME

Figure 1. PAC OJT Programme Structure



The structure of the PAC OJT Programme involves four key people, plus the OJT site administrator and the satellite PAC service site administrator:

- The **trainee**, who is already a healthcare provider, uses the PAC OJT course materials to learn to provide emergency management of abortion complications including: using MVA; offering pre- and postabortion counselling, including postabortion family planning; and providing the link with other RH services.

- The OJT **trainer**, who is a proficient PAC provider, serves as a coach to the trainee and demonstrates skills, observes the trainee's skill development, provides feedback and suggestions, interacts with the trainee by asking and answering questions and evaluates the trainee to ensure that the essential PAC knowledge and skills are being learned. The OJT trainer also administers the final skill assessment.

- The OJT **supervisor**, who should be oriented to the PAC programme, helps to select the trainees, assesses the appropriateness of sites for OJT, ensures OJT sites are appropriately equipped, orients site staff to the OJT programme, conducts the final knowledge assessment, reviews the skill assessment completed by the OJT trainer and arranges for trainee qualification according to the guidelines in the course outline.

- The **national PAC coordinator**, who is a technical person, oversees and mobilises support for the national PAC service delivery program, including the OJT programme. The national coordinator organises additional support for the PAC OJT training programme, such as training and supporting both the OJT trainers and supervisors.

In addition, the PAC Programme involves the following administrative personnel:

- the **OJT site administrator**, who is the head administrator at the PAC OJT site and supports the PAC OJT course by overseeing the site preparation prior to and during the training and monitoring the course progress. This individual also ensures that model PAC services are provided at the OJT site.

- the **satellite PAC service site administrator**, who is the head administrator of the site and provides the necessary support (management, human resources, supplies) to ensure that high quality PAC services are provided, and

The focus of this OJT course is on the trainee. For example, the focus of the training activities presented in the OJT course outline is on the trainee. As the trainee moves through a series of activities (e.g., reading information, observing the trainer, completing practice exercises, practising clinical skills using role plays and anatomic models, working with patients), there are corresponding activities for the trainer and supervisor. The focus, however, is always on the trainee.

Essential to this OJT course are four basic components. All of the training activities in which the trainee, trainer and supervisor are involved relate to one or more of these components:

- Transfer and assessment of the essential knowledge related to PAC. This knowledge is found in the reference manual *Postabortion Care: A Reference Manual for Improving Quality of Care* and is reinforced by interaction with the trainer and through various practice exercises.

- Transfer and assessment of counseling and clinical skills using role-plays and anatomic models. The skill demonstrations are provided by the trainer and the trainee will demonstrate

that s/he can competently provide counseling, management of abortion complications including MVA, Postabortion counseling in family planning and referrals with other RH services through role plays and demonstrations using models.

- Transfer and assessment of the above skills working with patients. The skill demonstrations on patients are first modeled by the trainer, and the trainee will then demonstrate that she or he can competently perform the skill.

- Attitude transfer through behaviour modeling by the trainer and interaction with the patients.

Key to the success of this individualized, self-paced, OJT programme is the motivation of the trainee and trainer. The trainee must be willing to read, study, complete assignments and work independently while staying on a schedule, in order to complete training in a reasonable period of time. The trainee also must be willing to observe the trainer and ask questions. The trainer must be willing to take the necessary time to mentor, teach and work closely with the trainee, in addition to providing quality services, throughout the course.

USING THE OJT LEARNING PACKAGE

This training course is built around use of the following elements:

- Need-to-know information contained in the reference manual *Postabortion Care: A Reference Manual for Improving Quality of Care*

- A Trainee's Guide containing a precourse questionnaire and skills assessment checklist, learning guides which break down the activity into its essential components, a step-by-step course outline and a series of practice exercises

- A Trainer's Guide containing all of the essential items found in the Trainee's Guide, along with the answer keys to the precourse questionnaire and practice exercises

- A Supervisor's Guide containing information on the OJT supervisor's various responsibilities and the final knowledge assessment with answer sheet

- The ZOE® anatomic model

- The videos:
  - *GATHER* (Johns Hopkins University Center for Communication Programs [JHU/CCP]),
  - *Put Yourself in Her Shoes* (JHU/CCP),
  - *Postabortion Care Services: Use of Manual Vacuum Aspiration and Recommended Practices for Processing MVA Instruments* (JHPIEGO), and
  - *Infection Prevention for Family Planning Service Programs* (AVSC International and JHPIEGO)

The reference manual *Postabortion Care: A Reference Manual for Improving Quality of Care*, is organized into 10 chapters and 9 appendices. It contains all the essential information needed to take this course.
This training approach for PAC stresses the importance of the cost-effective use of resources, application of relevant educational technologies and the use of more humane teaching techniques. The latter encompasses the use of anatomic models such as the ZOE pelvic model to minimize

patient risk and facilitate learning. Detailed (step-by-step) counseling and clinical skills learning guides have been developed to help trainees learn and measure their own progress. Finally, competency-based knowledge questionnaires and skills checklists are provided to assist the trainer and supervisor in evaluating a trainee's performance objectively.

Trainers are encouraged to conduct training activities in a highly interactive fashion, asking questions and involving the trainee as much as possible without disrupting services.

Because this is a self-paced OJT course, it is critical that the trainee, trainer and supervisor thoroughly read their respective guides before the trainee begins this programme. It is also essential that the administrator understand the time required for the trainer and trainee to carry out their respective activities.

COURSE SYLLABUS

Course description

This average 33 days individualized OJT on PAC is designed to provide the health providers (Physicians and certified nurses) to be competent in providing comprehensive of PAC care services, which includes FP, referral to other health services needed after emergency treatment.

Participant selection criteria:

Participants on the OJT training for PAC should have the following perquisite:
Physicians: should have IP and CTU Update.
Nurses: Certified nurses with knowledge of COFP and Counseling (Family Planning and IP) and Breast and Pelvic examination.

Course Goals

- To influence in a positive way the attitudes of the trainee towards PAC services
- To provide the trainee with the knowledge and skills needed for performing MVA as well as preventing and managing abortion complications or complications related to the MVA procedure
- To provide the trainee with counseling skills for Postabortion family planning
- To provide the trainee with the knowledge and skills needed to organize and manage quality PAC services
- To familiarize the trainee with the role of the healthcare provider in promoting Postabortion family planning
- To identify and provide opportunities for linkages to other RH services

Trainee Learning Objectives

By the end of the training course, the trainee will be able to:

1. Perform an initial assessment including medical history, physical examination and simple laboratory tests (if needed), of women presenting with possible complications of incomplete abortion.

2. Provide management of serious, life-threatening Postabortion complications (shock, severe vaginal bleeding, infection/sepsis and intra-abdominal injury) or stabilize patients with these complications prior to referral.

3. Exhibit good interpersonal communication skills throughout the provision of services, including talking to the patient regarding her condition, the MVA procedure and its indications and precautions.
4. Use recommended infection prevention (IP) practices that minimize the risk of post-MVA infections and transmission of serious diseases, such as hepatitis B or AIDS, to patients and healthcare staff.

5. Provide appropriate pain management for women treated for Postabortion complications using MVA.

6. Perform MVA using a gentle, no-touch technique.

7. Manage complications occurring before, during or after the MVA procedure.

8. Describe the important elements in follow-up of women treated for Postabortion complications.

9. Recognize patient's need for additional RH services or referral, including counseling her for postabortion family planning and, when appropriate, providing the contraceptive method selected by the patient.

10. Explain how the quality of care process can be used to improve and maintain high quality, patient-oriented PAC services.

11. Describe the skills needed to organize and manage high quality PAC services.

Training/Learning Methods

- Individual exercises
- One-on-one discussions with the trainer
- Role plays
- Case studies
- Simulated practice with anatomic (pelvic) models
- Guided clinical activities (performing MVA and counseling)
- A-V (Video Tapes)

Learning Materials

This PAC OJT course (including the Trainee's, Trainer's and Supervisor's Guides) is designed to be used with the following materials:

Reference manual: *Postabortion Care: A Reference Manual for Improving Quality of Care* (Postabortion Care Consortium).

Videotapes:

- ABHIBADAN (AVSC)
- *Put Yourself in Her Shoes* (JHU/CCP),
- *Postabortion Care Services: Use of Manual Vacuum Aspiration and Recommended Practices for Processing MVA Instruments* (JHPIEGO), and
- *Infection Prevention for Family Planning Service Programs* (AVSC International and JHPIEGO)

Instruments and Equipment

Instruments and equipment for providing the full range of PAC services (see pages 12–14) and pelvic model (ZOE)

Methods of Evaluation

Trainee

- Precourse Assessment Checklists for PAC OJT Counseling and Clinical Skills (Physical Breast and Breast examination) (to be completed by clinical trainer)

- Precourse Questionnaire and final knowledge assessment

- Learning Guides for Postabortion Care Clinical Skills, Verbal Anaesthesia and Family Planning Counseling Skills

- Checklists for Postabortion Clinical and Family Planning Counseling Skills (to be completed by clinical trainer)

Course

Course Evaluation (to be completed by the trainee)

Qualification of Trainees

Qualification at the end of the course is given to those trainees who:

- Score 85% or higher on the final knowledge assessment

- Achieve competency in all skills on the Checklists for Postabortion Family Planning Counseling and Clinical Skills

TRAINEE SELECTION CRITERIA

Trainees for this course should be clinicians (physicians, nurses or midwives) working in a healthcare facility that provides women's health services. Both the clinic and participant must be interested in and willing to provide PAC services. These clinicians should have participated in a Contraceptive Technology Update (CTU), Breast and Pelvic exam course and an IP update. Trainees will be selected by the supervisors, site administrators and trainers.

RESPONSIBILITIES OF THE OJT TRAINEE

The responsibilities of the trainee in an OJT course are somewhat different from a traditional, group-based training course. Because of the unique nature of OJT, the ideal trainee:

- Has an interest in, and will be able to provide, high quality PAC services
- Is interested in learning, understands the principles of OJT and is motivated to learn independently
- Has the prerequisite knowledge and skills as mentioned in the Trainee selection criteria.
- Uses checklists and learning guides
- Follows the OJT course outline

RESPONSIBILITIES OF THE OJT TRAINER

Critical to the success of the OJT course is the trainer. The OJT trainer is the primary contact for the trainee and has a tremendous influence on the development of the trainee's knowledge, attitudes and skills. The OJT trainer:

- Demonstrates proficient PAC service provision skills
- Aids the supervisor and the site administrator in the selection of the trainees
- Demonstrates an understanding of the OJT approach to training
- Demonstrates an understanding of the components of the PAC OJT learning package
- Follows the OJT course outline, including allowing sufficient time for learning sessions
- Coordinates OJT activities with the OJT supervisor
- Prepares the site for the OJT course in collaboration with the administrator and supervisor
- Ensures that equipment and supplies are available to support service delivery and clinical training
- Promotes linkages to other RH service programs
- Demonstrates effective IP skills
- Demonstrates effective counselling skills
- Demonstrates a positive attitude towards PAC patients
- Respects and observes PAC patients' rights
- Creates a positive learning climate
- Uses interactive learning techniques
- Uses learning guides and encourages use of learning guides by the trainee
- Demonstrates clinical skills, including effective patient-provider interaction and the use of verbacaine during the MVA procedure
- Uses anatomic models in clinical training
- Coaches in a clinical setting
- Identifies and manages learning and training problems
- Uses competency-based checklists to assess clinical skills
- Administers final skill assessment to trainees

- Determines if a healthcare provider is qualified to provide a clinical service
- Maintains OJT records
- Follows up with healthcare providers after training

RESPONSIBILITIES OF THE OJT SUPERVISOR

The OJT supervisor is the link between the OJT trainers and the national PAC coordinator. The supervisor assists in selecting the trainers and the trainees and ensures that the trainer is trained in clinical training skills. The OJT supervisor:

- Selects OJT clinical training sites in consultation with the national PAC coordinator and OJT site administrator
- Selects PAC trainers with the aid of the national PAC coordinator/OJT site administrator
- Aids the trainer and the site administrator in the selection of the trainees
- Identifies equipment required for service provision and clinical training
- Works with trainer and administrator to ensure that supplies are available to support service delivery and clinical training
- Orients the PAC OJT site staff and the PAC service staff to the concept of OJT
- Arranges a supervision schedule with the PAC site administrator and trainer
- Travels to various OJT sites for supportive supervision
- Monitors PAC OJT course progress
- Demonstrates an understanding of the clinical service being provided
- Demonstrates an understanding of the OJT approach to training
- Demonstrates an understanding of the components of the PAC OJT learning package
- Follows the OJT course outline
- Coordinates OJT activities with the OJT trainer
- Provides access to OJT reference materials
- Secures funding and resources for OJT activities
- Demonstrates effective time management skills
- Demonstrates effective communication skills
- Demonstrates effective leadership skills
- Maintains OJT records
- Administers final knowledge assessment to trainees
- Reviews skill assessments completed by OJT trainer
- Organises PAC certification for trainees competent in PAC services
- Promotes linkages to other RH service programs
- Promotes family planning counseling services

RESPONSIBILITIES OF THE NATIONAL PAC COORDINATOR

The National PAC Coordinator will manage all aspects of the OJT programme. The National PAC Coordinator:

- Oversees and mobilizes support for PAC services
- Ensures quality PAC services and OJT courses
- Identifies PAC OJT supervisors and provides them with training and support
- Assists OJT supervisors through the existing supervision structure
- Assists through the existing supervision structure in selecting/confirming OJT training sites
- Arranges for clinical skills and clinical training skills training for the PAC trainers
- Assists through the existing supervision structure in selecting/confirming OJT trainees

- Assists OJT supervisors through the existing supervision structure in acquiring sufficient supplies and equipment
- Assists through the existing supervision structure in the monitoring and evaluation of the OJT programme
- Assists through the existing supervision structure in collecting/compiling necessary reports
- Ensures that trainees competent in PAC services receive final certification

RESPONSIBILITIES OF THE OJT SITE ADMINISTRATOR

- Provide regular supplies necessary for the OJT course
- Assists the supervisor and the trainer in the selection of the trainees
- Allows the trainer time to teach
- Allows the trainee time to follow the OJT course outline
- Facilitates and oversees the upgrade of site services
- Provides on-going support to the trainer and trainee

RESPONSIBILITIES OF THE SATELLITE PAC SERVICE SITE ADMINISTRATOR

- Provide regular supplies necessary for the PAC service site
- Allows the trainee time to follow the OJT course outline
- Facilitates and oversees the upgrade of site services
- Provides ongoing support to the trainer and trainee

PAC OJT TRAINER SELECTION CRITERIA

The individuals selected as PAC trainers must:

- Be a practising clinician (physician, nurse or midwife)
- Be a clinician proficient in PAC service provision
- Have a positive attitude towards PAC patients
- Have participated in CTS.

PAC OJT SITE SELECTION CRITERIA

In order to provide effective OJT, the site where training will occur must meet specific criteria. An OJT site:

- Provides high quality PAC services according to national standards
- Shows interest in hosting a PAC OJT course
- Has staff members who are or want to be an OJT trainer and who meet the criteria for PAC OJT trainers
- Has adequate space
- Has a sufficient patient caseload (sees at least 2 PAC patients per week)
- Has an adequate water supply to maintain high IP standards
- Can demonstrate that it routinely has enough supplies, equipment and drugs to meet the needs of patients
- Has good support services (i.e., those needed for quality service provision such as a laboratory and pharmacy)

- Has IP practices in place
- Provides family planning services
- Has linkages to other RH services
- Has a range of other RH services to which PAC patients are routinely referred

PAC OJT EQUIPMENT AND SUPPLY REQUIREMENTS

In order to provide a quality learning experience on the job, there are certain supplies and pieces of equipment that must be in place:

- ZOE pelvic model
- Learning materials, including copies of the Trainer's Guide, Trainee's Guide and reference manual *Postabortion Care: A Reference Manual for Improving Quality of Care*
- IP standards and job aids
- Genital tract infection (GTI)/sexually transmitted infection (STI)/sexually transmitted disease (STD) standards and job aids
- Family planning methods flipchart or counselling tools
- Contraceptive methods/commodities
- TV/VCR
- Videos: *ABHIBADAN*, *Put Yourself in Her Shoes*, *Postabortion Care Services: Use of Manual Vacuum Aspiration and Recommended Practices for Processing MVA Instruments* and *Infection Prevention for Family Planning Service Programs, Breast and Pelvic examination video.*
- Medical record forms
- Daily Register
- Sink with adequate clean water
- IEC Materials

Instruments and Equipment

- Instrument tray and cover (2 each)
- Bivalve (Graves) specular (medium)
- Uterine tenaculum (Braun, straight, 9 ½") (1) or vulsellum forceps (1)
- Pan emesis (1)
- Kidney dish (1)
- Sponge (Foerster, straight 9 ½") forceps (2)∗*, vulsellum forceps, B.P. instrument, Stethoscope, thermometer, Torch light.
- MVA instruments
  - MVA vacuum syringe, double valve (1), single valve (1)
  - Plastic cannulae of different sizes (6mm to 12 mm)
  - Adapters
  - Silicone for lubricating MVA syringe o-ring (1 tube)
- Light source (to see cervix and inspect tissue)
- Strainer (for tissue inspection)
- Clear container or basin (for tissue inspection)
- Simple magnifying glass (x 4-6 power) (optional)
- Emergency drug tray

∗ If available, a curved placental forceps is preferable to the sponge forceps for removing POC.

- Bowl
- Cheattle forceps and container.

