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Family Planning Initiative
Addressing unmet need for postpartum family planning

Postabortion Care Curriculum:
Participant's Guide

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The United States Agency For International Development (USAID) Postabortion Care (PAC) Working Group was established in 1994 to promote quality postabortion care in order to reduce maternal morbidity and mortality and future unplanned pregnancies. The USAID PAC Working Group provides current information to and acts as a liaison for the Global Health Bureau, USAID/ Washington to USAID Missions, cooperating agencies, consultants, project design teams, the PAC Consortium and other relevant groups.

ACCESS-FP, a five-year, global program sponsored by the United States Agency for International Development (USAID), is an associate award under the ACCESS Program. ACCESS-FP focuses on meeting the family planning and reproductive health needs of women in the postpartum period. Interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical interventions. ACCESS-FP works to reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV. For more information about ACCESS-FP, please visit www.accesstohealth.org/about/assoc_fp.htm.

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* Deceased, October 27, 2010

PREFACE

Since 1994, the United States Agency for International Development (USAID) has supported postabortion care programs in more than 40 countries. A 2001 global evaluation of its postabortion care programs led to the development of a five-year strategy in 2003. The Postabortion Care (PAC) Model was revised, a results framework with indicators was developed and the development of a Postabortion Care Global Resource Package was identified as a key activity in the strategy to respond to the need for standardized materials.

A review of existing curricula for the Global PAC Resource Package demonstrated that programs needed a global, evidence-based curriculum to adapt for use in their countries. In keeping with the goal of the USAID PAC Working Group to produce evidence-based materials for postabortion care, this curriculum has been developed and field-tested in three different country contexts. This curriculum is adapted from the Kenya 2002 PAC curriculum developed by the Ministry of Health, and incorporates the strong evidence on postabortion care, provider job aids and client information. Evidence on postabortion care, which is consolidated in a review of literature and research from 1994 to 2003 published in *What Works: A Policy and Program Guide to the Evidence on Postabortion Care,* and a further review of literature and research from 2004 to 2009, is integrated throughout the curriculum. It is our hope that you will find this curriculum useful in your postabortion care educational and service delivery programs and that countries will adapt it for pre-service, in-service and structured, competency-based, on-the-job training programs.

Other evidence-based resources for postabortion care can be found at www.postabortioncare.org. Some items include a register for PAC clients, assessment tools for use in evaluating national policies, guidelines, communication materials, provider job aids, clinic wall charts, materials for community education and mobilization, a radio spot, client brochures and educational materials. These resources are available in English, French, Spanish and Russian. All materials can be downloaded free for immediate use.

Sincerely,
Carolyn Curtis, CNM, MSN, FACNM
USAID
Team Leader—Postabortion Care

Before Starting This Training Course

The technical content of this global Postabortion Care Curriculum was developed using the most recent evidence-based information possible. Ideally, local protocol should support the evidence and principles presented in the curriculum. Where local protocols are in conflict with evidence-based content—often due to a lapse in updating protocols—agreement should be obtained well in advance of training from the Ministry of Health or appropriate authority for provisional approval pending update of protocols in order to support providers in carrying out new practices.

The training approach used in this course is based on principles of adult learning and uses competency-based learning techniques. These principles are based on the assumption that people participate in training courses because they:

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

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

The materials have been designed for use by trainers who have been formally trained in adult learning principles and participatory learning skills. These trainers should also be proficient in the PAC skills of the sessions they facilitate.

Reorganization of Services: A Note for Program Managers

Before PAC can be provided, services must be redesigned (or expanded) to accommodate all components of PAC. A supportive policy environment is of utmost importance. PAC policies must be reviewed to ensure that they reflect evidence-based standards and that service delivery guidelines are consistent with these policies. When necessary, operational policies must be revised accordingly.

PAC service delivery models must be designed to provide the range of care needed by women suffering from the effects of incomplete abortion—and by their families and communities—to ensure that women receive the postabortion care they need. For example, using a PAC delivery model that consists of restructuring the environment; training providers in infection prevention, counseling and contraceptive technology; providing accurate information to patients regarding emergency treatment, complications, self-care, family planning methods and return to fertility; and improving contraceptive method availability at the site of emergency treatment can improve provider attitudes, increase provider counseling skills, increase the number of patients being discharged with a family planning method, increase referrals for contraceptive methods not available at the site, and increase quality of care and patient satisfaction.