Consumable Supplies

- Swabs/gauze
- Antiseptic solution (preferably an iodophor such as povidone iodine)
- Gloves, sterile or high-level disinfected surgical gloves or new examination gloves
- Gloves, utility
- All essential drugs listed in the reference manual (Appendix G)

Items That Should Be on Hand, but Are not Required for All MVA Procedures

- 10–20 ml syringe and 22-gauge needle for paracervical block (6 each)
- Local anaesthetic (e.g., 1–2% lidocaine without epinephrine)
- Curette, sharp, large (1)
- antibiotic/antispasmodic

Furniture and Equipment

Before beginning the MVA procedure, make sure that the following furniture and equipment are in the treatment room and in working order:

- Examination table with stirrups
- Strong light (e.g., gooseneck lamp)
- Seat or stool for clinician
- Plastic buckets for decontamination solution (0.5% chlorine)
- Puncture-proof container for disposal of sharps (needles)
- Leakproof container for disposal of infectious waste
- Aprons for clinicians - long enough to cover the feet of the provider
- Boots/slippers
- Instrument trolley
- Stop watch
- Cupboard
- Macintosh

For High-Level Disinfection or Sterilisation of Instruments

- Nonmetal (plastic containers)
- Detergent
- Clean water
- Chlorine solution (concentrated solution or dry powder)
- High-level disinfectant or sterilisation agent (optional)
- Large pot for boiling metal instruments
- Steamer for steaming surgical gloves, cannulae and surgical instruments
- Autoclave (steam)

For Emergency Resuscitation

These items are seldom required in uterine evacuation cases but are needed for possible emergency use:

- Spirits of ammonia (ampules)
- Atropine
- IV infusion equipment and fluid (DSW or D/S)
- Ambu bag with oxygen (tank with flow meter)
- Oral airways
- Stenoed - Dexamethasone/Hydrocolisone
- Syringe
- Adrenalve

INSTRUCTIONS FOR USING ZOE® GYNAECOLOGIC SIMULATORS

The ZOE Gynaecologic Simulator is a model of a full-sized, adult female lower torso (abdomen and pelvis). It is a versatile training tool developed to assist healthcare providers to teach the processes and skills needed to perform many gynaecologic procedures. ZOE models are ideal for demonstrating and practicing the following procedures:

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

CONTENTS OF THE ORIGINAL ZOE MODEL

The original ZOE Gynaecologic Simulator kit includes the following:

Item	Quantity
Normal ante- and retroverted uteri with clear tops, attachments for round and ovarian ligaments as well as fallopian tubes and normal patent cervical os for pelvic examination and IUD insertion	2
6-8 week uterus (incomplete abortion) with dilated (open) cervical os which allows passage of a 5 or 6 mm flexible cannula.	1
10-12 week uterus with round ligaments, with dilated (open) cervical os which allows passage of a 10 or 12 mm flexible cannula.	1
Postpartum uterus (20 week size) with attached fallopian tubes for practicing postpartum tubal occlusion by minilaparotomy	1

Cervices (not open) for use in visual recognition:

Normal cervix	11
• Cervix with proliferation of columnar epithelium (ectropion)	1
• Cervix with inclusion (nabothian) cyst and endocervical polyp	1
• Cervix with lesion (cancer)	
Extra normal cervices with open os for IUD insertion/ removal	4
Extra cervices for 6–8 week and 10–12 week uteri (2 of each size)	4
Normal tubal fimbriae and ovaries (2 each)	4
Fallopian tubes for tubal occlusion	10
Simulated round and ovarian ligaments (set of 2 each)	4
Extra thin cervical locking rings	3
Flashlight with batteries	1
Soft nylon carrying bag	1

A later version of the ZOE model has been adapted for use with a postpartum IUD and minilaparotomy kit. This later version comes with all of the above items. The only difference is that it has a removable introitus with vagina and rectum, and two extra locking pins. Unless the postpartum kit is used, however, assembly and care of the model is exactly the same as for the original version.

Outer Skin

The **outer skin of the model** is foam-backed in order to simulate the feel of the anterior pelvic wall. The entire outer skin is removable to allow the model to be used for demonstration purposes (e.g., performing IUD insertion or MVA procedure).

The 3 cm incision (reinforced at each end) located just **below** the umbilicus can be used to insert a laparoscope to look at the uterus, round ligaments, ovaries and fallopian tubes, and practice laparoscopic tubal occlusion. This incision also can be used for practicing postpartum tubal ligation by minilaparotomy.

The 3 cm incision located a few centimeters **above** the symphysis pubis is used for practicing interval minilaparotomy. This incision also is reinforced which allows the skin to be retracted to facilitate demonstration of the minilaparotomy technique.

Cervices

The **normal** cervices have a centrally located, oval-shaped os which permits insertion of a uterine sound, uterine elevator or IUD. The **abnormal** cervices are not open and can be used for demonstration only.
Each of the cervices for treatment of incomplete abortion has a centrally located, oval-shaped os which is dilated to allow passage of a 5 or 6 mm or 10 or 12 mm flexible cannula, respectively.

The **normal** cervices and interchangeable uteri feature the patented "screw" design for fast and easy changing.

ASSEMBLY OF THE ZOE MODEL

To use the ZOE pelvic model for demonstrations or initially to learn how to change the parts (e.g., cervices and uteri), you need to know how to remove the skin.

Removing and Replacing the Detachable Skin and Foam Backing

First, carefully remove the outer skin and its foam lining away from the rigid base at the "top" end of the model. ("Top" refers to the portion of ZOE nearest to the metal carrying handle located above the umbilicus.)

Lift the skin and foam up and over the legs, one leg at a time.

Be as gentle as possible. The detachable skin is made of material that approximates skin texture and it *can* tear.

If you wish to change the anteverted uterus and normal cervix which are shipped attached to ZOE, first you must remove the uterus.

Start by pulling the round ligaments away from the wall.

Then grasp the uterus while turning the *wide* grey ring counterclockwise until the cervix and uterine body are separated.

To remove the *cervix,* turn the *thin* grey ring counterclockwise until it comes off.

You then can push the cervix out through the vagina.

To **reassemble**, simply reverse this process.

To replace the skin and foam lining, start by pulling them down around the legs.

Then make sure the rectal opening is aligned with the opening in the rigid base.

Pull the skin and foam over the top of the model.
Finally, make sure both are pulled firmly down around the rigid base, and the skin is smoothly fitted over the foam.

Once you understand how ZOE's anatomic parts fit together, we suggest you change them through the opening at the top of the model. This helps to preserve ZOE's outer shell as you will

only have to remove it for demonstrations or to change the postpartum (20 week size) uterus.

The anteverted and retroverted uteri have transparent top halves and opaque lower halves for use in demonstrating IUD insertion. These uteri are supported by round ligaments attached to the pelvic wall. The round ligaments, ovaries and fallopian tubes are removable.

To **remove the uterus**:
Unscrew the wide locking ring attached to the uterus using a **counterclockwise rotation**.

To **remove the cervix**:
Unscrew the thin locking ring immediately outside the apex of the vagina.

The cervix should be pushed through the vagina and removed from the introitus.

To **reassemble**, proceed in reverse order.

PERFORMING PROCEDURES WITH THE ZOE MODEL

Speculum examination:

- Use a **medium** bivalve speculum.
- Prior to inserting the speculum, dip it into clean water containing a small amount of soap. (This makes inserting the speculum easier).
- To see the cervix, fully insert the speculum, angle it posteriorly (as in the human, the vagina in the ZOE model is angled posteriorly), **then** open the blades fully.
- To increase the diameter of the opening, use the speculum thumb screw (Pederson or Graves specula).

Passing instruments (uterine sound, uterine elevator, dilator or cannula) through the cervical os: Apply a small amount of clean water containing **a drop or two** of soap solution to the cervix (just as you would apply it with antiseptic solution in a patient). This will make passing the instrument through the cervical os easier.

Sounding the uterus, inserting an IUD and interval minilaparotomy or laparoscopy: Use either the normal (nonpregnant) anteverted or retroverted uterus with a cervix having a patent os.

Postpartum minilaparotomy (tubal occlusion): Use the postpartum uterus (20 week size) with a cervix having a patent os.

Treatment of incomplete abortion using MVA: Use either the 6 to 8 or 10 to 12 week uteri (incomplete abortion) with the appropriate size cervix.

CARE AND MAINTENANCE OF THE ZOE MODEL

The care and maintenance of the ZOE model is the same regardless of the version being used.

- ZOE is constructed of material that approximates skin texture. Therefore, in handling the model, use the same gentle techniques as you would in working with a patient.

- To avoid tearing ZOE's skin when performing a pelvic examination, use a dilute soap solution to lubricate the instruments and your gloved fingers.

- Clean ZOE after every training session using a mild detergent solution; rinse with clean water.
- **DO NOT** write on ZOE with any type of marker or pen, as these marks may not wash off.

- **DO NOT** use alcohol, acetone or Betadine, or any other antiseptic which contains iodine on ZOE. They will damage or stain the skin.

- Store ZOE in the carrying case and plastic bag provided with your kit.

- **DO NOT** wrap ZOE in other plastic bags, newspaper, plastic wrap or any other kinds of material, as these may discolor the skin.

OJT COURSE OUTLINE

USING THE OJT COURSE OUTLINE

The course outline serves as a guide for the trainee to follow during a PAC OJT course. The outline also provides suggested activities for the OJT trainer and supervisor. It is divided into four columns.

The **time** column provides estimates of the time required for completing the activities within the major sections of the outline. Note that these are estimates—one trainee may complete a section in more or less time than another trainee. Variables that affect the time required include patient availability, access to the OJT trainer, patient caseloads and the motivation level of the trainee. The trainer should monitor the trainee's progress and if activities are requiring too much time to complete, then determine why and attempt to keep the trainee on schedule. The approximate time required to complete this course is 33 days, assuming that the trainee is also currently providing services while participating in this OJT course. Note that for each major section there is an approximate number of days indicated. These are not necessarily consecutive days. For example, completion of a 3-day section may occur during 5 working days, or may require only 2 days. These are estimates of how much time should be allowed to complete the readings, exercises, observations, role plays and procedures.

The **trainee activities** column is the heart of the PAC training course. The steps listed in this column move the trainee through a series of readings, practice exercises, observations and interactions with the trainer and patients. The trainee should record her or his name and the date the course is started at the top of the first page of the outline. As each activity presented in the outline is completed (e.g., Read Chapter 1), the trainee should make a tick in the space provided. At the end of each section, the trainer will sign and write the date in the space provided, indicating that all activities in that section have been completed.

The **trainer activities** column describes the trainer's supporting activities and includes tasks such as giving demonstrations using an anatomic model and clients; reviewing answers to practice exercises; arranging for the trainee to observe the trainer working with patients; assessing trainee knowledge and skills; and being available to observe, coach and provide feedback to the trainee. The trainer will use the checklists to conduct all skill assessments for determining trainee competency.

The **supervisor activities** occur primarily before the trainee begins training and then again at the end of the course. The pre-training activities include ensuring the OJT site is ready, working with the trainer and orienting site staff to both PAC services and the OJT course. The remaining supervisor activities occur at the end of the trainee's course and involve administering the final knowledge assessment and verifying the trainer's skill assessments. Although there are no supervisor activities listed during the OJT course, the supervisor is encouraged to schedule several visits to the site during training to monitor and provide feedback to both the trainer and trainee.

TRAINER'S NAME: _____ DATE STARTED COURSE_____

Upon completion of each activity within the course outline, the trainee should tick off the activity in the blank provided

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
At least 2 weeks prior to the start of the training activities		**PREPARATION**—before a trainee starts the OJT course, the trainer should: Review the OJT **Trainer's Guide**, **Trainee's Guide** and course outline. Set up a training area according to the guidelines in the **Trainer's Guide** including materials, supplies, the anatomic model and a video player and monitor. Review *Postabortion Care: A Reference Manual for Improving Quality of Care*. Preview the video tapes listed in the **Trainer's Guide**. Review all of the practice exercises, learning guides and checklists. If needed, practise specific skills using the anatomic model. Ensure that the site is appropriate and that all equipment and supplies for service provision and training are available. PAC patients may not be available immediately, so whenever there is a PAC patient, provide an opportunity for the trainee to observe.	**PREPARATION**—before a trainee starts the OJT course, the supervisor should: Review the OJT **Trainer's/Supervisor's Guide.** Ensure that the site is ready and that all equipment and supplies for service provision and training are available. Meet with the trainer to ensure she or he is prepared and then review the OJT course outline. Establish a schedule to visit the site. Orient site staff to PAC services and to the OJT course. Ensure that at least 3 meetings with Trainer/Trainee/Supervisor is scheduled to ensure that training is progressing as planned.

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Day 1	**INTRODUCTION** _____ Read the "Introduction" in the **Trainee's Guide**.	Provide the trainee with the **Trainee's Guide** and the reference manual on the first day of the course	Conduct initial meeting with Trainer and Trainee to discuss the roles of the trainer, trainee and supervisor. Fix schedule for mid-course meeting to assess the progress of on-the-job training and also to provide support to OJT.
	_____ Meet with your trainer, and identify & plan course to be completed in the coming days.	Meet with your trainee to discuss the OJT course, the goals and objectives, review the learning package and then discuss the responsibilities of the trainee, trainer and supervisor. Review the OJT course outline and explain that the trainee should mark and date each step as it is completed. The trainer will sign off each section where indicated. Discuss the pre- and post-training knowledge and skill assessments.	
	_____ Complete the precourse questionnaire in the **Trainee's Guide**.	Administer and score the precourse questionnaire following the guidelines found in the **Trainer's Guide**. Discuss the results with the trainee	
	_____ Complete the precourse skill assessment (counselling).	Administer the precourse skill assessment for counselling. Role play with the trainee as a service provider and the trainer as a patient. Use the **Checklist for Postabortion Care Family Planning Counselling Skills**. Discuss the results with the trainee.	
	_____ Complete the precourse skill assessment (pelvic examination).	Administer the precourse skill assessment (pelvic examination) following the guidelines found in the **Trainer's Guide**. Discuss the results with the trainee.	
	Activities completed: **Trainer _____Date _____**	When the trainee has completed the knowledge and skill assessments, sign and date this section.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Day 2-4	**POSTABORTION CARE** _____ Read **Chapter 1: Postabortion Care** in *Postabortion Care: A Reference Manual for Improving Quality of Care*. Note that all chapters to be read are in the reference manual.	Assign to Read Chapters 1-2, Checklist and Learning guide Practice 1-4 Exercise	
	_____ Complete Practice Exercises #1 and #2. Note that all practice exercises are in the **Trainee's Guide**.		
	TALKING WITH PATIENTS _____ Read **Chapter 2: Talking with Patients**. Watch the video *Put Yourself in Her Shoes*		
	_____ Complete Practice Exercises #3 and #4.		
	_____ Meet with your trainer to review your responses to Practice Exercises #1, #2, #3 and #4.	Meet with your trainee to review the answers to Practice Exercises #1, #2, #3 and #4. Discuss the exercise with the trainee and ask the trainee to correct or complete any incomplete section of the exercise.	
	Activities completed: **Trainer _____ Date _____**	When the exercises have been completed, sign and date this section.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Days 5–8	**INFECTION PREVENTION** _____ Read **Chapter 4: Infection Prevention**. Watch the video *Infection Prevention for Family Planning Service Programs*.		
	_____ Complete Practice Exercises #5 and #6.		
	INITIAL ASSESSMENT _____ Read **Chapter 3: Initial Assessment**.		
	_____ Read Appendix K Anatomy & Physiology of female Reproductive System. _____ Read **Appendix A: Assessment and Treatment of Complications**. Note that all appendices are in the reference manual.		
	_____ Review **Appendix B: General Principles of Emergency Postabortion Care**.		
	____ Review **Appendix C: Sample Referral Form: Postabortion Complications**.		
	_____ Review **Appendix G: Essential Drugs For Emergency Postabortion Care**.		
	_____ Review the first two sections (Initial Assessment and Medical Evaluation) of the **Learning Guide for Postabortion Care Clinical Skills** in the **Trainee's Guide**. Note that all learning guides are in the **Trainee's Guide**.		