For additional information on policies and systems for PAC, consult the PAC Resource Package at: www.postabortioncare.org.

Selection of Participants

This course is designed for skilled personnel such as midwives, nurses and physicians. It is essential that participants be currently working in a relevant clinical setting and competent in the following skills:

- Family planning counseling and service provision
- Pelvic assessment:
  - Sizing of non-pregnant and early pregnant uterus
  - Use of speculum

Appendix I, an Addendum to the Participant Invitation Letter, outlines what participants should bring in order to be prepared for their clinical experience.

Ideally, a pre-course skills assessment would assist facilitators in ensuring that participants have the requisite skills. However, this can be time-consuming. Instead, a questionnaire of skills experience might be used. An example of such a questionnaire can be found in Appendix II.

When training non-physicians, be sure the local service delivery guidelines allow these providers to provide PAC services, including the use of manual vacuum aspiration (MVA) equipment. The training can be adapted for different cadres depending on the type of uterine evacuation available or in use.

Lastly, due to the short time of the course, additional clinical time may be needed after the initial training. Participants will need to be available for on-the-job or other practice opportunities.

Rationale for PAC Clinical Skills Training

Training of reproductive health providers will help to:

- Ensure the accessibility, acceptability and use of quality PAC services for all women who need them
- Make PAC services available 24 hours a day, 7 days a week
- Update those who are currently providing PAC services
- Sensitize providers to the magnitude of the problem of incomplete abortion and to the PAC client's need for quality medical, emotional and supportive care
- Encourage provider partnership and linkages with the community, including private voluntary organizations (PVOs) and nongovernmental organizations (NGOs)

- Introduce PAC into larger reproductive health training programs and possibly to pre-service faculty and programs
- Equip reproductive health workers to provide family planning services and services for sexually transmitted infections (STIs)/HIV as an integral part of PAC
- Equip providers to provide appropriate counseling throughout postabortion care and to include the client's partner and/or family, with the client's consent when appropriate
- Equip providers to be sensitive to vulnerable populations

Mastery Learning

The mastery learning approach to clinical training assumes that all participants can master (learn) the required knowledge, attitudes and skills, provided sufficient time is allowed and appropriate training 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 training is based.

While some participants 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 training methods.

The mastery learning approach also enables the participant 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 participants' 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 participant learning. With this approach, it is essential that the clinical trainer regularly inform participants 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 emphasizes 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 participants with continual feedback on how successful they are in meeting the course objectives and, when appropriate, to adapt the course to meet learning needs.
- Less stressful, because from the outset participants, both individually and as a group, 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 behavior modeling
- Is competency-based
- Incorporates humanistic training techniques

Behavior Modeling

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 modeling to be successful, the trainer must clearly demonstrate the skill or activity so that participants 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 participant sees others perform the procedure and acquires a mental picture of the required steps. Once the mental image is acquired, the participant attempts to perform the procedure on a model, with supervision.

Skill Acquisition

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

Skill Competency

The participant knows the steps and their sequence (if necessary) and can perform the required skill or activity. Only when skill competency has been demonstrated with models, however, should participants have their first contacts with clients.

Skill Proficiency

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

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 participant performs (i.e., a combination of knowledge, attitudes and, most important, skills) is emphasized rather than just what information the participant 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 analyzed to determine the most efficient and safe way to perform and learn it. This process is called standardization. Once a procedure, such as IUD insertion, has been standardized, 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 participant'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 participant to provide guidance in learning the skills through return demonstration, monitors progress and helps the participant overcome problems.

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

- Before practice—the clinical trainer and participant should meet briefly before each practice session to review the skill/activity, including the steps/tasks which will be emphasized during the session.
- During practice—the clinical trainer observes, coaches and provides feedback as the participant 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 participant'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 videos. The effective use of models facilitates learning, shortens training time and minimizes risks to clients. For example, by using anatomic models initially, participants more easily reach the performance levels of skill competency and beginning skill proficiency before they begin working in the clinic setting with clients.