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Complete Practice Exercise #5, #6 and #7.		
	_____ Meet with your trainer to review your answers to Practice Exercise #5, #6 and #7.	Meet with your trainee to discuss the answers to Practice Exercise #5, #6 and #7. Discuss the exercise with the trainee and ask the trainee to correct or complete any incomplete section of the exercise.	
	_____ Arrange for the trainer to demonstrate limited physical (heart, lungs and abdomen) and pelvic examinations. You should then practise performing these examinations several times under the supervision of your trainer. Refer to the first two sections of the **Learning Guide for Postabortion Care Clinical Skills**. Continue to practise these important skills whenever time permits.	Demonstrate to your trainee the procedure for performing limited physical (heart, lungs and abdomen) and pelvic examinations. Use the anatomic model for the pelvic examination. Demonstrate the other examinations with the trainee acting as the patient. Follow the steps in the **Learning Guide for Postabortion Care Clinical Skills**. Ask the trainee to repeat the demonstrations using the anatomic model for the pelvic examination and then you should act as the patient for the other examinations. Use the learning guide or checklist to assess the trainee's competence at performing this procedure. Provide feedback to the trainee. **Note: When the trainee has demonstrated competence in initial assessment skills, after this point the trainee will be allowed to do initial assessments with patients under the trainer's observation.** **Note: Record all skill assessments in the Trainee's Guide and keep that copy for review by the supervisor at the end of the course.**	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Arrange to observe your trainer performing PAC patient assessments until you feel comfortable with the procedure. Refer to the first two sections of the **Learning Guide for Postabortion Care Clinical Skills**. Complete case management notes for each patient observed. Note that the case management notes are in the **Trainee's Guide** and will be reviewed by your trainer and the supervisor. Note that PAC patients may not be immediately available so that you should continue with your individual study and complete these observations when possible.	Arrange for your trainee to observe you performing PAC patient assessments. Following each observation, be sure to discuss the case with the trainee. Review and discuss the trainee's case management notes. Note that PAC patients may not be immediately available so that the trainee should continue with their individual study and complete these observations when possible.	
	_____ Perform initial assessments with PAC patients until you feel competent. Be sure to complete the patient records. Your trainer will observe, coach and provide feedback using the **Checklist for Postabortion Care Clinical Skills**. When you are competent, you can move on to the next clinical skill. If you require more practice, please arrange this with your trainer. Be sure to complete your case management notes. Note that PAC patients may not be immediately available so that you should continue with your individual study and complete these patient procedures when possible.	Arrange for your trainee to perform initial assessments with PAC patients. Be sure the trainee completes the patient records. You will observe, coach and provide feedback using the **Checklist for Postabortion Care Clinical Skills**. When your trainee is competent, s/he can move on to the next clinical skill. If your trainee requires more practice, please arrange this. Note that PAC patients may not be immediately available, so your trainee should continue with individual study and complete these patient procedures when possible.	
	Activities completed: **Trainer _____Date _____**	When all activities are satisfactorily completed, sign and date this section.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Days 9-12	**POSTABORTION FAMILY PLANNING** _____ Read **Chapter 9: Postabortion Family Planning**		
	_____ Read **Learning Guide for Postabortion Family Planning Counselling Skills**		
	_____ Watch video entitled ABHIBADAN, review Put Yourself in her shoes video.		
	_____ Complete Practice Exercise # 10		
	_____ Complete Practice Exercise # 11 with your trainer		
	_____ Arrange to observe your trainer performing postabortion counselling sessions with patients until you feel comfortable with the procedure. Refer to the **Learning Guide for Postabortion Family Planning Counselling Skills**. Complete case management notes for each patient observed. Note that PAC patients may not be immediately available so that you should continue with your individual study and complete these observations when possible. Observe and practice family planning counselling and services with family planning patients.	Arrange for your trainee to observe you performing postabortion counselling sessions with patients. Following each observation, be sure to discuss the case with the trainee. Review and discuss the trainee's case management notes. Note that PAC patients may not be immediately available, so the trainee should continue with their individual study and complete these observations when possible.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	____ Perform several postabortion counselling sessions with patients. Be sure to complete the patient records. Your trainer will observe, coach and provide feedback using the **Checklists for Postabortion Family Planning Counslling Skills**. When you are competent, you can move on to the next activity. If you require more practice, please arrange this with your trainer. Be sure to complete your case management notes. Note theat patients may not be immediately available, so you should continue with your individual study and complete these patient procedures when possible. Observe and practice family Planning counselling and services with family planning patients.	Arrange for your trainee to perform postabortion counselling sessions with patients. Be sure the trainee completes the patient records. You will observe, coach and provide feedback using the **Checklist for Postabortion Family Planning Counselling Skills.** When your trainee is competent, she or he can move on to the next activity skill. If your trainee requires more practice, please arrange this. Note that patients may bot be immediately available, so your trainee should continue with their individual study and complete these patient procedures when possible.	
	PAIN MANAGEMENT _____ Read **Chapter 5: Pain Management**.		
	_____ Review the **Learning Guide for Verbal Anaesthesia**.		
	_____ Review **Appendix E: Use of Medications for Pain**.		
	_____ Review the pain management section of **Appendix B: General Principles of Emergency Postabortion Care**.		
	_____ Review the **Administering Paracervical Block** section of the **Learning Guide for Postabortion Care Clinical Skills**.		

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Complete Practice Exercise #8.		
	_____ Meet with your trainer to review your answers to Practice Exercise #8, #9, #10 and #11.	Meet with your trainee to discuss the answers to Practice Exercise #8, #9, #10 and #11. Discuss the exercise with the trainee and ask the trainee to correct or complete any incomplete section of the exercise.	
	_____ Complete Case Management Notes for each patient you work with. The form for your Case Management Notes can be found in the **Trainee's Guide.**	Meet with your trainee to discuss their cases and to review case Management Notes.	
	_____ Arrange for the trainer to demonstrate initial patient assessment focusing on the use of verbal anaesthesia. You should then practise performing this assessment several times under the supervision of your trainer. Refer to the **Learning Guide for Verbal Anaesthesia**. Continue to practise this important skill whenever you interact with patients.	Demonstrate to your trainee the procedure for using verbal anaesthesia during an initial patient assessment. The trainee should act as the patient as you use the anatomic model. Follow the steps in the **Learning Guide for Verbal Anaesthesia**. Ask the trainee to repeat the demonstration using the anatomic model as you act as the patient. Use the learning guide or checklist to assess the trainee's competence at performing this procedure. Provide feedback to the trainee.	
	_____ Arrange for the trainer to demonstrate administering paracervical block using the anatomic model. You should then practise performing this procedure using the model several times under the supervision of your trainer. Refer to the **Learning Guide for Postabortion Care Clinical Skills**. Continue to practice this important skill whenever time permits.	Demonstrate to your trainee the procedure for administering paracervical block using the anatomic model. Follow the steps in the **Learning Guide for Postabortion Care Clinical Skills**. Ask your trainee to repeat the demonstration as you observe, coach and provide feedback. Use the learning guide or checklist to assess the trainee's competence at performing this procedure. Provide feedback to the trainee.	
	Activities completed: **Trainer** _____ **Date** _____	When all activities are satisfactorily completed, sign and date this section.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Days 13-15	**TREATMENT OF INCOMPLETE ABORTION** _____ Read **Chapter 6: Treatment of Incomplete Abortion**.		
	_____ Read **Appendix F: Equipment and Supplies Needed for MVA**.		
	_____ Read **Appendix H: Precautions for Performing MVA**.		
	_____ Read **Appendix I: Preparing Instruments for MVA**.		
	_____ Read **Learning Guide for Postabortion Care Clinical Skills**.		
	_____ Watch the video entitled **Postabortion Care Services: Use of Manual Vacuum Aspiration and Recommended Practices for Processing MVA Instruments**.		
	_____ Arrange for your trainer to demonstrate through role play the set up and use of the MVA instruments. Refer to your learning guide during the demonstrations.	Demonstrate through role play with your trainee the set up and use of the MVA instruments. Ask the trainee to follow along in the learning guide during the demonstrations. Following the demonstration, ask your trainee to repeat the demonstration as you observe, coach and provide feedback.	
	_____ Arrange for your trainer to demonstrate through role play the MVA procedure using the anatomic model. Refer to your learning guide during the demonstration.	Demonstrate through role play with your trainee the MVA procedure using the anatomic model. Ask the trainee to follow along in the learning guide during the demonstration. Following the demonstration, ask your trainee to repeat the demonstration as you observe, coach and provide feedback. Using the learning guide or checklist, determine if the trainee is competent performing the MVA procedure on a model. Provide feedback to the trainee.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Arrange to observe your trainer performing MVA procedures with patients until you feel comfortable with the procedure. Refer to the **Learning Guide for Postabortion Care Clinical Skills**. Complete case management notes for each patient observed. Note that PAC patients may not be immediately available so you should continue with your individual study and complete these observations when possible.	Arrange for your trainee to observe you performing MVA procedures with patients. Following each observation, be sure to discuss the case with the trainee. Review and discuss the trainee's case management notes. Note that PAC patients may not be immediately available, so the trainee should continue with their individual study and complete these observations when possible.	
	PROCESSING MVA EQUIPMENT AND OTHER ITEMS _____ Read **Chapter 8: Processing MVA Equipment and Other Items**.		
	_____ Read **Appendix D: Processing Surgical Gloves**.		
	_____ Read the instrument processing section of the **Learning Guide for Postabortion Care Clinical Skills**.. Watch the video *Infection Prevention for Family Planning Service Programs*		
	_____ Complete Practice Exercise #12. _____ Meet with your trainer to review your answers to Practice Exercise #12. _____ Ensure that the following week's activity of providing MVA services is closely supervised by Trainer.	Meet with your trainee to review Practice Exercise #12. Schedule time with trainee to observe and perform MVA procedure.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Arrange to observe your trainer demonstrating the processing of instruments related to the MVA procedure including decontamination, cleaning, high- level disinfection, sterilization and storage. Refer to the instrument processing section of the **Learning Guide for Postabortion Care Clinical Skills**.	Demonstrate the processing of instruments related to the MVA procedure including decontamination, cleaning, high-level disinfection, sterilization and storage. Ask the trainee to follow along in the learning guide during the demonstration. Following the demonstration, ask your trainee to repeat the demonstration as you observe, coach and provide feedback. Determine if the trainee correctly performs the infection prevention steps on the checklist. Provide feedback to the trainee.	
	Activities completed: **Trainer**_____ **Date** _____	When all activities are satisfactorily completed, sign and date this section.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Days 16-20	**MANAGEMENT OF PROBLEMS AND COMPLICATIONS DURING MVA** _____ Read **Chapter 7: Management of Problems and Complications During MVA**.		
	_____ Read **Appendix A: Assessment and Treatment of Complications**.		
	_____ Read **Appendix H: Precautions for Performing MVA**.		
	_____ Complete Practice Exercise #9.		
	_____ Meet with your trainer to review your answers to Practice Exercise #9.	Meet with your trainee to review Practice Exercise #9.	
	_____ Perform MVA procedures with patients until you feel competent. Be sure to complete the patient records. Your trainer will observe, coach and provide feedback using the **Checklist for Postabortion Care Clinical Skills**. When you are competent, you can move on to the next clinical skill. If you require more practice, please arrange this with your trainer. Be sure to complete your case management notes. Note that PAC patients may not be immediately available, so you should continue with your individual study and complete these patient procedures when possible.	Arrange for your trainee to perform MVA procedures with patients. Be sure the trainee completes the patient records. You will observe, coach and provide feedback using the **Checklist for Postabortion Care Clinical Skills**. When your trainee is competent, she/he can move on to the next clinical skill. If your trainee requires more practice, please arrange this. Note that PAC patients may not be immediately available, so your trainee should continue with their individual study and complete these patient procedures when possible.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	ORGANISING AND MANAGING SERVICES _____ Read **Chapter 10: Organizing and Managing Services**.		
	_____ Complete Practice Exercise #9 and #13.		
	_____ Meet with your trainer to review your answers to Practice Exercise #9 and #13.	Meet with your trainee to discuss Practice Exercise #13.	
	_____ Complete Case Management Notes for each patient you work with. The form for your Case Management Notes can be found in the **Trainee's Guide.**	Meet with your trainee to discuss their cases and to review their Case Management Notes.	
	Activities completed: **Trainer _____ Date _____**	When all activities are satisfactorily completed, sign and date this section.	

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Day 21	**FINAL ASSESSMENTS** _____ Prepare a summary of your training experiences by completing Practice Exercise #14.		
	_____ Meet with your trainer to review Practice Exercise #14 and to discuss your preparation for the final knowledge assessment. During this meeting, complete the **OJT PAC Course Evaluation Form** and give it to your trainer.	Meet with your trainee to discuss Practice Exercise #14 and to offer any suggestions for preparing for the knowledge assessment. Have the trainee fill in the **OJT PAC Course Evaluation Form** at the end of the meeting. The completed form should be given to the OJT Supervisor. Contact the OJT Supervisor to arrange a date for the final knowledge assessment.	When contacted by the trainer, arrange a date for the knowledge assessment. Make a copy of the midcourse questionnaire and answer sheet.
	_____ Review the chapters in the reference manual in preparation for the knowledge assessment. Your trainer can let you know when the final knowledge assessment will be given.		

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
Day 22-27	_____ Complete the final knowledge assessment and score at least 85%.	Depending on availability of Trainer/Trainee/Supervisor find suitable time to conduct knowledge assessment.	Administer and score the final knowledge assessment. If the trainee scores at least 85%, then the trainee's skills assessment records can be reviewed for final qualification. If the trainee scores less than 85%, ask the trainee to review the areas where there were problems and retake the questionnaire until a score of 85% is achieved. After completing the final knowledge assessment, collect the answer as well as the question sheet from the Trainee.

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Review your clinical skill assessments with your trainer and the supervisor. The supervisor will also ask to review your case management notes and your course outline to review the dates various activities were completed.	Review the trainee's clinical assessments with the supervisor and trainee. By this time, the trainee must have demonstrated competence in performing all of the skills learned during this course. Review the checklists for the clinical skills with the supervisor.	Review the trainee's clinical assessments (checklists completed by the trainer). Discuss these with the trainer to ensure the trainee is competent at performing all of the skills. Also review the **Training Review Sheet** (Practice Exercise #14), the trainee's case management notes and the trainee's course outline. When reviewing the course outline, check the date each activity was completed and that the trainer has signed indicating satisfactory completion of each activity. Upon a satisfactory review, indicate that the trainee has completed the course and is a qualified PAC service provider.

COURSE OUTLINE FOR ON-THE-JOB TRAINING FOR POSTABORTION CARE			
TIME	**TRAINEE ACTIVITIES**	**TRAINER ACTIVITIES**	**SUPERVISOR ACTIVITIES**
	_____ Receive a statement of qualification indicating that you are qualified as a PAC Service Provider.	Assist with the presentation of the statement of qualification.	Present the statement of qualification. Send the **Training Review Sheet** to the national PAC coordinator.
	Agree on a followup plan with your supervisor, and when s/he will visit you at your own site. Periodically ask for assistance and pursue additional learning opportunities as necessary.	Periodically observe and assist the newly trained service provider as necessary.	Periodically observe and assist the newly trained service provider as necessary.

PRECOURSE QUESTIONNAIRE AND ANSWER KEY

HOW THE RESULTS WILL BE USED

The main objective of the **Precourse Questionnaire** is to assist both the **clinical trainer** and the **trainee** as they begin their work together in the course by assessing what the trainee knows about the course topic. This allows the clinical trainer to identify topics that may need additional emphasis during the course. Receiving the results of the precourse assessment enables the trainee to focus on individual learning needs. In addition, the questions alert the trainee to the content that will be presented in the course.

The questions are presented in the true-false format. **For the clinical trainer**, the questionnaire results will identify particular topics, which may need additional emphasis during the learning sessions. **For the trainee**, the learning objective(s) related to each question and the corresponding chapter(s) in the reference manual are noted beside the answer column. To make the best use of the limited course time, the trainee is encouraged to address individual learning needs by studying the designated chapter(s).

PRECOURSE QUESTIONNAIRE

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

INITIAL ASSESSMENT

1. A woman who is admitted with possible complications of incomplete abortion should first be assessed to determine the presence of shock.	_____	Trainee Objective 1 (Chapter 3)
2. Taking a complete medical history is the first step in assessing a patient with possible complications of incomplete abortion.	_____	Trainee Objectives 1 and 3 (Chapters 2 and 3)
3. An abdominal examination is the best way to determine uterine size.	_____	Trainee Objective 1 (Chapters 2 and 3)
4. A woman presenting with vaginal bleeding and signs and symptoms of pregnancy may have an ectopic pregnancy.	_____	Trainee Objectives 1 and 3 (Chapters 2 and 3)
5. Foul-smelling discharge may indicate infection due to incomplete abortion.	_____	Trainee Objectives 1 and 2 (Chapters 2 and 3)

INFECTION PREVENTION

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilised by boiling them in water for 20 minutes.	_____	Trainee Objective 4 (Chapters 4 and 8)
7. High-level disinfection of surgical (metal) instruments, which have been thoroughly cleaned, can be done by soaking them in 0.1% chlorine solution prepared with boiled water.	_____	Trainee Objective 4 (Chapters 4 and 8)
8. To minimise the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, instruments and reusable gloves **first** should be soaked overnight in 8% formaldehyde solution.	_____	Trainee Objective 4 (Chapters 4 and 8)
9. Cannulae should be sterilised by autoclaving for 20 minutes at 121^{o}C.	_____	Trainee Objective 4 (Chapters 4 and 8)
10. The MVA syringe must be high-level disinfected between patients.	_____	Trainee Objective 4 (Chapters 4 and 8)

MVA PROVISION

11. The MVA procedure is complete when foam is visible in the MVA syringe.	_____	Trainee Objective 6 (Chapter 6)
12. Pain management for treatment of an uncomplicated incomplete abortion requires paracervical block and a non-narcotic analgesic.		Trainee Objective 5 (Chapter 5)

13. The patient **must** return to the clinic if she has spotting or bleeding during the few days following an MVA to treat complications of incomplete abortion.	_____	Trainee Objective 8 (Chapter 6)
14. MVA is an effective treatment for incomplete abortion if the uterine size is up to 12 weeks.	_____	Trainee Objective 6 (Chapter 6)
15. The vacuum in the MVA syringe will be lost if the uterus is perforated.	_____	Trainee Objective 7 (Chapter 7)

POSTABORTION FAMILY PLANNING

16. The goal of postabortion family planning is to help a woman choose a method of contraception.	_____	Trainee Objective 9 (Chapter 9)
17. Describing adverse side effects is the most important part of postabortion family planning counselling.	_____	Trainee Objective 9 (Chapter 9)
18. The physician is the person best qualified to choose a contraceptive method for a woman in good health.	_____	Trainee Objective 9 (Chapter 9)
19. The IUD is not recommended for immediate use by postabortion care patients.	_____	Trainee Objective 9 (Chapter 9)
20. A woman's fertility usually returns only after her first menstrual period following an incomplete abortion.	_____	Trainee Objective 9 (Chapter 9)

PRECOURSE QUESTIONNAIRE ANSWER KEY

INITIAL ASSESSMENT

1. A woman who is admitted with possible complications of incomplete abortion should first be assessed to determine the presence of shock.	**TRUE**	Trainee Objective 1 (Chapter 3)
2. Taking a complete medical history is the first step in assessing a patient with possible complications of incomplete abortion.	**FALSE**	Trainee Objectives 1 and 3 (Chapters 2 and 3)
3. An abdominal examination is the best way to determine uterine size.	**FALSE**	Trainee Objective 1 (Chapters 2 and 3)
4. A woman presenting with vaginal bleeding and signs and symptoms of pregnancy may have an ectopic pregnancy.	**TRUE**	Trainee Objectives 1 and 3 (Chapters 2 and 3)
5. Foul-smelling discharge may indicate infection due to incomplete abortion.	**TRUE**	Trainee Objectives 1 and 2 (Chapters 2 and 3)

INFECTION PREVENTION

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilised by boiling them in water for 20 minutes.	**FALSE**	Trainee Objective 4 (Chapters 4 and 8)
7. High-level disinfection of surgical (metal) instruments, which have been thoroughly cleaned, can be done by soaking them in 0.1% chlorine solution prepared with boiled water.	**TRUE**	Trainee Objective 4 (Chapters 4 and 8)
8. To minimise the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, instruments and reusable gloves **first** should be soaked overnight in 8% formaldehyde solution.	**FALSE**	Trainee Objective 4 (Chapters 4 and 8)
9. Cannulae should be sterilised by autoclaving for 20 minutes at 121^{o}C.	**FALSE**	Trainee Objective 4 (Chapters 4 and 8)
10. The MVA syringe must be high-level disinfected between patients.	**FALSE**	Trainee Objective 4 (Chapters 4 and 8)

MVA PROVISION

11. The MVA procedure is complete when foam is visible in the MVA syringe.	**TRUE**	Trainee Objective 6 (Chapter 6)
12. Pain management for treatment of an uncomplicated incomplete abortion requires paracervical block and a non-narcotic analgesic.	**FALSE**	Trainee Objective 5 (Chapter 5)

13. The patient **must** return to the clinic if she has spotting or bleeding during the few days following an MVA to treat complications of incomplete abortion.	**FALSE**	Trainee Objective 8 (Chapter 6)
14. MVA is an effective treatment for incomplete abortion if the uterine size is up to 12 weeks.	**TRUE**	Trainee Objective 6 (Chapter 6)
15. The vacuum in the MVA syringe will be lost if the uterus is perforated.	**FALSE**	Trainee Objective 7 (Chapter 7)

POSTABORTION FAMILY PLANNING

16. The goal of postabortion family planning is to help a woman choose a method of contraception.	**TRUE**	Trainee Objective 9 (Chapter 9)
17. Describing adverse side effects is the most important part of postabortion family planning counselling.	**FALSE**	Trainee Objective 9 (Chapter 9)
18. The physician is the person best qualified to choose a contraceptive method for a woman in good health.	**FALSE**	Trainee Objective 9 (Chapter 9)
19. The IUD is not recommended for immediate use by PAC patients.	**FALSE**	Trainee Objective 9 (Chapter 9)
20. A woman's fertility usually returns only after her first menstrual period following an incomplete abortion.	**FALSE**	Trainee Objective 9 (Chapter 9)

PRE-TRAINING ASSESSMENT CHECKLISTS FOR PAC OJT CLINICAL AND COUNSELING SKILLS

USING THE CHECKLISTS

This skills assessment activity is intended to assist both the **trainer** and **trainee** as they begin their work together in the OJT course. The results will identify those counseling and clinical skills (i.e., pelvic examination), which are performed satisfactorily, and those, which may need to be learned or require additional practice during training.

Each trainee will receive a copy of her or his completed assessment at the beginning of training. The trainee should use the results of the assessment to guide her/his learning activities during guided clinical activity sessions.

In using the checklists, it is important that the scoring be done carefully and correctly. If the task is performed satisfactorily, the trainer should mark a "✓" in the "**Satisfactory**" column. If any step or task is performed incorrectly or out of sequence, the trainer should mark an "**x**" in the "**Unsatisfactory**" column. For any "**Unsatisfactory**" rating, the trainer should note specific deficiencies to assist the trainee in learning or correcting the performance of this step or task during the clinical practice sessions.

Satisfactory: Performs the task or skill according to written procedure or guidelines without requiring assistance from trainer

Unsatisfactory: Does not perform the task or skill according to written procedure or guidelines or requires assistance from trainer

PRE-TRAINING ASSESSMENT CHECKLIST FOR PAC OJT COUNSELING SKILLS

Instructions: Place a "✓" in the "Satisfactory" column if the step or task is performed correctly, or an "**x**" in the "Unsatisfactory" column if task performed incorrectly or out of sequence.

Trainee_____**Date**_____

STEP/TASK	SAT.	UNSATISFACTORY/ COMMENT
COUNSELING (General)		
Greets woman respectfully and with kindness.		
Assesses whether counseling is appropriate at this time (if not, arranges for her to be counseled at another time).		
Assures necessary privacy.		
Obtains biographic information (name, address, etc.).		
Asks if she was using contraception before she became pregnant. If she was, find out if she: · Used the method correctly · Discontinued use · Had any trouble using the method · Has an concerns about the method		
Provides general information about family planning.		
Explores any attitudes or religious beliefs that either favour or rule out one or more methods.		
Gives the woman information about the contraceptive choices available and the risks and benefits of each: · Shows where and how each is used · Explains how the method works and its effectiveness · Explains possible side effects and other health problems · Explains the common side effects		
Discusses the patient's needs, concerns and fears in a thorough and sympathetic manner.		
Helps patient begin to choose an appropriate method.		

PRE-TRAINING ASSESSMENT CHECKLIST FOR PAC OJT CLINICAL SKILLS

Instructions: Place a "✓" in the "Satisfactory" column if the step or task is performed correctly, or an "x" in the "Unsatisfactory" column if task performed incorrectly or out of sequence.

Trainee_____**Date**___

STEP/TASK	SAT.	UNSATISFACTORY/ COMMENT
Greets woman respectfully and with kindness.		
Assures necessary privacy.		
PELVIC EXAMINATION		
Puts new examination or high-level disinfected or sterile gloves on **both** hands.		
Inspects external genitalia.		
Speculum Examination		
Inserts vaginal speculum. Checks for vaginal discharge and appearance of the cervix.		
Collects vaginal, cervical or urethral specimens if indicated.		
Places all instruments in 0.5% chlorine solution after use.		
Bimanual Examination		
Determines if there is cervical motion tenderness.		
Determines size, shape and position of uterus.		
Palpates pelvic adnexa for abnormalities.		
Performs rectovaginal examination, if indicated.		
Removes gloves and correctly disposes of surgical gloves or immerses reusable gloves in 0.5% chlorine solution.		

PRACTICE EXERCISES AND ANSWER KEY

PE1 Postabortion Care (Chapter 1, question and answer)

PE2 Postabortion Care (Chapter 1, case studies)

PE3 Interpersonal Communication (Chapter 2, case studies)

PE4 Interpersonal Communication (Chapter 2, video *Put Yourself in her Shoes*)

PE5 Infection Prevention (Chapter 4, IP video)

PE6 Infection Prevention (Chapter 4, observation guide)

PE7 Initial Assessment (Chapter 3, case studies)

PE8 Pain Management (Chapter 5, case studies)

PE9 Management of Problems & Complications (Chapter 7, case studies)

PE10 Postabortion Counselling (Chapter 9 and video *GATHER*, case studies)

PE11 Postabortion Counselling (Chapter 9 and video *GATHER*, role plays)

PE12 Instrument Processing (Chapter 8, observation and question-answer)

PE13 Management and Organisation of PAC Services (Chapter 10, exercise)

PE 14 Summary of Training Experience

Practice Exercise #1: INTRODUCTION TO POSTABORTION CARE

ACTIVITY DESCRIPTION: This questionnaire will review basic information on PAC which you will find in Chapter 1 of the reference manual. It also will help you look at the service delivery system to see how PAC services are organised and delivered in your hospital's catchment area. After reading Chapter 1, answer the following questions about this training topic. Refer to the chapter, as well as to your hospital records and colleagues, as necessary.

QUESTIONS

1. How many women (on average) come to your own hospital each week with some abortion-related complication? **(Hospital based)**

2. What percentage of all pregnancies end in spontaneous abortion?
   At least 15% of all pregnancies end in spontaneous abortion.

3. What are the five main elements of PAC?
   - **Counseling and client provider interaction to identify and respond to women's Health needs.**
   - **Emergency treatment of incomplete abortion and potentially life-threatening complications**
   - **Postabortion family planning counselling and services**
   - **Links between postabortion emergency services and the reproductive health care system**
   - **Community and service provider partnerships for prevention of unwanted pregnancies and unsafe abortion, and ensure that services meet community expectations and needs.**

4. Which of these elements are provided to every woman treated at your own hospital for abortion related complications?
   (Hospital based)

5. Why is postabortion family planning so important in PAC services?
   For those women who may have experienced complications from induced abortion and have already experienced an unwanted pregnancy, family planning services may prevent future unwanted pregnancies. Also, some women may wish to become pregnant soon after having an incomplete abortion, and there is no reason to discourage them from doing so, barring medical reasons.

6. If women in your hospital are currently treated by sharp curettage, how long is their average stay in the hospital? What is the frequency of complications? **(Hospital based)**

7. Why is MVA the preferred method over dilatation and curettage (D&C)?
   - **The risk of complications is reduced.**
   - **Access to services is increased.**
   - **The resources used are reduced.**
   - **The cost of postabortion services is reduced.**

Practice Exercise #2: POSTABORTION CARE

ACTIVITY DESCRIPTION: This case study will review basic information on PAC, which you will find in Chapter 1 of the reference manual. It also will help you look at the service delivery system to see how PAC services are organised and delivered in your hospital's catchment area. After reading Chapter 1 and completing Practice Exercise #1, read the case study and answer the questions that follow.

CASE STUDY: Maya is 27, and has not had her period for a couple of months. She has been cramping and bleeding for seven days. She lives far from the hospital, but now her family is concerned so they bring her to the hospital.

At the hospital, she is admitted by the nurse. The nurse greets her and asks her what her problem is, and when she describes her symptoms the nurse explains that she will be seen by the specialist and takes her to the provider who will take care of her. The provider, Sita, asks her about her symptoms, and takes a thorough medical history. She explains that she will conduct an exam, and does a limited physical and pelvic exam. Upon examination, she finds that Maya has had an incomplete abortion. Sita explains her findings to Maya and tells her what needs to be done. She explains the procedure, and with Maya's consent she evacuates her uterus with MVA.

Once the procedure is complete, she is taken to the recovery room to rest. In the recovery room, Sita comes to check on her condition and to talk to her about her condition and other reproductive health needs. Sita reminds her of their initial discussion, and talks about her reproductive goals. Because Maya has three children and does not want any more, they discuss long term contraception. Maya decides that she would like to use Norplant implants, which she is able to get the same day before she leaves the hospital.

At the same time, they discuss the fact that Maya has some cervical warts, which the provider noted in the initial examination. They discuss the risks that this condition presents for HIV/AIDS and the need to use dual protection. Maya is concerned that her husband won't agree to use condoms, so Sita agrees to talk to the two of them together. In addition, they talk about the need for further investigation of her medical status, and Sita arranges for a follow-up appointment after 1 week when she will also do a Pap smear. At this point, the provider also explains the situation to Maya's family, and emphasises the importance of returning for the follow-up.

QUESTIONS

1. What are the components of PAC covered in this case?
   Emergency treatment of the incomplete abortion
   Postabortion family planning counseling and services
   Linkages to other reproductive health services

2. What are the linkages to other reproductive health services?
   Counseling on dual protection for HIV/AIDS
   Scheduling a Pap smear at the follow up to investigate the cervical warts observed

Practice Exercise #3: INTERPERSONAL COMMUNICATION

ACTIVITY DESCRIPTION: After reading Chapter 2, read the case studies below and answer the questions.

CASE STUDY 1: When Maya is brought to the hospital by her family, the nurse in admission recognizes that she is very anxious and uncertain. She makes an effort to put Maya at ease and make her feel comfortable and confident, and asks her about her problems. At the next stage, when Maya met Sita, the service provider, for her initial examination and eventually for her procedure, Sita also made Maya feel comfortable and reassured. She made Maya feel as though she was in control of her own care by giving her the necessary information and letting her have a choice in her own care. Throughout the examination and the procedure, she was careful to explain what she was going to do before she did it and as she performed any steps, which might have been uncomfortable or disturbing for Maya. After the procedure, she spoke to Maya about the outcomes, but also about other important issues in her reproductive health. She also involved Maya's family in the discussions when appropriate.

QUESTIONS

1. What are the important interpersonal communication skills exhibited?
   Listening
   Being nonjudgmental
   Providing information
   Being supportive and attentive
   Allowing the patient to chose

2. What impact is this type of interpersonal relationship likely to have on Maya's reproductive health?
   Answers might include the following:
   - **Maya is more likely to be truthful with Sita and provide her with complete information and ask questions if she is confident and at ease with her.**
   - **The procedure was probably easier, because Maya was more relaxed and less anxious and well prepared for what was to come.**
   - **Maya is more likely to have confidence in and be receptive to Sita's counseling and advice.**
   - **She is more likely to carry through with next steps (contraception, follow-up visits, etc.).**

CASE STUDY 2**: A patient is lying on the procedure table when the doctor enters the room and goes to the trolley to check the instruments. The nurse is also standing by the trolley, not talking to the patient. The following is the dialogue that goes on during the MVA procedure.

Doctor says to nurse, still without looking at patient or saying anything to her:

Doctor: Did she admit to provoking it?

Nurse: No, Doctor. She denies doing anything, but I suspect that she has gone to a quack to cause this abortion.

∗ *Adapted from*: Yordy L, S Johnson and J Winkler. 1993. *MVA Trainer's Handbook*. IPAS: Carrboro, North Carolina

Doctor: Well, it looks like we're out of lidocaine. It's a good thing our women have a high tolerance for pain!

Nurse: Yes, Doctor.

Doctor begins procedure, still without talking to patient.

Doctor: Sister, how many more incompletes are out there today? Today is my clinic day and I don't want to spend much time on these evacuations.

Nurse: There are ten patients there, Doctor.

Doctor shakes his head and says:

Doctor: When will these women learn to be responsible for their actions?

Doctor pats patient on the knee and says:

Doctor: All right, dear. You're all cleaned up. Let's be a little more careful next time, eh?

Doctor turns away, takes off his gloves and says to nurse:

Doctor: Go ahead and bring the next one in.

QUESTIONS

1. Describe the attitudes reflected by the doctor and the nurse in the case study and how they exhibited those attitudes.

Answers might include:

BEHAVIOUR	ATTITUDE/BELIEF
Asking if patient "admits" interfering with pregnancy	**Judgmental**
Not giving pain control drugs	**Women don't need pain control**
Not assessing patient's need for pain control	
Displaying impatience	**Abortion patients aren't worth much time**
Saying, "let's be a little more careful"	**Degrading women**
Talking about the patient as an absent person in her presence	**Insensitivity toward her feelings**

2.Which of the patient's rights were violated?

Most of the patient's rights to be treated with dignity were violated. Specifically regarding the topic at hand, interpersonal communication was very bad. Among the rights violated those mentioned in the chapter include:

- **Right to information**
- **Right to discuss and express freely**
- **Right to supportive attention to reduce anxiety and lessen pain**
- **Right to decide freely (consent for treatment)**
- **Right to privacy and confidentiality (doctor and nurse were talking about other patients in front of this patient)**

3. Why is good patient-provider interaction important?

Good patient-provider interaction is important to help ease the anxiety and concern of the patients, to respect their rights and needs, and to provide opportunities for both patients and providers to give and gather the important information. It also helps the provider gain the confidence of the patient.

4. What are the characteristics of the provider's attitude in a good patient-provider relationship?

Respectful, nonjudgmental, open, receptive (a good listener)

5. Refer to the case described in Practice Exercise #2 (Maya and Sita). List the points in the PAC service where there should be good patient-provider interaction.

Good patient-provider interaction should be continuous throughout the patient's stay at the centre, especially during:

- **Admission procedure**
- **Initial Assessment period**
- **MVA**
- **Postabortion**

Practice Exercise #4: INTERPERSONAL COMMUNICATION

ACTIVITY DESCRIPTION: After reading Chapter 2 and completing Practice Exercise #3, watch the video entitled *Put Yourself in Her Shoes* and answer the following questions∗.

QUESTIONS

Scene One

How would you describe Rose's behaviour and attitude in the first scene?

Negative; she scolded and blamed the patient publicly and did not have time or care for the patient.

Why is it important for healthcare providers to provide family planning counseling to women who have undergone an unsafe abortion?

A counseling session may be the *only* opportunity the patient has to learn how to prevent future unwanted pregnancies and repeat abortions.

What effect did Rose's behaviour have on Mulenga?

It made Mulenga feel bad, foolish and afraid. Mulenga left the hospital without information on family planning methods and soon became pregnant again.

How soon does fertility return after an abortion?

A woman's fertility returns almost immediately, as early as 11 days, even before her next period.

Scene Two

Describe the concept of *empathy* as defined by Sister Rose. How do you define empathy?

Empathy is not just feeling sorry for someone. It means understanding how the other person feels. Sister Rose's definition of empathy is: Showing understanding, concern and a desire to help in a way that encourages open, honest communication.

What helps Sister Rose to empathise with a woman who has just had an unsafe abortion?

A healthcare provider can empathise with a woman who has just had an unsafe abortion if the provider remembers:

- **The woman may have had a miscarriage or spontaneous abortion.**
- **It may not be her fault for not having enough information about family planning.**
- **Offering family planning can make a difference in preventing another abortion.**
- **She is in a crisis and needs support to get through it.**

Scene Three

When is the best time to begin family planning counseling for women who have had an abortion? Who is the best person to conduct this counseling?

It is important to counsel women at bedside or in a private setting and if possible to give them a method before they leave. This may be their only opportunity to learn about family planning and receive a method. All health care providers who come in contact with

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∗ *Questions adapted from*: Johns Hopkins University Population Communication Services. 1997. *Video Discussion Guide for Trainers.*

postabortion patients should be able to provide counseling, or at least refer patients to family planning services.

What are some of the special considerations to keep in mind when counseling young women who have recently had an abortion? How would you let them know that abstinence is an option?

It is important to encourage young patients to talk about their feelings and actively participate in the counseling session. We may express our fear for the well being of a young patient by becoming angry. However, a judgmental attitude and scolding will not be effective; a provider should be prepared to discuss issues common to young people, including relationships and the option of abstinence.

Scene Four

What are the three essential messages of family planning counseling to prevent repeat abortion? How did Rose express these to Martha?

Three essential messages that must be communicated to the patient during family planning counseling to prevent abortion are:

- **Fertility returns immediately, even before a woman's next period.**
- **Modern family planning methods are safe, effective and available to prevent or delay pregnancy.**
- **Patients need to know exactly where and how to obtain family planning services.**

Scene Five

Why is it important to let the patient's partner participate in the discussion and explanation of postabortion care, family planning and STDs?

Involving men is important for supporting women in their choice and use of contraceptive method. Involving men also may prevent the spread of STDs and AIDS by promoting the use of condoms.

What is the purpose of providing a referral to the patient and/or of discussing follow-up visits?