Before a Participant Attempts a Clinical Procedure with a Client, Two Learning Activities Should Occur

- The clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g., video).
- While being supervised, the participant should practice the required skills and client 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 participants have their first contacts with clients. See Appendix III for a form to track participants' progress in completing their practice sessions, and Appendix IV for information on selection of clinical training sites.

When mastery learning, which is based on adult learning principles and behavior 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.

Clients' Rights during Clinical Training[1]

The rights of the client to privacy and confidentiality should be considered at all times during any clinical training course. When a client is undergoing a physical examination, it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g., service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).

The client's permission must be obtained before having a clinician-in-training (participant) observe, assist with or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training/participant. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit a trainee to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.

Clinical trainers must be discreet in how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could cause harm or discomfort to the client. Excessive negative feedback can create anxiety for both the client and clinician-in-training.

It can be difficult to maintain strict confidentiality in a training situation when specific cases are used in learning activities such as case studies and clinical conferences. Such discussions always should

[1] *Source*: *Comprehensive Reproductive Health and Family Planning Training Curriculum, Module 3, Counseling for Family Planning Services*. Pathfinder, March 2000.

take place in a private area, out of hearing of other staff or clients, and should be conducted without reference to the client by name.

Components of the Postabortion Care Training Curriculum

This clinical training course is built around use of the following components:

- Need-to-know information contained in the *Postabortion Care Curriculum: Reference Manual* (USAID/ACCESS-FP) and *Family Planning: A Global Handbook for Providers* (USAID/JHU/WHO)
- A Participant's Guide containing a questionnaire and practice checklists, which break down the skill or activity (e.g., MVA procedure, counseling skills) into its essential steps
- A Trainer's Guide, which includes questionnaire answer keys and detailed information for conducting the course:
  - Session plans are designed to give a general outline of objectives and suggested training methodologies and time allocated for each activity. These plans should be adapted as appropriate. Specific details of the session plan (i.e., how to carry out a learning activity or methodology) are the responsibility of the trainer/training team.
- Well-designed teaching aids and audiovisual materials, such as videos, anatomic models and other training aids
- Competency-based performance evaluation

The reference manual recommended for use in this course is the *Postabortion Care Curriculum: Reference Manual*. It is organized into four modules containing 12 sessions that correspond with the modules and sessions in the participant and trainer guides. It contains essential information on the following topics: components of postabortion care, initial assessment, pain management, treatment of incomplete abortion, management of complications, postabortion family planning counseling and services, and recommended infection prevention practices.

Because a major objective of PAC services is to reduce maternal mortality by reducing the unmet need for family planning that can result in repeat, unplanned pregnancy and repeat abortion, family planning counseling and service provision are a part of this training. It is strongly recommended that participants selected are those who are currently providing family planning services and have had updated training on the available methods.

If this is not the case, trainers are advised to conduct a 1–2 day family planning update for participants prior to the workshop or incorporate the content into the PAC training schedule. The recommended primary text for this update is *Family Planning: A Global Handbook for Providers*, but any other appropriate text can be used. The family planning update should be tailored to the learning needs of the participants.

Postabortion Care Training

Delivery of PAC services is a team effort, requiring the knowledge and skills of trained clinicians (physicians, nurses and midwives), family planning counselors and support staff. Although the material in this course is primarily designed for group training in all aspects of postabortion care, it is easily adapted for individual or on-the-job training. A good example of a PAC curriculum specifically designed for on-the-job-training is entitled Postabortion Care On-the-Job Training, published in 2006 and can be found on the PAC Global Resources Web site: http://www.postabortioncare.org/pac/

The curriculum was developed in Nepal and includes resources for trainers, participants and supervisors, all of which can be downloaded from the above site.