Referrals and follow-up visits are important for a number of reasons:

- **To allow for further medical evaluation, if needed**
- **To confirm health status and completion of treatment**
- **To confirm if the selected family planning method is satisfactory and being used correctly**
- **To repeat instructions regarding use**
- **To provide additional supplies**
- **To answer questions**
- **To help a woman choose a new method**
- **To provide a backup method if appropriate**

Scene Six

What are the three major elements that can improve treatment for women in the Postabortion period and prevent their having repeat abortions?

- **Providing emergency treatment of abortion complications**
- **Providing FP counseling and FP services to prevent repeat abortion**
- **Forging links between Postabortion emergency services and the reproductive health care system**

Practice Exercise #5: INFECTION PREVENTION

ACTIVITY DESCRIPTION: After reading Chapter 4, watch the Overview of the IP Video (the first 20 minutes) and answer the following questions.

QUESTIONS

1. What is the purpose of infection prevention?
   Minimize disease transmission for both patients and staff

2. Define the following terms:
   a. Antisepsis
      Killing or inhibiting microorganisms on skin and other body tissues by using a chemical agent
   b. Decontamination
      Process before cleaning that makes objects safer to be handled by staff
   c. High-level disinfection
      Process that eliminates most microorganisms except bacterial endospores
   d. Sterilization
      Process that eliminates all microorganisms, including bacterial endospores, from inanimate objects

3. Match each type of glove with its appropriate use:

Sterile surgical gloves	MVA procedure	**(clean exam gloves)**
Utility gloves	Caesarean section	**(sterile gloves)**
Clean exam gloves	Washing used, decontaminated instruments	**(Utility gloves)**

4. During an MVA procedure, when is hand washing indicated?
   - **Before touching the patient**
   - **Before putting on and after taking off gloves**

Practice Exercise #6: INFECTION PREVENTION

PRACTICAL APPLICATION OF INFECTION PREVENTION PRACTICES

ACTIVITY DESCRIPTION: After reading Chapter 4, watching the overview of the IP Video and completing Practice Exercise #5, complete the following practical exercise. In this exercise, you will observe healthcare providers' infection prevention practices that must be part of everyday hospital procedures. Record your observations on the guide below. (N/A = Not Applicable)

OBSERVATION OF PATIENT PREPARATION AND CLINICAL PROCEDURES				
	OBSERVATION	**RESPONSE**		
1.	Hands are washed prior to:			
	· examining a patient	**Yes**	**No**	**N/A**
	· putting on gloves	**Yes**	**No**	**N/A**
2.	Hands are washed after:			
	· examining a patient	**Yes**	**No**	**N/A**
	· removing gloves	**Yes**	**No**	**N/A**
	· contact with blood or other body fluids	**Yes**	**No**	**N/A**
3.	After washing, hands are:			
	· air dried	**Yes**	**No**	**N/A**
	· dried on personal towel or a paper towel	**Yes**	**No**	**N/A**
	· other—write in:	**Yes**	**No**	**N/A**
4.	Gloves are used when exposure to blood or other body fluids is expected	**Yes**	**No**	**N/A**
5.	Masks and eye shields are used if splashing of blood or other body fluids is likely	**Yes**	**No**	**N/A**

Practice Exercise #7: INITIAL ASSESSMENT

ACTIVITY DESCRIPTION: After reading Chapter 3 and Appendices A, B, C, G of the manual, read the case studies and answer the questions that follow.

CASE STUDY 1: Sita conducts an initial examination for Maya, a 27-year-old woman who has come to the hospital complaining of cramping and vaginal bleeding for 7 days. She describes her bleeding as moderate over the past 7 days, accompanied by mild to severe cramping. She has not noticed any products of conception. During the medical history, Sita finds out that Maya has three living children, 10, 7, and 3 years old, and she has had one previous miscarriage and one child who died in infancy. Maya's last menstrual period was 11 weeks earlier, and she had not been using any family planning. She does not want more children, but she does not know of any place near her home where she can get services. Her physical examination reveals no significant findings and there is no sign of shock or infection, though during the pelvic exam Sita notices the presence of a few cervical warts. The uterus appears slightly enlarged, indicating a gestational age of about 8 weeks. The cervix is dilated and there appear to be some products of conception visible in the vaginal canal. There is no sign of intra-abdominal injury.

QUESTIONS

1. What would you recommend based on the above findings of the initial assessment?
   Diagnosis of incomplete abortion; perform MVA.
   Diagnosis of cervical warts; counsel about risks of STI and HIV/AIDS as well as for further investigation.
   Desires no more children; counsel for long-term contraception.

2. At what point(s) should Sita be talking to Maya during the examination?
   Throughout the examination, describing what she is doing and also what she is finding, and at the end to discuss recommendations.

CASE STUDY 2: The patient is a 30-year-old woman who lives far away from the hospital. Her symptoms are not severe, but her sister persuaded her to seek treatment. She doesn't think she is pregnant. The findings of your initial medical history include the following:

- Moderate bleeding for 3 days
- Last period ended about 7 weeks ago
- Some cramping, not severe
- 2 previous births
- 1 previous miscarriage
- Using injections for birth control; last injection was 7 months ago

QUESTIONS

1. What are the possible diagnoses?
   Incomplete, threatened, or missed abortion
   Ectopic pregnancy
   Normal period after amenorrhoea caused by injections

2. What further assessments would you do to confirm a diagnosis?
   Take further medical history
   Conduct physical examinations: focused physical exam, abdominal and pelvic
   Laboratory tests (pregnancy test recommended if available, Rh test if available, ultrasound if available)

3. You arrive at the diagnosis of incomplete abortion. What were the findings that led you to this diagnosis?
   Moderate bleeding from the cervical os
   Dilated soft cervix
   Uterus soft and enlarged, tender
   Products of conception observed

CASE STUDY 3: The patient is a 15-year-old girl who is alone, in considerable pain, and very anxious that her family does not know about her condition. She presents with all the symptoms of an incomplete abortion. In addition, she has a high fever, the vaginal discharge is brown and foul smelling and she shows cervical motion tenderness.

QUESTIONS

1. What do you conclude about her condition?
   Incomplete septic abortion

2. What would be your immediate recommended course of action?
   Reassure the patient, and continue to do so throughout the procedure and exams.
   Check vital signs and assure airway is open.
   Begin IV antibiotics.
   Give her tetanus toxoid if indicated or if vaccination history is uncertain.
   If unstable, give IV fluids.
   Check haemoglobin and platelets, type and cross match blood.
   High vaginal swab
   Monitor urine output.
   Reassure the patient and provide pain management (verbacaine, analgesic/antipyretic).
   Refer for additional complications, if indicated.
   Manage incomplete abortion (evacuate uterus) once antibiotic coverage is established; wait for a period equal to the half-life of the antibiotic used.

CASE STUDY 4: The patient is 34 years old, and brings two children with her to the hospital. She is in severe pain and very frightened. Your initial exam shows:
- 6 previous births
- 2 previous miscarriages
- Last period about 8 weeks ago
- Moderate cramping for last 12 hours
- Heavy bleeding
- Severe abdominal pain began suddenly in lower belly; now hurts all over
- Right shoulder hurts
- Using withdrawal for contraception
- When asked, denies interfering with pregnancy

QUESTIONS

1. What are the possible diagnoses?
   Intra-abdominal injury (due to ruptured ectopic pregnancy or perforation)

2. What would you look for to support this diagnosis?
   Distended abdomen
   Decreased bowel sounds
   Rigid abdomen
   Rebound tenderness
   Nausea, vomiting, pain, fever, abdominal pain, cramping
   Pallor, rapid pulse, low blood pressure

3. What additional condition(s) should you be concerned about?
   Possible shock, infection

4. How do you recommend managing this patient?
   If shock is present, stabilize the patient.
   Provide pain management, blood, and fluids as necessary.
   Ultrasound/X-ray if available
   Arrange for immediate surgical treatment (laparotomy).

Practice Exercise #8: PAIN MANAGEMENT

ACTIVITY DESCRIPTION: After reading Chapter 5 and Appendix E (and reviewing the section on pain management in Appendix B) of the manual, read the case studies and answer the questions that follow.

CASE STUDY 1: Maya had some mild cramping when she arrived at the hospital. Her cervix was dilated and she did not have any particular cervical or abdominal sensitivity evident during the preliminary exam. Sita decided that the procedure would be very quick and easy, so she did not use any sedation or anaesthesia.

QUESTIONS

1. What should Sita do throughout the procedure for pain management?
   Provide verbal anaesthesia. Explain to Maya what she is doing and prepare her for procedures that might be uncomfortable, reassure her that things are going well, let her know how long the procedure will last and let her know when it is completed.

CASE STUDY 2: The patient is a 25-year-old woman who has no prior pregnancy. She comes to the hospital with severe bleeding, severe cramping, and she is very anxious. She has the following signs and symptoms:

- Last period 12 weeks ago
- Heavy bleeding and cramping
- Not using any contraception
- Difficulty during bimanual and speculum exam because of her anxiety and pain
- Cervix slightly dilated

The service provider diagnoses the patient with an incomplete abortion. The service provider decides to perform the MVA procedure. Despite the verbal anaesthesia, the patient is in pain and very anxious. The service provider decides that some additional pain management is required.

QUESTIONS

1. In deciding to use pain medication, what should the service provider consider?
   - **The emotional status of the patient**
   - **Extent of the pain**
   - **The degree of dilation of the cervix**
   - **The anticipated length of the procedure**

2. In this case, what medication would you use, and why?
   Analgesics, sedatives, and local anaesthetic (paracervical block)
   She is very anxious, she is in pain, the cervix is slightly (not fully) dilated

3. What are the possible complications of paracervical block?

MILD EFFECTS

- **Numbness of lips and tongue**
- **Metallic taste in mouth**
- **Dizziness and light-headedness**
- **Ringing in ears**
- **Difficulty in focusing eyes**

SEVERE EFFECTS

- **Sleepiness**
- **Disorientation**
- **Muscle twitching and shivering**
- **Slurred speech**
- **Tonic-clonic convulsions (generalized seizures)**
- **Respiratory depression or arrest**

Practice Exercise #9 INSTRUMENT PROCESSING

ACTIVITY DESCRIPTION: After reading Chapter 8 and Appendix D, watch the overview of the IP Video (first 20 minutes), and then conduct the following observation exercise and answer the following questions, which test the knowledge you have learned on infection prevention.

OBSERVATION: In this exercise, you will observe the infection prevention practices that must be part of everyday clinic procedures. Record your observations on the guide below. The guide has three sections: Observation of Handling Instruments and Equipment. Observation of Disinfection and Sterilization, and Observation of Waste Disposal. (N/A = Not Applicable)

OBSERVATION OF HANDLING INSTRUMENTS AND EQUIPMENT				
	OBSERVATION	**RESPONSE**		
1.	After each use, needles and syringes are handled properly:			
	• decontaminated in 0.5% chlorine solution	Yes	No	N/A
	• disposed of in a puncture-proof container	Yes	No	N/A
	• If recapped, the one-handed scoop technique is used.	Yes	No	N/A
	• disassembled, cleaned and sterilized (autoclave/pressure cooker)	Yes	No	N/A
	• disassembled, cleaned and high-level disinfected by boiling.	Yes	No	N/A
	• stored in a high-level disinfected, dry, covered container.			
2.	After use, instruments are handled properly:			
	• decontaminated in 0.5% chlorine solution	Yes	No	N/A
	• Cleaned with soap and water and soft brush	Yes	No	N/A
3.	After each use, gloves are handled properly:			
	· decontaminated in 0.5% chlorine solution	Yes	No	N/A
	· disposed of in a waste container (if examination gloves or if torn)	Yes	No	N/A
	· cleaned and sterilised (autoclave/pressure cooker)	Yes	No	N/A
	· cleaned and high-level disinfected by steaming	Yes	No	N/A
	· stored in a high-level disinfected, dry, covered container	Yes	No	N/A

OBSERVATION OF DISINFECTION AND STERILISATION				
	OBSERVATION	**RESPONSE**		
1.	What method is used for sterilization or high-level disinfection of metal instruments?			
	· autoclave or pressure cooker (if yes, go to #2)	Yes	No	N/A
	· dry heat oven (if yes, go to #3)	Yes	No	N/A
	· boiling (if yes, go to #4)	Yes	No	N/A
	· steaming (if yes, go to #5)	Yes	No	N/A
	· chemical disinfection (if yes, go to #6)	Yes	No	N/A
2.	When autoclaving, is the:			
	· temperature 121°C (250°F)	Yes	No	N/A
	· pressure 101 kPa (15 lb/in^2)	Yes	No	N/A
	· timing at least 20 minutes	Yes	No	N/A
3.	When using dry heat, is			
	· temperature 170°C (340°F)	Yes	No	N/A
	· timing at least 1 hour	Yes	No	N/A
4.	When boiling, are metal instruments			
	· completely open or disassembled	Yes	No	N/A
	· completely submerged	Yes	No	N/A
	· boiled for at least 20 minutes	Yes	No	N/A
5.	When steaming gloves, are they:			
	· placed in pans so that steam can reach all items	Yes	No	N/A
	· steamed for 20 minutes	Yes	No	N/A

OBSERVATION OF DISINFECTION AND STERILISATION (CONTINUED)				
	OBSERVATION	**RESPONSE**		
6	When using chemical disinfection, are:			
	· solutions diluted correctly	Yes	No	N/A
	· solutions changed at least weekly (bleach daily)	Yes	No	N/A
	· needles and syringes excluded	Yes	No	N/A
	· instruments completely disassembled	Yes	No	N/A
	· instruments submerged and filled with disinfectant	Yes	No	N/A
	· instruments rinsed thoroughly with boiled or sterile water or saline	Yes	No	N/A
	· stored in high-level disinfected, dry, covered containers	Yes	No	N/A
OBSERVATION OF WASTE DISPOSAL				
	OBSERVATION	**RESPONSE**		
1.	Waste is disposed of by:			
	· incineration	Yes	No	N/A
	· burying	Yes	No	N/A
	· municipal/commercial removal	Yes	No	N/A
2.	Utility gloves are worn while handling used items and medical wastes, cleaning instruments and cleaning up after a procedure	Yes	No	N/A
3.	Exam/operating tables and other potentially contaminated surfaces are wiped down with chlorine solution between patients	Yes	No	N/A
4.	Facilities are adequately cleaned at the end of each day/hospital session	Yes	No	N/A

QUESTIONS

1. List the steps to be followed after using reusable gloves until they are ready for use with the next patient:
   Decontamination
   - **Cleaning**
   - **Drying**
   - **Packing for autoclaving**
   - **HLD/Sterilisation**

2. Which solutions should be used for:

   a. Antiseptics
   - **Iodophors, e.g., Betadine**
   - **Chlorhexidine**
   - **Alcohols 60-90%**

   b. Decontamination
   - **Sodium hypochlorite 0.5%**

   c. High-level disinfection
   - **Sodium hypochlorite 0.1%**
   - **Glutaraldehyde**

   d. Sterilisation
   - **Glutaraldehyde**

3. List the different methods of sterilisation:
   - **Dry heat**
   - **Steam heat**
   - **Chemical**

4. Which of the following steps in the MVA procedure are IP practices?

   a. Conducting a bimanual exam ***NO***

   b. Cleaning the cervix with antiseptic solution ***YES***

   c. Visualising the cervix with the speculum ***NO***

   d. Wearing clean exam gloves ***YES***

   e. Gently applying the tenaculum to the cervix ***NO***

   f. Decontaminating the instruments in 0.5% chlorine solution for10 minutes ***YES***

5. Is this statement true or false: surgical (metal) instruments which have been decontaminated and thoroughly cleaned can be sterilised by boiling them in water for 20 minutes.

   FALSE

6. The lowest level of processing that is acceptable for instruments to be used in the MVA procedure is (circle one):

   High-Level Disinfection

7. List all the steps to be followed after using the MVA syringe until it is ready for use with the next patient.
   - **Decontamination,**
   - **Cleaning,**
   - **Storage, and**
   - **Reassembly**

8. List all the steps to be followed after using the cannula until it is ready for use with the next patient.
   - **Decontamination,**
   - **Cleaning,**
   - **Sterilisation or High-Level Disinfection, and**
   - **Storage**

Practice Exercise #10: POSTABORTION COUNSELLING

ACTIVITY DESCRIPTION: After reading Chapter 9 and watching the *ABHIBADAN* video, read the case studies and answer the questions that follow.

CASE STUDY 1: Reread the case study in Practice Exercise #2, with the patient Maya and service provider Sita.

QUESTIONS

1. When Maya completed her MVA, she decided to have Norplant implants inserted. What other methods might have been appropriate for Maya?
   Any family planning method is appropriate for a postabortion patient. Given that Maya doesn't want to have any more children, other long-term methods might be most appropriate (IUD, tubal ligation, vasectomy).

CASE STUDY 2: A 32 year old woman comes to the hospital; she is very concerned because she and her husband were looking forward to a third child. Upon examination, she has the following symptoms:

- Mild cramping for a few days
- Moderate bleeding for a few days
- Her periods are irregular
- She thinks her last period was 10 weeks ago, but it was spotty and very short
- 2 previous births
- 3 previous miscarriages
- No birth control

She is diagnosed with an incomplete abortion, and she has an MVA procedure.

1. What are her additional service needs?

Answers might include the following:
- **Referral for infertility investigation**
- **Compassionate counseling**
- **Information and encouragement to seek antenatal care if she gets pregnant**
- **Provide information on related topics (STIs and HIV/AIDS, cancer screening, etc.) and relevant services**

2. What if she does not want to get pregnant again immediately?
   - **Family planning counseling and services**

Practice Exercise #11: POSTABORTION COUNSELLING

ACTIVITY DESCRIPTION: After reading Chapter 9, watching the *ABHIBADAN* video, and completing Practice Exercise #10, conduct the following role-plays with your trainer. (Ask your trainer to act the part of the patient, while you act the role of the service provider.)

ROLE PLAY 1: You are counselling a young patient (age 15) after she has had MVA for incomplete abortion. She has no particular findings during the examination or procedure.

Be sure that the trainee covers the following main points:

- **Family planning counseling and services (including abstinence)**
- **Sexuality counseling**
- **Information on STIs and HIV/AIDS**
- **Dual protection**
- **Postoperative care**

ROLE PLAY 2: You are counseling a 27-year-old patient after she has had MVA for incomplete abortion. She has been on the pill on and off. Her husband is a migrant worker and is away from home much of the time. She is not sure whether she wants more children in the future, but she doesn't want any now.

Be sure that the trainee covers the following main points:

- **Discussion of reproductive goals**
- **Family planning counseling and services**
- **Screening for cancers (breast, cervix, etc.)**
- **Information on STIs and HIV/AIDS**
- **Dual protection**

Practice Exercise #12: MANAGEMENT OF PROBLEMS AND COMPLICATIONS

ACTIVITY DESCRIPTION: After reading Chapter 7 and Appendices A and H of the manual, read the case studies below and answer the questions that follow.

CASE STUDY 1: While Sita is performing the MVA procedure on Maya, the cannula slips out of the cervix and the vacuum is lost.

QUESTIONS

1. What should Sita do at this point?
   Remove the syringe and cannula, taking care that the cannula does not touch the vaginal wall and does not contaminate it. Disconnect the syringe and cannula, empty the syringe, reinsert the cannula, reestablish the vacuum in the syringe and reconnect the syringe to the cannula to continue with the procedure.

2. What if the cannula touches the vaginal wall or other non-sterile surface?
   Remove the syringe and cannula, and place the cannula in the decontamination solution. Empty the syringe and reestablish the vacuum. Continue the procedure using another sterile or high-level disinfected cannula.

CASE STUDY 2: A patient suspected of incomplete abortion at 7 weeks amenorrhoea undergoes manual vacuum aspiration. When the clinician inspects the aspirated tissue no villi are seen.

QUESTIONS

1. Give two or more possible explanations which the hospitalian should investigate.
- **The patient was not pregnant.**
- **The patient had conceived, but the pregnancy had not implanted itself in the uterus.**
- **POC are present in the uterus but were missed by the MVA (incomplete evacuation).**
- **The patient has an ectopic pregnancy.**
- **A complete abortion had occurred.**

2. What should the clinician do to manage the patient at this point?
   Do a pregnancy test. If negative, repeat after 1 week. If positive, exclude ectopic pregnancy by ultrasound or laparoscopy (refer immediately if these tests are not available).

CASE STUDY 3: You are called by your assistant to see a patient who had an MVA procedure yesterday. She is in significant pain; the uterus is enlarged, firm, tense and tender; and she is febrile. She is not bleeding and has hardly bled at all since the procedure.

QUESTIONS

1. What is the likely diagnosis?
   Answers might include the following points:
   - **Post-abortal syndrome (acute haematometra) may occur from a few hours to several days after evacuation**
   - **Blood flow from uterus is blocked**
   - **Postabortion sepsis**
   - **Uterine perforation**

2. What additional information is useful before treatment?
   Answers might include the following points:
   - **Is there any sign of infection or intra-abdominal injury?**
   - **What was the gestation at the time of MVA?**
   - **Did aspirated tissue include villi?**
   - **Check for fever (to exclude postabortion sepsis).**

3. How should this case be managed?
   If haematometra, perform re-evacuation, administer oxytocics or massage.
   If intra-abdominal injury, refer for surgery.
   If postabortion sepsis, give IV antibiotics, IV fluids.

4. What may have caused this condition?
   Answers might include the following points:
   - **Excessive bleeding behind a closed cervix**
   - **Patient anxiety**
   - **Perforation prior to or during MVA**
   - **Infection prior to arrival, or due to poor infection prevention practices**

CASE STUDY 4: A patient arrived at the hospital having aborted at home after 4 months of pregnancy. She reported having lost a lot of blood. When she arrived at the hospital she was very anaemic and febrile. The pelvic examination revealed a 12-week sized uterus and a few pieces of placenta remains which were removed by MVA. She was advised to have a blood transfusion and was given antibiotics (ampicillin IM). One hour after the MVA procedure she complains of a headache and is agitated. She has a fast pulse, low blood pressure, pallor, and rapid breathing.

QUESTIONS

1. What is the most likely diagnosis?
   Answers might include the following points:
   - **Hypovolaemic shock caused by haemorrhage**
   - **Septic shock**
   - **Possible intra-abdominal injury (perforation)**

2. How would you manage this patient?

   Answers might include the following points:

   - **Make sure the airway is open.**
   - **Place in head-down position to maximise venous return to the head.**
   - **Keep her warm (but not too warm).**
   - **Give IV fluids and blood transfusion.**
   - **Give IV antibiotics.**
   - **Reassess to exclude intra-abdominal injury; refer if necessary.**
   - **Continue monitoring vaginal bleeding and vital signs.**

CASE STUDY 5: A woman with 4 children was admitted in your hospital. She gave the history of bleeding per vagina for one day following amenorrhea for 3 months. She also gave history of some fleshy mass through the vagina, few hours ago. You have diagnosed her to be suffering from incomplete abortion. You treated her with MVA but after the procedure you found that she was still bleeding from the uterus.

1. How are you going to manage her?

The management include the following points:

1. Confirm that uterus is empty by bimanual examination and repeating MVA.
2. Bimanual massage of the uterus.
3. Inject Oxytocics/IM, I.V.
4. Observe for any continuous bleeding P/V

Practice Exercise #13: MANAGEMENT AND ORGANIZATION OF PAC SERVICES

ACTIVITY DESCRIPTION: After reading Chapter 10, complete the exercise below.

EXERCISE: Name the specific staff at the training site responsible for each of the key elements critical to providing quality postabortion care services. If you are from a site other than the training site, also name the staff at your own site who are or would be responsible for these things. If some services are not available, name the referral site where you would send patients for these services. After you have completed the table below, answer the questions that follow.

ELEMENTS OF PAC	STAFF PERSON RESPONSIBLE		REFERRAL SITE (IF REFERRAL REQUIRED
	Training Site	Own Site (If different)	
Admission			
Initial examination			
Evacuation of the uterus			
Severe complications (e.g., intra-abdominal injury)			
Immediate postabortion monitoring of the patient			
Postabortion counseling			
Family planning method provision			
Infertility counseling and services			
STI and HIV counseling and services			
Cancer screening services			
Conducting routine laboratory examinations (pregnancy, Rh, haemoglobin, platelet)			
Antenatal care			
Discharge of the patient			
Follow-up visits to the patient to the health service site			
Follow-up of the patient after treatment (in her home community)			
Ordering medicines and supplies			

ELEMENTS OF PAC	STAFF PERSON RESPONSIBLE		REFERRAL SITE (IF REFERRAL REQUIRED
	Training Site	Own Site (If different)	
Stocking and managing medicines and supplies (including contraceptives)			
Blood bank			
Ensuring that necessary supplies, medicines, equipment and instruments are available			
Setting up the procedure room			
Decontamination			
Cleaning			
Preparing instruments for sterilisation or HLD			
Sterilisation or HLD			
Completing patient records			
Completing facility registers			
Establishing patient fees			
Collecting patient fees			
Waiving patient fees for those who cannot pay			
Record keeping			
Reporting			
Quality assurance			
Supervision			

QUESTIONS

1. How many different staff are responsible for parts of the patient's care? What are the implications for the organization of services for continuity of care?
2. If PAC services are not currently provided at your site, how will you orient the staff responsible for important components of quality PAC services?
3. If PAC services are currently provided at your site, do you feel that you could improve the quality of services? How would you plan to do this?

Practice Exercise #14: SUMMARY OF TRAINING EXPERIENCE

ACTIVITY DESCRIPTION: In this activity, review the experience you have had during training by summarizing several items on the form below. This should be reviewed with, and this sheet given to, your trainer at the meeting you will have at the end of the training. All cases observed or performed must be described in you case management notes.

TRAINING REVIEW SHEET		
TRAINING IDENTIFICATION/SUMMARY		
Name of trainee:		
Position:		
Location:		
Date training started:		
Date of qualification (Date that OJT supervisor gives Final Knowledge Assessment and Qualification)		
Duration of training		
TRAINING ACTIVITIES	***Number***	***Remarks***
PAC patient assessments observed		
PAC patient assessments performed		
MVA procedures observed		
MVA procedures performed		
Postabortion counseling sessions observed		
Postabortion counseling sessions performed		
Postabortion family planning patients for whom you provided a method		

LEARNING GUIDES AND CHECKLISTS FOR POSTABORTION CARE CLINICAL SKILLS AND FAMILY PLANNING COUNSELING SKILLS

USING THE LEARNING GUIDES AND CHECKLISTS

The Learning Guides and Checklists for Postabortion Care Clinical Skills and Family Planning Counseling Skills are designed to help the trainee learn the steps or tasks involved in:

- Screening a potential MVA patient for serious complications and further evaluating her if medical problems are identified
- Talking with patients before and during the MVA procedure
- Using MVA to treat complications of incomplete abortion
- Counseling a patient about postabortion family planning

There are three **learning guides** in this handbook:

- **Learning Guide for Postabortion Care Clinical Skills**
- **Learning Guide for Verbal Anaesthesia**
- **Learning Guide for Postabortion Family Planning Counseling Skills**

Each learning guide contains the steps or tasks performed by the counselor and clinician when providing PAC services. These tasks correspond to the information presented in relevant chapters of *Postabortion Care: A Reference Manual for Improving Quality of Care* (**Chapter 6**: Treatment of Incomplete Abortion, **Chapter 5**: Pain Management and **Chapter 9**: Postabortion Family Planning) as well as in the training photoset. Use of the manual and photoset will facilitate trainee review of essential information.

The two **checklists** focus only on the key steps in providing MVA services:

- **Checklist for Postabortion Care Clinical Skills**
- **Checklist for Postabortion Family Planning Counselling Skills**

The Checklists for Postabortion Care Clinical Skills and Postabortion Care Family Planning Counselling Skills included here for skill practice by the trainee are the same as the checklists, which the clinical trainer will use to evaluate the trainee's performance at the end of the course.

The trainee is not expected to perform all of the steps or tasks correctly the first time s/he practices them. Instead the learning guides are intended to:

- Assist the trainee in learning the correct steps and sequence in which they should be performed (**skill acquisition**)
- Measure progressive learning in small steps as the trainee gains confidence and skill (**skill competency**).

Prior to using the **Learning Guide for Postabortion Care Clinical Skills** and **Learning Guide for Verbal Anaesthesia**, the clinical trainer will review the entire MVA procedure with the trainee using the training photoset. In addition, the trainee will have the opportunity to witness an MVA procedure, including the use of verbal anaesthesia, during a demonstration session with the ZOE pelvic model and/or to observe the activity being performed in the clinic with a patient.

Used consistently, the learning guides and checklists for practice enable each trainee to chart her/his progress and to identify areas for improvement. Furthermore, the learning guides are designed to make communication (coaching and feedback) between the trainee and clinical trainer easier and more helpful. When using either learning guide, it is important that the trainee and clinical trainer work together as a team. For example, **before** the trainee attempts the skill or activity (e.g., MVA) the first time, the clinical trainer should briefly review the steps involved and discuss the expected outcome. The trainer should ask the trainee if s/he feels comfortable going on. In addition, immediately **after** the skill or activity has been completed the clinical trainer should debrief with the trainee. The purpose of the debriefing is to provide **positive feedback** regarding learning progress and to define the areas (knowledge, attitude or practice) where improvement is needed in subsequent practice sessions.

Because the learning guides are used to assist in developing skills, it is important that the rating (scoring) be done carefully and as objectively as possible. The trainee's performance of each step is rated on a three-point scale as follows:

1	**Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted
2	**Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but trainee does not progress from step to step efficiently
3	**Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

Using the Learning Guides

The **Learning Guides for Postabortion Care Clinical Skills** and **Verbal Anaesthesia** are designed to be used primarily during the early phases of learning (i.e., skill acquisition) when the trainee is practicing with the pelvic model.

The **Learning Guide for Postabortion Family Planning Counseling Skills** should be used initially during practice (simulated) counseling sessions using volunteers or with patients in real situations.

Initially, the trainee can use the learning guides to follow the steps as the clinical trainer demonstrates the MVA procedure using a training model or role-plays verbal anaesthesia. Subsequently, during the classroom practice sessions, they serve as step-by-step guides for the trainee as s/he performs the skill using the pelvic model, practices verbal anaesthesia or counsels a volunteer "patient."

Using the Checklists for Practice

As the trainee progresses through the course and gains experience, dependence on the detailed learning guides decreases, and s/he advances to using the condensed **Checklist for Postabortion Clinical Skills** and the **Checklist for Postabortion Care Family Planning Counseling Skills**. These guides focus on **key** steps in an entire procedure.

Remember: It is the goal of this training that **every** trainee performs **every** task or activity correctly with patients by the end of the course.

LEARNING GUIDE FOR *POSTABORTION CARE CLINICAL SKILLS*

(To be used by the **Trainee**)

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

1 **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2 **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but trainee does not progress from step to step efficiently

3. **Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR *POSTABORTION CARE CLINICAL SKILLS*					
STEP/TASK	**CASES**				
INITIAL ASSESSMENT					
1. Assess patient for shock and other life-threatening conditions.					
2. If any complications are identified, stabilize patient and transfer if necessary.					
MEDICAL EVALUATION					
1. Take a reproductive health history.					
2. Perform limited physical (heart, lungs and abdomen) and pelvic examinations.					
3. Perform indicated laboratory tests.					
4. Give the woman information about her condition and treatment plan.					
5. Discuss her reproductive goals, as appropriate. Note any reproductive health issues that should be discussed with the patient after the MVA procedure.					
6. If she is considering Norplant implants · She should be fully counselled regarding Norplant implants use. · The decision to insert the implants following the MVA procedure will be dependent on the clinical situation.					
GETTING READY					
1. Treat the patient with respect and kindness.					
2. Ensure the necessary privacy and confidentiality.					
3. Tell the patient what is going to be done and encourage her to ask questions.					
4. Tell her she may feel discomfort during some of the steps of the procedure and you will tell her in advance.					
5. Ask about allergies to antiseptics and anaesthetics.					
6. Determine that required sterile or high-level disinfected instruments are present.					
7. Make sure that the appropriate size cannulae and adapters are available.					

LEARNING GUIDE FOR *POSTABORTION CARE CLINICAL SKILLS*					
STEP/TASK	**CASES**				
8. Check the MVA syringe and charge it (establish vacuum).					
9. Check that patient has recently emptied her bladder.					
10. Check that patient has thoroughly washed and rinsed her perineal area.					
11. Put on clean plastic or rubber apron. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
12. Put new examination or high-level disinfected or sterile surgical gloves on both hands.					
13. Arrange sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.					
PRE-MVA TASKS					
1. Perform bimanual pelvic examination, checking the size and position of uterus and degree of cervical dilation.					
2. Insert the speculum and remove blood or tissue from vagina using sponge forceps and sterile gauze.					
3. Remove any products of conception (POC) protruding from the cervical os and check cervix for tears.					
4. Apply antiseptic to cervix and vagina two times using gauze or cotton sponge.					
5. Put single tooth tenaculum or vulsellum forceps on lower lip of cervix (5 or 7 o'clock).					
Administering Paracervical Block (when necessary)					
6. Fill a 10 ml syringe with local anaesthetic (1% without epinephrine).					
7. With tenaculum or vulsellum forceps on the cervix, use slight traction and movement to help identify the area between the smooth cervical epithelium and the vaginal tissue.					
8. Insert the needle just under the epithelium and aspirate by drawing the plunger back slightly to make certain the needle is **not** penetrating a blood vessel.					
9. Inject about 2 ml of a 1% local anaesthetic just under the epithelium, not deeper than 2 to 3 mm at 3, 5, 7 and 9 o'clock.					
10. Wait a minimum of 2 to 4 minutes for the anaesthetic to have maximum effect.					
MVA PROCEDURE					
1. Gently apply traction on the cervix to straighten the cervical canal and uterine cavity.					
2. If necessary, dilate cervix using progressively larger cannulae.					
3. While holding the cervix steady, push the selected cannula gently and slowly into the uterine cavity until it just touches the fundus (not > 10 cm). Then withdraw the cannula slightly away from the fundus.					
4. Attach the prepared syringe to the cannula by holding the cannula in one hand and the tenaculum and syringe in the other. Make sure cannula does not move forward as the syringe is attached.					

LEARNING GUIDE FOR *POSTABORTION CARE CLINICAL SKILLS*					
STEP/TASK	**CASES**				
5. Release the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity.					
6a. Evacuate any remaining contents of the uterine cavity by rotating the cannula and syringe from 10 to 2 o'clock and moving the cannula gently and slowly back and forth within the uterus.					
6b. If the syringe becomes half full before the procedure is complete, detach the cannula from the syringe. Remove **only** the syringe, leaving the cannula in place.					
6c. Push the plunger to empty POC into the strainer.					
6d. Recharge syringe, attach to cannula and release pinch valve(s).					
7. Check for signs of completion (red or pink foam, no more tissue in cannula **or** "gritty" sensation). Withdraw the cannula and MVA syringe gently.					
8. Remove cannula from the MVA syringe and push the plunger to empty contents into the strainer.					
9. Rinse the tissue with water or saline.					
10. Quickly inspect the tissue removed from the uterus to be sure the uterus is completely evacuated.					
11. If no POC are seen, reassess situation to be sure it is not an ectopic pregnancy.					
12. Remove forceps or tenaculum from the cervix before removing the speculum.					
13. Perform bimanual examination to check size and firmness of uterus.					
14. Insert speculum and check for bleeding.					
15. If uterus is still soft or bleeding persists, repeat steps 3–10.					
POST-MVA TASKS					
1. Before removing gloves; dispose of waste materials in a leak proof container or plastic bag.					
2. Place speculum and metal instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
3. If reusing needle or syringe, fill syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination. · If disposing of needle and syringe, flush needle and syringe with 0.5% chlorine solution three times, then place in puncture-proof container.					
4. Attach used cannula to MVA syringe and flush both with 0.5% chlorine solution.					
5. Detach cannulae from syringe and soak them in 0.5% chlorine solution for 10 minutes for decontamination.					
6. Empty POC into utility sink, flushable toilet, latrine or container with tight-fitting lid.					