The person who actually provides PAC may vary from country to country, depending on national and programmatic policies. Thus, while one individual (or team member) may need more opportunities for learning and practicing vacuum aspiration (VA) and/or family planning counseling, other team members can spend more time on counseling techniques, infection prevention and follow-up of clients. Even if a participant will not carry out a specific task, s/he needs to be familiar with it in order to ensure quality service delivery. Therefore, all course participants should be provided the opportunity to observe or perform on models the skills/activities associated with the safe delivery of postabortion care services.

Course Design

This clinical training course is designed for service providers (physicians, nurses and midwives). It builds on each participant's past knowledge and takes advantage of her/his high motivation to accomplish the learning tasks in the minimum time. Training emphasizes doing, not just knowing, and uses competency-based evaluation of performance. This training course differs from traditional courses in several ways:

- During the morning of the first day, participants are introduced to the key features of mastery learning and then are briefly tested (Pre-Course Questionnaire) to determine their individual and group knowledge of the management of postabortion care services.
- Classroom and clinic sessions focus on key aspects of service delivery (e.g., initial assessment).
- Progress in knowledge-based learning is measured during the course using a standardized written assessment (Mid-Course Questionnaire).
- Clinical skills training builds on the participant's previous family planning experience. Participants first practice on anatomic models using learning guides that list the key steps. In this way, they learn more quickly the skills needed in a standardized way.
- Progress in learning new skills is documented using the counseling and MVA clinical skills learning guides.

- Evaluation of each participant's performance is conducted by a clinical trainer using competency-based skills checklists.

Successful completion of the course is based on mastery of both the content and skills components, as well as satisfactory overall performance in providing postabortion care services to patients.

Evaluation

This clinical training course is designed to produce qualified postabortion care service providers. Qualification is a statement by the training institution(s) that the participant has met the requirements of the course in knowledge, skills and practice. Qualification does not imply certification. Personnel can be certified only by an authorized organization or agency.

Qualification is based on the participant's achievement in three areas:

- Knowledge: a score of at least 85% on the Mid-Course Questionnaire.
- Skills: satisfactory performance of PAC clinical skills and family planning counseling.
- Practice: demonstrated ability to provide PAC services in the clinical setting.

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

The evaluation methods used in the course are described briefly below:

- Mid-Course Questionnaire. This knowledge assessment will 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 take the Mid-Course Questionnaire again at any time during the remainder of the course.
- Provision of Services (Practice). During the course, it is the clinical trainer's responsibility to observe each participant's overall performance in providing postabortion care services. This provides a key opportunity to observe the impact on patients of the participant's attitude—a critical component of quality service delivery. Only by doing this can the clinical trainer assess the way the participant uses what s/he has learned.
- Family Planning Counseling and Clinical Skills Checklists. The clinical trainer will use these checklists to evaluate each participant as she/he performs skills and talks with and counsels patients. Evaluation of the communication and counseling skills of each participant may be done with patients; however, it may be accomplished at any time during the course through observation during role plays using participants or volunteers. Evaluation of the clinical skills usually will be done during the last 2 days of the course (depending on class size and patient caseload).

In determining whether the participant is qualified, the clinical trainer(s) will observe and rate the participant's performance for each step of the skill or activity. The participant must be rated "satisfactory" in each skill or activity to be evaluated as qualified.

Course Syllabus

This clinical training course is designed to prepare participants to provide postabortion care services. Arrangements should be made to allow for additional skills practice even after the completion of the course. Such arrangements can be made through apprenticeship, on-the-job experience and follow-up by trainers or facilitators.

Course Goals

- To influence in a positive way the attitudes of the participant toward postabortion care services
- To provide the participant with the knowledge and skills needed for performing uterine evacuation (vacuum aspiration [VA] or the method appropriate to the setting) as well as preventing and managing complications related to the procedure
- To provide the participant with counseling skills for postabortion family planning
- To provide the participant with the knowledge and skills needed to organize and manage quality postabortion care services
- To familiarize the participant with her/his role in counseling and provision of family planning as the core component of PAC

Training/Learning Methods

- Illustrated lectures and group discussions
- Individual and group exercises
- Role plays
- Simulated practice with anatomic (pelvic) models
- Guided clinical activities (performing vacuum aspiration and counseling)

Training Materials—This Guide Is Designed to Be Used with the Following Materials

- *Postabortion Care Curriculum: Reference Manual* (USAID)
- *Family Planning: A Global Handbook for Providers* (USAID/JHU/WHO)
- Postabortion care audiovisuals (depending on availability in each setting)
- PowerPoint slides for each session as appropriate:
  - The PowerPoint slides are based on the text in the reference manual. If the slides are used, trainers should select those which best enhance the sessions they decide to cover and are strongly encouraged not to use lecture as the only form of training methodology. An abbreviated set of slides is included to assist trainers with summarizing the information.
- Instruments and Equipment for VA:
  - Electric vacuum or MVA kits, (as designated by the setting), and pelvic models
  - Family planning counseling and teaching aids

- Course Evaluation (to be completed by each participant)

Course Duration

- 10 sessions in a 2-week (10–12 day) sequence

The course size will be limited by the available space (classroom and demonstration areas/rooms) at the training facility and the potential number of patients needing postabortion care services at the clinical training site(s).

Sample Training Schedule—Week 1						
	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**
TIME	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
8:00–8:30 am	Registration and welcome	• Agenda • Warm-up • Re-cap	• Agenda • Warm-up • Re-cap	• Agenda • Warm-up • Re-cap	• Agenda • Warm-up • Re-cap	
8:30–9:30 am	**Module 1.1: Postabortion Care: Issues Surrounding Miscarriage, Induced Abortion and the Delivery of PAC Services (Course Intro)** • Introduction • Expectations • Group norms • Logistics/admin • Course goal, objectives, schedule • Review of course materials and evaluation system	**Module 1.2: Postabortion Care: The PAC Model**	**Module 2.2: Emergency Treatment: Evacuation Methods**	**Module 2.5 (cont.)** **Module 2.6: Postabortion Complications and Management**	**Module 3.1 (cont.)**	
9:30–10:30 am	Pre-course assessment of knowledge					
10:30–10:45 am	BREAK					
10:45 am–1:00 pm	**Module 1.1 (cont.)** Pre-course skill assessment	**Module 1.3: Values and Attitudes**	**Module 2.3: Emergency Treatment: Pain Management**	**Module 2.6 (cont.)**	**Module 3.1 (cont.)**	
1:00–2:00 pm	LUNCH					

Sample Training Schedule—Week 1						
	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**
TIME	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
2:00–3:00 pm	**Module 1.1 (cont.)**	**Module 2.1: PAC Core Component One: Emergency Treatment: Preparation and Client Assessment**	**Module 2.5: Emergency Treatment: Vacuum Aspiration**	**Module 3.1:Family Planning Counseling and Service Provision, STI Evaluation and Treatment, and HIV Counseling and/or Testing:** Family Planning Counseling and Service Provision **FP/contraceptive technology update**	**Module 3.2: Family Planning Counseling and Service Provision, STI Evaluation and Treatment, and HIV Counseling and/or Testing (STI/HIV):** STI and HIV Service Provision	
3:00–3:15 pm	BREAK					
3:15–4:30 pm	**Module 1.1 (cont.)** Wrap-up	Wrap-up				
Reading Assignment	Read Modules 1.1, 1.2, 1.3 and 2.1	Read Modules 2.2, 2.3, 2.4 and 2.5	Read Modules 2.5, 2.6 and 3.1	Read Modules 3.1 and 3.2	Read Module 4.1	

SAMPLE TRAINING SCHEDULE—WEEK 2 Classroom and Clinical Practice						
	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	
TIME	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
8:00–8:30 am	• Agenda • Warm-up • Re-cap	• Agenda • Warm-up • Re-cap	Group discussion (review clinical experiences)	Group discussion (review clinical experiences)	Group discussion (review clinical experiences)	
8:30–10:30 am	**Module 4.1: Infection Prevention and Processing VA Instruments for Reuse**	**Classroom practice sessions on models**	Practice in clinical areas	Practice in clinical areas	Practice in clinical areas	Course evaluations Wrap up any unfinished work Departure
10:30–11:00 am	BREAK					
11:00 am–1:00 pm	**Module 4.1** (cont.)	• Orientation to clinical practice sessions • Review of clinical schedule	Practice in clinical areas	Practice in clinical areas	• Develop action plans to complete clinical practice and follow-up • Post-course questionnaire	
1:00–2:00 pm	LUNCH					
2:00–3:30 pm	**Module 4.1** (cont.)	**As learners are ready, practice in clinical areas begin**	**Clinical Conference**	**Clinical Conference**	**Closing ceremony**	
3:30–4:30 pm						
4:30–5:30 pm						
Evening	**Classroom practice**					