LEARNING GUIDE FOR *POSTABORTION CARE CLINICAL SKILLS*					
STEP/TASK	**CASES**				
7. Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out. · If disposing of gloves, place in leak proof container or plastic bag. · If reusing surgical gloves, submerge in 0.5% chlorine solution for 10 minutes for decontamination.					
8. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
9. Allow the patient to rest comfortably for at least 30 minutes where her recovery can be monitored.					
10. Check for bleeding at least once and ensure that cramping has decreased before discharge.					
11. Instruct patient regarding postabortion care and warning signs.					
12. Tell her when to return if follow-up is needed and that she can return anytime she has concerns.					
13. Discuss reproductive goals and, as appropriate, provide family planning.					

LEARNING GUIDE FOR *VERBAL ANAESTHESIA*

(To be used by the **Trainee**)

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

1. **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2. **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but trainee does not progress from step to step efficiently

3. **Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR *VERBAL ANAESTHESIA*					
STEP/TASK	**CASES**				
GETTING READY					
1. Greet woman respectfully and with kindness.					
2. Assure the necessary privacy and confidentiality.					
3. Tell patient what you are going to do and encourage her to ask questions.					
4. Tell patient she may feel discomfort during some of the steps and you will tell her in advance.					
5. Assess need for pain management medication.					
PROCEDURE					
1. Explain each step of the procedure prior to performing it.					
2. Ask the patient throughout the procedure if she is experiencing any pain.					
3. Wait after performing each step or task for patient to prepare for next one.					
4. Move slowly, without jerky or quick motions.					
5. Use instruments with confidence.					
6. Avoid saying things like, “This won’t hurt” when it will hurt or, “I’m almost done” when you’re not.					
7. Talk with the patient throughout the procedure.					

LEARNING GUIDE FOR *POSTABORTION FAMILY PLANNING COUNSELING SKILLS*

(To be used by the **Trainee**)

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

1 **Needs Improvement**: Step or task not performed correctly or out of sequence (if necessary) or is omitted

2 **Competently Performed**: Step or task performed correctly in proper sequence (if necessary) but trainee does not progress from step to step efficiently

3 **Proficiently Performed**: Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR *POSTABORTION FAMILY PLANNING COUNSELING SKILLS*					
STEP/TASK	**CASES**				
INITIAL INTERVIEW					
1. Greet woman respectfully and with kindness.					
2. Assess whether counseling is appropriate at this time (if not, arrange for her to be counseled at another time).					
3. Assure necessary privacy and confidentiality.					
4. Use effective interpersonal communication: · Two-way communication · Listening · Includes non-verbal communication					
5. Encourage patient to talk (e.g., ask questions, express feelings).					
6. Obtain biographic information (name, address, etc.).					
7. Ask if she was using contraception before she became pregnant. If she was, find out if she: · Used the method correctly · Discontinued use · Had any trouble using the method · Has any concerns about the method					
8. Provide general information about family planning.					
9. Explore any attitudes or religious beliefs that either favour or rule out one or more methods.					
10. Give the woman information about the contraceptive choices available that are appropriate postabortion, and the benefits and limitations of each: · Show where and how each is used · Explain how the method works and its effectiveness · Explain possible side effects and other health problems · Explain the common side effects					
11. Discuss the patient's needs, concerns and fears in a thorough and sympathetic manner.					
12. Help the patient begin to choose an appropriate method.					

LEARNING GUIDE FOR *POSTABORTION FAMILY PLANNING COUNSELING SKILLS*					
STEP/TASK	**CASES**				
SCREENING					
1. Screen the patient carefully to make sure there is no medical condition that would be a problem (completes Patient Screening Checklist).					
2. Explain potential side effects and make sure that each is fully understood.					
3. Perform further evaluation (physical examination), if indicated. (Non-medical counselors must refer patient for further evaluation.)					
4. Discuss what to do if the patient experiences any side effects or problems.					
5. Provide follow-ups visit instructions.					
6. Assure patient she can return to the same clinic at any time to receive advice or medical attention.					
7. Ask the patient to repeat instructions.					
8. Answer patient questions.					

CHECKLISTS FOR POSTABORTION CARE CLINICAL SKILLS AND FAMILY PLANNING COUNSELING SKILLS

USING THE CHECKLISTS FOR PRACTICE

The **Checklist for Postabortion Care Clinical Skills** and the **Checklist for Family Planning Counseling Skills** are derived from the information provided in the learning guides. As the trainee progresses through the course and gains experience, dependence on the detailed learning guides decreases and the checklist may be used in their place. The checklist focuses only on the key steps in the **entire** procedure, and can be used by the trainee when providing services in a clinical situation, to rate her/his own performance. These checklists that the trainee uses for practice are the same as the checklists that the clinical trainer will use to evaluate the trainee's performance at the end of the course. The rating scale used is described below:

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by trainee during evaluation by trainer

CHECKLIST FOR *POSTABORTION CARE CLINICAL SKILLS*

(To be used by the **Trainee** for practice and by the **Trainer** at the end of the course)

Place a "✓" in case box if step/task is performed satisfactorily, an "**X**" if it is not performed satisfactorily, or **N/O** if not observed.

1. Satisfactory: Performs the step or task according to the standard procedure or guidelines

2. Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

3. Not Observed: Step or task or skill not performed by trainee during evaluation by clinical trainer

CHECKLIST FOR *POSTABORTION CARE CLINICAL SKILLS*					
STEP/TASK	**CASES**				
GETTING READY					
1. Tells patient what is going to be done and encourages her to ask questions.					
2. Tells patient she may feel discomfort during some of the steps and that s/he will tell her in advance.					
3. Checks that patient has thoroughly washed her perineal area and has recently emptied her bladder.					
4. Determines that required sterile or high-level disinfected instruments and cannulae are present.					
5. Checks MVA syringe and charges it (establishes vacuum).					
6. Puts on apron, washes hands thoroughly with soap and water and dries with clean, dry cloth or air dries.					
7. Puts new examination or sterile or high-level disinfected gloves on both hands.					
8. Arranges sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.					
MVA PROCEDURE					
1. Explains each step of the procedure prior to performing it.					
2. Performs bimanual pelvic examination to confirm uterine size, position and degree of cervical dilation.					
3. Checks the vagina and cervix for tissue fragments and removes them.					
4. Applies antiseptic solution two times to the cervix (particularly the os) and vagina.					
5. Puts tenaculum or vulsellum forceps on posterior lip of cervix.					
6. Correctly administers paracervical block (if necessary).					
7. Dilates the cervix (if needed).					
8. While holding the cervix steady, inserts the cannula gently through the cervix into the uterine cavity.					
9. Attaches the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other.					
10. Evacuates contents of the uterus by rotating the cannula and syringe and moving the cannula gently and slowly back and forth within the uterine cavity.					

CHECKLIST FOR *POSTABORTION CARE CLINICAL SKILLS*					
STEP/TASK	**CASES**				
11. Inspects tissue removed from uterus for quantity and presence of POC and to assure complete evacuation.					
12. When the signs of a complete procedure are present, withdraws the cannula and MVA syringe and removes forceps or tenaculum and speculum.					
13. Performs bimanual examination to check size and firmness of uterus.					
14. Inserts speculum and checks for bleeding.					
15. If uterus is still soft or bleeding persists, repeats steps 4–11.					
POST-MVA TASKS					
1. Before removing gloves, disposes of waste materials and soaks instruments and MVA items in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Immerses both gloved hands in 0.5% chlorine solution and removes gloves by turning inside out. · If disposing of gloves, places in leak proof container or plastic bag. · If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination.					
3. Washes hands thoroughly with soap and water and dries with clean, dry cloth or air dries.					
4. Checks for amount of bleeding and if cramping has decreased at least once before discharge.					
5. Instructs patient regarding postabortion care (e.g., when patient should return to clinic).					
6. Discusses reproductive goals and, as appropriate, provides family planning.					

CHECKLIST FOR *POSTABORTION FAMILY PLANNING COUNSELING SKILLS*

(To be used by the **Trainee** for practice and by the **Trainer** at the end of the course)

Place a "✓" in case box if step/task is performed satisfactorily, an "**X**" if it is not performed satisfactorily, or **N/O** if not observed.

1. Satisfactory: Performs the step or task according to the standard procedure or guidelines

2. Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

3. Not Observed: Step or task or skill not performed by trainee during evaluation by clinical trainer

CHECKLIST FOR POSTABORTION FAMILY PLANNING *COUNSELING SKILLS*					
STEP/TASK	**CASES**				
INITIAL INTERVIEW					
1. Greets woman respectfully and with kindness.					
2. Assesses whether counseling is appropriate at this time (if not, arranges for her to be counseled at another time).					
3. Assures necessary privacy.					
4. Obtains biographic information (name, address, etc.).					
5. Asks if she was using contraception before she became pregnant. If she was, finds out if she: · Used the method correctly · Discontinued use · Had any trouble using the method · Has any concerns about the method					
6. Provides general information about family planning.					
7. Explores any attitudes or religious beliefs that either favour or rule out one or more methods.					
8. Gives the woman information about the contraceptive choices available and the risks and benefits of each: · Shows where and how each is used · Explains how the method works and its effectiveness · Explains possible side effects and other health problems · Explains the common side effects					
9. Discusses patient's needs, concerns and fears in a thorough and sympathetic manner.					
10. Helps patient begin to choose an appropriate method.					
PATIENT SCREENING					
1. Screens patient carefully to make sure there is no medical condition that would be a problem (completes Patient Screening Checklist).					
2. Explains potential side effects and make sure that each is fully understood.					

CHECKLIST FOR POSTABORTION FAMILY PLANNING *COUNSELING SKILLS*					
STEP/TASK	**CASES**				
3. Performs further evaluation (physical examination), if indicated. (Non-medical counselors must refer patient for further evaluation.)					
4. Discusses what to do if the patient experiences any side effects or problems.					
5. Provides follow-ups visit instructions.					
6. Assures patient she can return to the same clinic at any time to receive advice or medical attention.					
7. Asks the patient to repeat instructions.					
8. Answers patient's questions.					

The Number Game
(Estimated time: 15 minutes)

The **purpose** of this activity is to demonstrate the **importance of practice** in learning a skill.

Instructions to Clinical Trainer: Participants should be given three copies of the Number Game. Ask them to place the sheets face down so that they cannot see the placement of the numbers. Tell them this is a simple hand-eye coordination exercise in which they are to work as fast as they possibly can within a given time period. Then tell the participants to start by turning over the top sheet and with pen or pencil, draw a line from #1 to #2 to #3, etc., until they are told to stop.

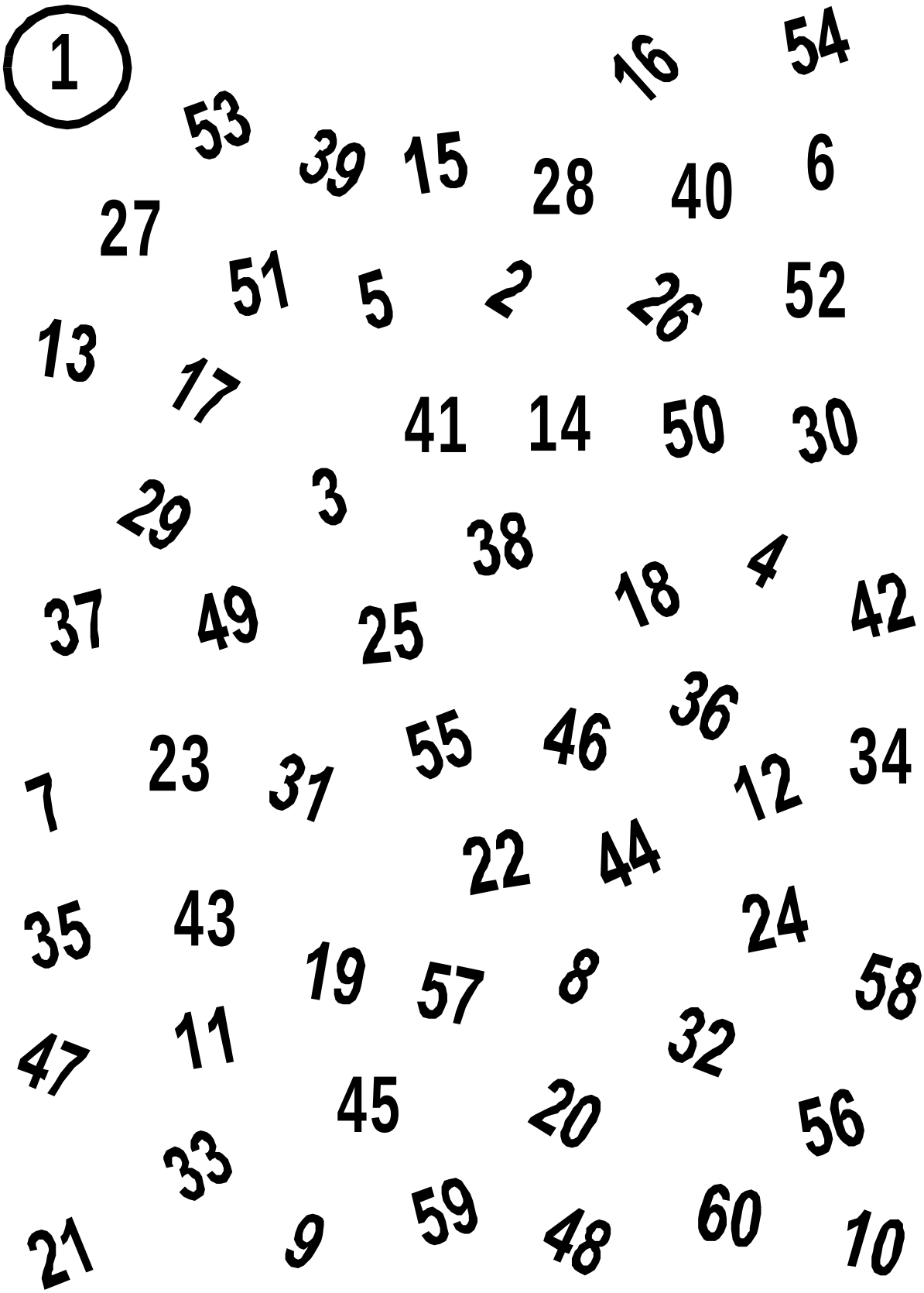
Allow 60 seconds. Then ask them to stop. They are to circle the highest number reached.

Repeat this exact procedure two (2) more times, each time allowing 60 seconds. Make certain each sheet is numbered in the sequence in which it was completed (#1, #2, #3).

Discussion questions:

1. In all honesty, how did you feel when you were going through the exercise? (**Note**: Responses may range from excited and challenged to nervous, frustrated, upset, mad, etc.)