Notes:

- Module 2, Session 4, PAC Core Component One—Emergency Treatment: Uterine Evacuation, Dilatation and Curettage, should be included in the training if D&C is the only method of evacuation available.
- Module 4, Session 1, Infection Prevention and Processing VA Instruments for Reuse, may be completed on Day 6 of Week One.
- Practice times may be in shifts; late afternoon or evening shifts may be needed to allow for more clinical experience. “On call” schedule may be useful (on call during daytime shifts up to late evening). Clinical practice to focus on family planning and emergency treatment.
- Clinical practice “on-call” may begin in Week One as learners are ready for certain aspects of observation and practice.

USING ZOE® GYNECOLOGIC SIMULATORS

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

- Bimanual pelvic examination including palpation of normal and pregnant uteri
- Vaginal speculum examination
- Visual recognition of normal 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)

Care and Maintenance of All ZOE Models

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

- 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 client.
- To avoid tearing ZOE's skin when performing a pelvic exam, 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 that 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.

How the Results Will Be Used

The main objective of the Pre-Course Questionnaire is to assist both the clinical trainer and the participant as they begin their work together in the course by assessing what the participants, individually and as a group, know about the course topic. This allows the clinical trainer to identify topics that may need additional emphasis during the course. Providing the results of the pre-course assessment to the participants enables them to focus on their individual learning needs. In addition, the questions alert participants to the content that will be presented in the course.

The questions are presented in the true-false format. A special form, the Individual and Group Assessment Matrix, is provided to record the scores of all course participants. Using this form, the clinical trainer and participants can quickly chart the number of correct answers for each of the 20 questions. By examining the data in the matrix, the group members can easily determine their collective strengths and weaknesses and jointly plan with the clinical trainer how best to use the course time to achieve the desired learning objectives.

For the clinical trainer, the questionnaire results will identify particular topics that may need additional emphasis during the learning sessions. Conversely, for those categories where 85% or more of participants answer the questions correctly, the clinical trainer may elect to use some of the allotted time for other purposes. For example, if the participants as a group did well (85% or more correct) in answering the questions in the category "Postabortion Family Planning" (questions 16 through 20), the clinical trainer may elect to assign some of the material for that topic as homework rather than spending all of the suggested time in class. Such a situation may happen, for example, with groups who have recently had training or updates in family planning counseling and service provision.

For the participants, the learning objective(s) related to each question and the corresponding session(s) in the reference manual are noted beside the answer column. To make the best use of the limited course time, participants are encouraged to address their individual learning needs by studying the designated session(s).

PRE-COURSE QUESTIONNAIRE

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

Initial Assessment

1. A woman who is admitted with possible complications of incomplete abortion should first be assessed to determine the presence of shock. _____ Participant Objective 3a (Module 2, Session 1) and Participant Objective 2a (Module 2, Session 6)

2. Taking a complete medical history is the first step in assessing a patient with possible complications of incomplete abortion. _____ Participant Objective 3b (Module 2, Session 1)

3. An abdominal examination is the best way to determine uterine size. _____ Participant Objective 3c (Module 2, Session 1)

4. A woman presenting with vaginal bleeding and signs and symptoms of pregnancy may have an ectopic pregnancy. _____ Participant Objective 3 (Module 2, Session 1)

5. Foul-smelling discharge may indicate infection due to incomplete abortion. _____ Participant Objective 3 (Module 2, Session 1) and Participant Objective 2 (Module 2, Session 6)

Infection Prevention

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

7. High-level disinfection of surgical (metal) instruments, which have been thoroughly cleaned, can be done by soaking them in 8% formaldehyde or a 0.1% chlorine solution prepared with boiled water. _____ Participant Objective 9 (Module 4, Session 1)

8. To minimize 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. _____ Participant Objective 9 (Module 4, Session 1)

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

10. The MVA syringe must be high-level disinfected between patients. _____ Participant Objective 9 (Module 4, Session 1)

VA Provision

11. One sign that the VA procedure is complete is when foam is visible around the cannula. _____ Participant Objective 4 (Module 2, Session 5)

12. Pain management should be a part of care for all women requiring uterine evacuation for treatment. _____ Participant Objective 1 (Module 2, Session 3)

13. The patient **must** return to the clinic if she has spotting or bleeding during the few days following treatment to treat complications of incomplete abortion. _____ Participant Objective 5 (Module 2, Session 5)

14. Manual vacuum aspiration is an effective treatment for incomplete abortion if the uterine size is up to 12 weeks. _____ Participant Objective 4 (Module 2, Session 2)

15. When performing VA procedures, the vacuum will be lost if the uterus is perforated. _____ Participant Objectives 1 and 2 (Module 2, Session 2)

Postabortion Family Planning

16. The goal of postabortion family planning is to help a woman choose a method of contraception. _____ Participant Objectives 1, 2 and 3 (Module 3, Session 1)

17. Describing adverse side effects is the most important part of postabortion family planning counseling. _____ Participant Objectives 1 and 2 (Module 3, Session 1)

18. The doctor is the person best qualified to choose a contraceptive method for a woman in good health. _____ Participant Objective 3 (Module 3, Session 1)

19. The IUD is not recommended for immediate use by postabortion care patients. _____ Participant Objective 3 (Module 3, Session 1)

20. A woman's fertility usually returns only after her first menstrual period following an incomplete abortion. _____ Participant Objective 3 (Module 3, Session1)

Course Introduction

Summary

This introductory session orients the trainee to postabortion (PAC) training and the three-component PAC model. The pre-course questionnaire helps both participants and trainers to assess learning needs. Participants also begin to take an active part in their learning through sharing expectations and norms, and reviewing the objectives and learning approaches used during the course. The importance of working in partnership with other providers and the community is emphasized from the start of the training program.

Session Objectives

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

1. Note their individual strengths and limitations based on the pre-course questionnaire
2. Share individual expectations about the training
3. Agree on the norms set by participants and facilitators
4. Explain, in their own words, the rationale behind PAC training and the overall training goal

POSTABORTION CARE TRAINING

Rationale for PAC Clinical Skills Training

Training of reproductive health providers will help to:

- Ensure the accessibility, acceptability and use of quality PAC services for all women who need them
- Make PAC available 24 hours a day, 7 days a week
- Update those who are currently providing PAC services
- Sensitize providers to the magnitude of the problem of incomplete abortion and to the PAC client's need for quality medical, emotional and supportive care
- Encourage provider partnership and linkages with the community, including PVOs and NGOs
- Introduce PAC into larger reproductive health training programs and possibly to pre-service faculty and programs
- Equip reproductive health workers to provide family planning and STI/HIV services as an integral part of PAC
- Equip providers to give appropriate counseling throughout postabortion care and to include the client's partner and/or family with the client's consent when appropriate
- Equip providers to be sensitive to vulnerable populations
- Sensitize providers to the unique needs of youth clients

PAC Training Program Overall Goal

The goal of the training program is to:

- Provide updated, evidence-based PAC training to reproductive health providers who will implement this care at their worksites
- Facilitate community involvement in the catchment areas of the providers

TRAINEE'S JOURNAL

OPTIONAL

Purpose	▪ To have information important to you, as the trainer or the trainee, recorded for use during the training and at your work-site after training.
Examples of important information	▪ What I have learned from the sessions and experiences during training ▪ What I intend to do in order to keep improving on the new skills and knowledge that I have acquired? ▪ What will I now do differently as a result of this training? ▪ What help do I need to perform the newly acquired skills and apply the knowledge at my worksite? ▪ Whom will I contact for this assistance?
How to keep the journal	▪ Use a recording method of your choice, but it must be easy to find when needed
When do you collect the information?	▪ During the session, e.g., when discussing learning insights, what to do differently, what would I apply at my work
When will you use the information?	▪ Any time during the training ▪ Near the end of the training for including in the skills application (back home) plan ▪ After the training, at your worksite
Instructions	▪ Use the information during all sessions when giving feedback or comments to speaker (Trainer or trainee, client, community)