2. "Practice makes perfect." If this is really true, we all should have shown a consistent increase in the number attained with each attempt. Is it true for each of the participants? If not, why?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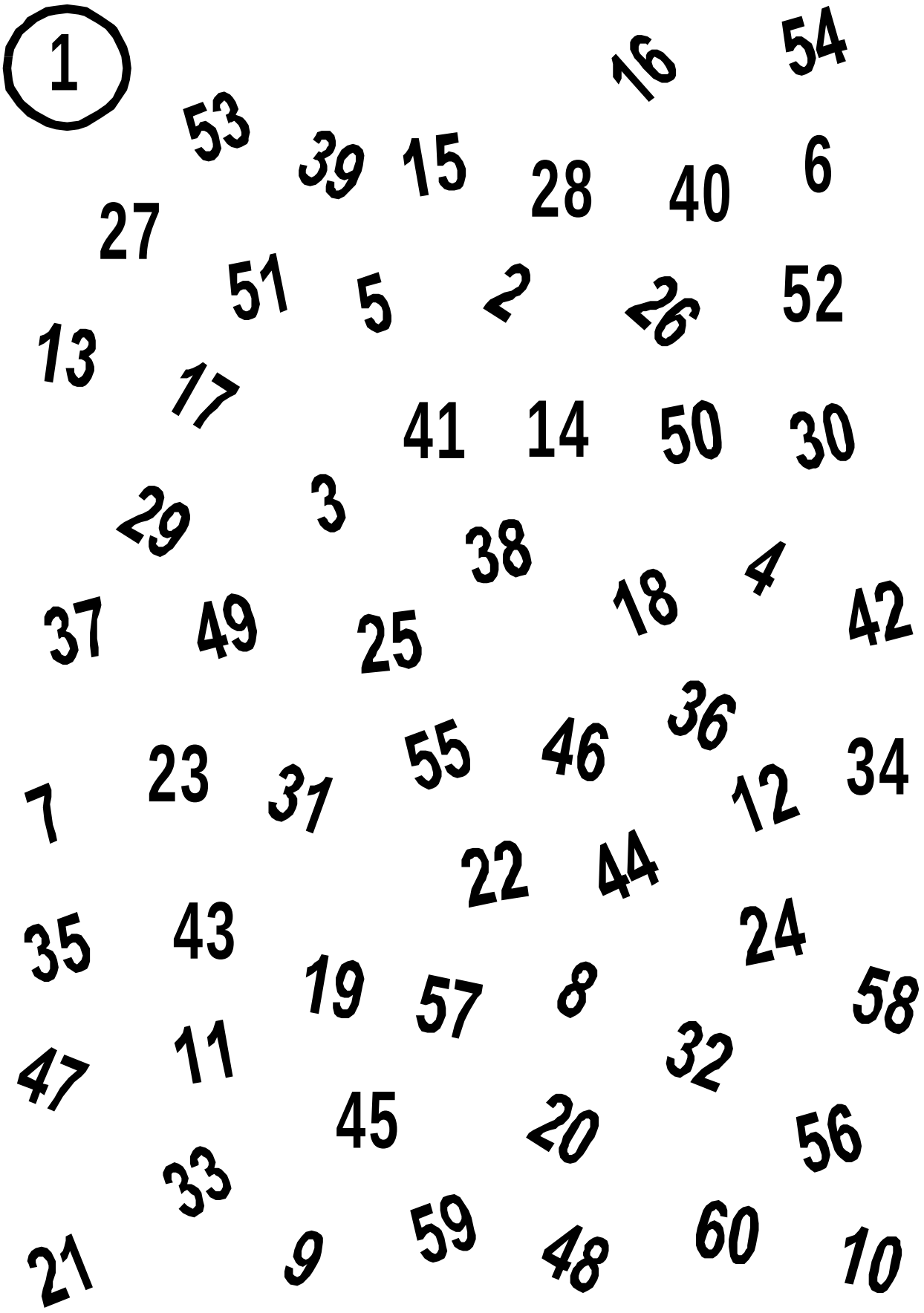
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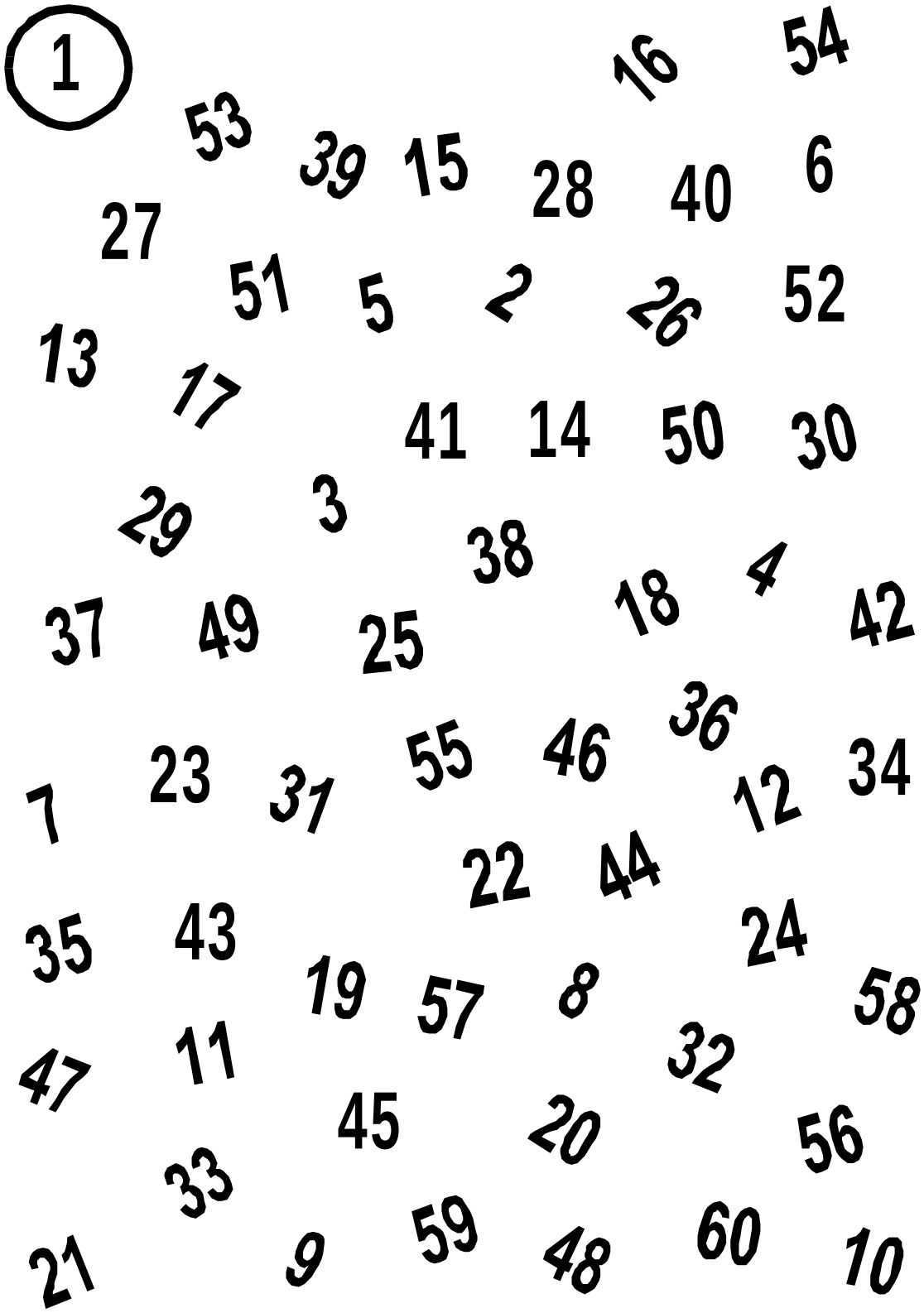
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ACTIVITY 3

The Nine Dots Puzzle
(Estimated time: 15 minutes)

The **purpose** of this activity is to illustrate the importance of seeking new solutions to old problems and allow new ways of thinking. If we only allow one way of thinking (or problem solving), then the solutions are very limited.

Instructions to Clinical Trainer: Draw nine dots on the writing board, flipchart, or overhead transparency:

Participants should copy the drawing of the dots on a clean piece of paper. **Give these instructions**: "Without taking pen or pencil off your paper, connect all nine dots with four (4) straight lines."

If some of the participants have seen this puzzle, ask them to do it with only three (3) straight lines.

Discussion questions:

1. If you had difficulty solving the puzzle, what were some of the constraints? (boxed in, too difficult, etc.)

2. We often find ourselves constrained or boxed in on many projects. How can we counteract such situations?

As a reminder, the most frequently used solution for connecting all nine dots with four (4) straight lines is shown here:

To connect all nine dots with three (3) straight lines, try this solution:

MIDCOURSE QUESTIONNAIRE

USING THE QUESTIONNAIRE

This knowledge assessment is designed to help the participants monitor their progress during the course. By the end of the course, **all** participants are expected to achieve a score of 85% or better.

The questionnaire should be given at the time in the course when all subject areas have been presented. A score of 85% or more correct indicates knowledge-based mastery of the material presented in the reference manual. For those scoring less than 85% on their first attempt, the clinical trainer should review the results with the participant individually and guide her/him on using the reference manual to learn the required information. Participants scoring less than 85% can retake the Questionnaire at any time during the remainder of the course.

Repeat testing should be done **only** after the participant has had sufficient time to study the reference manual.

MIDCOURSE QUESTIONNAIRE

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

INITIAL ASSESSMENT

1. The postabortion complication that needs to be assessed first is:

    a. uterine perforation
    b. shock
    c. severe vaginal bleeding
    d. infection/sepsis

2. The first step in conducting an initial assessment is to:

    a. check the vital signs
    b. take a complete medical history
    c. perform a bimanual examination
    d. order laboratory tests, if available

3. The best way to determine uterine size is by:

    a. looking at the cervix
    b. history of amenorrhea based on LMP
    c. bimanual examination
    d. abdominal examination

4. A woman presenting with vaginal bleeding and signs and symptoms of pregnancy may have:

    a. threatened abortion
    b. incomplete abortion
    c. ectopic pregnancy
    d. all of the above

5. Infection due to incomplete abortion is indicated by:

    a. little or no abdominal pain
    b. foul-smelling vaginal discharge
    c. high blood pressure
    d. nausea/vomiting

INFECTION PREVENTION

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilized by:

    a. heat (autoclave or dry heat sterilizer)
    b. soaking them for 30 minutes in fresh, 1–3% iodine solution
    c. boiling them for 20 minutes
    d. exposure to ultraviolet light for one hour

7. Other than sterilization, the **only** acceptable alternative method for processing surgical (metal) instruments used for MVA is high-level disinfection by boiling or soaking for 20 minutes in:

    a. chlorhexidine (e.g., Savlon®)
    b. povidone iodine solution (e.g., Betadine®)
    c. 2% glutaraldehyde (e.g., Cidex®)
    d. all of the above

8. To minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, all instruments and other items **first** should be:

    a. rinsed in water and scrubbed with a brush before high-level disinfecting by boiling
    b. soaked in a fresh solution of 0.5% chlorine for 10 minutes for decontamination before cleaning
    c. rinsed in water and scrubbed with a brush before sterilizing
    d. soaked for 20 minutes in 8% formaldehyde

9. Cannulae are sterilized by:

    a. autoclaving for 20 minutes at 121^{o}C
    b. dry heat sterilizing
    c. boiling in water for 20 minutes
    d. soaking in 2% glutaraldehyde for 10 hours

10. After decontamination, the MVA syringe must be:

    a. high-level disinfected
    b. sterilized
    c. cleaned
    d. discarded

MVA PROVISION

11. The MVA procedure is considered complete when:

    a. the walls of the uterus feel smooth
    b. the vacuum in the syringe decreases
    c. foam is visible in the syringe
    d. the uterus relaxes

12. Pain management for treatment of an uncomplicated incomplete abortion usually only requires:

    a. verbal anesthesia (vocal local) and a non-narcotic analgesic
    b. paracervical block and a non-narcotic analgesic
    c. general anesthesia
    d. verbal anesthesia (vocal local)

13. The patient should return to the clinic if she has:

    a. uterine cramping over the next few days
    b. severe or increased lower abdominal pain
    c. spotting or light vaginal bleeding
    d. all of the above

14. MVA is an effective method for treatment of incomplete abortion if the uterine size is not greater than:

    a. 8 weeks
    b. 10 weeks
    c. 12 weeks
    d. 14 weeks

15. The vacuum will be lost if:

    a. the syringe is full
    b. the cannula is withdrawn too far
    c. the uterus is perforated
    d. all of the above

POSTABORTION FAMILY PLANNING

16. The most important part of counseling is:

    a. providing brochures about contraceptive methods to the women for review with her partner
    b. identifying questions about using contraceptives and answering her questions
    c. obtaining formal consent for the procedure from the client
    d. describing adverse side effects to the client

17. All women receiving postabortion care need counseling to ensure that they understand:

    a. they can become pregnant again before the next menses
    b. there are safe methods to prevent or delay pregnancy
    c. where and how they can obtain family planning services and methods
    d. all of the above

18. A contraceptive method is best selected by the:

    a. woman herself
    b. physician providing health services to the woman
    c. counselor who sees the woman
    d. woman's husband

19. The contraceptive method not recommended for immediate use by postabortion clients is:

    a. IUD
    b. Norplant
    c. Natural family planning
    d. Condoms

20. After a first- or second-trimester abortion, a woman's fertility usually returns:

    a. after 6 weeks
    b. after her first menstrual period
    c. within 2 weeks
    d. immediately

MIDCOURSE QUESTIONNAIRE ANSWER SHEET

INITIAL ASSESSMENT

1. ____ Participant Objectives 1 & 2 (Chapter 2)
2. ____ Participant Objective 1 (Chapter 2)
3. ____ Participant Objective 1 (Chapter 2)
4. ____ Participant Objective 1 (Chapter 2)
5. ____ Participant Objectives 1 & 2 (Chapter 2)

INFECTION PREVENTION

6. ____ Participant Objective 4 (Chapter 4)
7. ____ Participant Objective 4 (Chapter 4)
8. ____ Participant Objective 4 (Chapter 4)
9. ____ Participant Objective 4 (Chapter 4)
10. ____ Participant Objective 4 (Chapter 4)

MVA PROVISION

11. ____ Participant Objective 6 (Chapter 6)
12. ____ Participant Objective 5 (Chapter 5)
13. ____ Participant Objective 8 (Chapter 6)
14. ____ Participant Objective 6 (Chapter 6)
15. ____ Participant Objectives 6 & 7 (Chapter 6)

(Continued on reverse)

POSTABORTION FAMILY PLANNING

16. ____ Participant Objective 9 (Chapter 8)

17. ____ Participant Objective 9 (Chapter 8)

18. ____ Participant Objective 9 (Chapter 8)

19. ____ Participant Objective 10 (Chapter 8)

20. ____ Participant Objective 9 (Chapter 8)

MIDCOURSE QUESTIONNAIRE ANSWER KEY

INITIAL ASSESSMENT

1. The postabortion complication that needs to be assessed first is:

   a. uterine perforation
   B. SHOCK
   c. severe vaginal bleeding
   d. infection/sepsis

2. The first step in conducting an initial assessment is to:

   A. CHECK THE VITAL SIGNS
   b. take a complete medical history
   c. perform a bimanual examination
   d. order laboratory tests, if available

3. The best way to determine uterine size is by:

   a. looking at the cervix
   b. history of amenorrhea based on LMP
   C. BIMANUAL EXAMINATION
   d. abdominal examination

4. A woman presenting with vaginal bleeding and signs and symptoms of pregnancy may have:

   a. threatened abortion
   b. incomplete abortion
   c. ectopic pregnancy
   D. ALL OF THE ABOVE

5. Infection due to incomplete abortion is indicated by:

   a. little or no abdominal pain
   B. FOUL-SMELLING VAGINAL DISCHARGE
   c. high blood pressure
   d. nausea/vomiting

6. Surgical (metal) instruments, which have been decontaminated and thoroughly cleaned, can be sterilized by:

   A. HEAT (AUTOCLAVE OR DRY HEAT STERILIZER)
   b. soaking them for 30 minutes in fresh, 1–3% iodine solution
   c. boiling them for 20 minutes
   d. exposure to ultraviolet light for one hour

7. Other than sterilization, the **only** acceptable alternative method for processing surgical (metal) instruments used for MVA is high-level disinfection by boiling or soaking for 20 minutes in:

   a. chlorhexidine (e.g., Savlon)
   b. povidone iodine solution (e.g., Betadine)
   C. 2% GLUTARALDEHYDE (e.g., CIDEX)
   d. all of the above

8. To minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, all instruments and other items **first** should be:

   a. rinsed in water and scrubbed with a brush before high-level disinfecting by boiling
   B. SOAKED IN A FRESH SOLUTION OF 0.5% CHLORINE FOR 10 MINUTES FOR DECONTAMINATION BEFORE CLEANING
   c. rinsed in water and scrubbed with a brush before sterilizing
   d. soaked overnight in 8% formaldehyde

9. Cannulae are sterilized by:

   a. autoclaving for 20 minutes at 121^{o}C
   b. dry heat sterilizing
   c. boiling in water for 20 minutes
   D. SOAKING IN 2% GLUTARALDEHYDE FOR 10 HOURS

10. After decontamination, the MVA syringe must be:

    a. high-level disinfected
    b. sterilized
    C. CLEANED
    d. discarded

MVA PROVISION

11. The MVA procedure is complete when:

    a. the walls of the uterus feel smooth
    b. the vacuum in the syringe decreases
    C. FOAM IS VISIBLE IN THE SYRINGE
    d. the uterus relaxes

12. Pain management for treatment of an uncomplicated incomplete abortion usually only requires:

    a. verbal anesthesia (vocal local) and a non-narcotic analgesic
    b. paracervical block and a non-narcotic analgesic
    c. general anesthesia
    D. VERBAL ANESTHESIA (VOCAL LOCAL)

13. The patient should return to the clinic if she has:

    a. uterine cramping over the next few days
    B. SEVERE OR INCREASED LOWER ABDOMINAL PAIN
    c. spotting or light vaginal bleeding
    d. all of the above

14. MVA is an effective method for treatment of incomplete abortion if the uterine size is not greater than:

    a. 8 weeks
    b. 10 weeks
    C. 12 WEEKS
    D. 14 WEEKS

15. The vacuum will be lost if:

    a. the syringe is full
    B. The cannula is withdrawn too far
    c. the uterus is perforated
    D. all of the above

POSTABORTION FAMILY PLANNING

16. The most important part of counseling is:

    a. providing brochures about contraceptive methods to the women for review with her partner
    B. IDENTIFYING QUESTIONS ABOUT USING CONTRACEPTIVES AND ANSWERING HER QUESTIONS
    c. obtaining formal consent for the procedure from the client
    d. describing adverse side effects to the client

17. All women receiving postabortion care need counseling to ensure that they understand:

    a. they can become pregnant again before the next menses
    b. there are safe methods to prevent or delay pregnancy
    c. where and how they can obtain family planning services and methods
    D. ALL OF THE ABOVE

18. A contraceptive method is best selected by the:

    A. WOMAN HERSELF
    b. physician providing health services to the woman
    c. counselor who sees the woman
    d. woman's husband

19. The contraceptive method not recommended for immediate use by postabortion clients is:

    a. IUD
    b. Norplant
    C. NATURAL FAMILY PLANNING
    d. Condoms

20. After a first- or second-trimester abortion, a woman's fertility usually returns:

    a. after 6 weeks
    b. after her first menstrual period
    C. WITHIN 2 WEEKS
    d. immediately

Initial Assessment:- **k|/Des kl/If0f**

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PAC OJT PARTICIPANT TRACKING SHEET

Name of Trainee:	Training Start Date:	Trainer/Site: Supervisor:

KNOWLEDGE COMPONENT

Please check (✓) the box of the date when you complete a chapter and all its assignments. If you finish reading the chapter, but do not complete all the assignments until the next day, check both days. Fill in the number of hours spent in covering training materials.

Week of Training	Week One						Week Two						Comments
Date													
Precourse questionnaire: %													
Chapter 1													
Chapter 2													
Chapter 3													
Chapter 4													
Chapter 5													
Chapter 6													
Chapter 7													
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Mid-course questionnaire: %													
CLINICAL PRACTICE (MODEL)													
First demonstration on model													
First practice on model													
Continued practice on model													
Assessed as competent on model													
TIME SPENT WITH TRAINER FOR Training Activity (mins/hr**)**													

PAC OJT PARTICIPANT TRACKING SHEET

Name of Trainee:	Training Start Date:	Trainer/Site: Supervisor:

CLINICAL PRACTICE (CLIENT)

Instructions for Completing: Participant should list all postabortion care cases once assessed as competent on the model. Each case should be listed by client name or ID #, and the participant should code his/her level of involvement in the case with the following codes:
Observed (O), Assisted (A), Performed while Supervised (PS), Performed Competently (PC)
At the end of the day, the trainer should verify the level of involvement in each case by initialing in the left margin. For each PS or PC, trainer should use the checklist during the procedure to guide and monitor performance.

		LEVEL OF PARTICIPATION (FOR EACH CASE, BY DATE PERFORMED)																	
Week of Training		Week Three						Week Four						Comments					
Date		1	2	3	4	5	6	8	9	10	11	12	13						
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