DAILY PAC TRAINING EVALUATION REPORT

1. Which topic was most useful to you?

2. Which topic was least useful to you?

3. Which topic was repetition for you?

4. What other issues do you suggest to improve this workshop?

Postabortion Care: Issues Surrounding Miscarriage, Induced Abortion and the Delivery of PAC Services

Summary

This introductory session is a brief orientation to postabortion care (PAC). It begins by describing the magnitude of maternal mortality and morbidity, factors that may cause spontaneous abortion (miscarriage), reasons why women may choose to seek abortion services and why women delay seeking postabortion care services. This is then followed by a brief consideration of national legislation and service delivery guidelines on the provision of postabortion care.

Session Objectives

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

1. Define the term "abortion"
2. Discuss the magnitude of maternal mortality worldwide as well as in their country (if known)
3. Explain possible reasons for spontaneous abortion (miscarriage)
4. Explain possible reasons why women resort to induced abortion
5. Describe the abortion laws and regulations in their country and how they impact PAC services
6. Describe policies for postabortion care at their home facilities and how they impact PAC services

Questions to Think About

- What happens to a woman when she presents for PAC services in your facility?
- Where does she present?
- Who sees her first? Is she admitted or not?
- Who providers the PAC services and where are they provided?
- Who provides FP counseling and where is the counseling provided?
- Are FP commodities available?
- Are there policies for providing services to youth?
- What is the cost of PAC services?

FACTORS CONTRIBUTING TO SPONTANEOUS AND INDUCED ABORTION: GROUP EXERCISE

Brainstorming exercise and discussion—instructions:

- Identify three factors from each of the following areas that contribute to the ability to provide PAC services or to provide access to PAC services:
  - Individual (e.g., age, marital status)
  - Community
  - Health services
- Explain why the factor may assist or prevent a woman from seeking PAC services, whether the factor is avoidable and steps that can be taken to avoid the contributing factor.

Large or Small Group Exercise: Factors That Hinder or Facilitate the Delivery of Postabortion Care Services			
Contributing factor	Why the factor may lead to abortion	Is the factor avoidable?	What can be done to avoid the contributing factor

Postabortion Care: The PAC Model

Summary

Postabortion care (PAC) is a **package of services** provided to women who have had a miscarriage or an induced abortion. PAC comprises three core components, which should be implemented in a **systematic way**. This session will define PAC; explain the rationale for postabortion care programs; introduce the core components of the postabortion care model; and introduce the benefits of postabortion family planning counseling and services.

Session Objectives

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

1. Define postabortion care
2. Explain why counseling should be integrated throughout all components of PAC
3. Outline the three components of the PAC Model and the main elements of each
4. Define the difference between emergency obstetrical care and postabortion care
5. State three benefits of providing postabortion care services

LEARNING ACTIVITIES

PAC Story and Discussion

Mrs. Joko has been married for the last 2 years. She has been trying hard to have a child but every time the pregnancy comes out at 2–3 months. She does not know why this happens and she has been very sad lately, often crying at night when no one is listening. Even the neighbors have noticed her saddened appearance. They also have wondered why she has not given birth after more than 2 years of being married. Last night she started bleeding again. Her husband went to look for transport and eventually took her to the health center.

The midwife/PAC trainee is at the health center when Mrs. Joko arrives. She is also the in-charge of the facility during the current shift. During the history, the midwife is told that this is Mrs. Joko's fourth pregnancy that has ended in a miscarriage. She says she feels fine, but is worried that she is losing another pregnancy. Her physical exam reveals an incomplete abortion.

Mrs. Joko and her husband are counseled by the midwife regarding her diagnosis and proposed treatment. They discuss the frequent miscarriages and the emotional strain they have been going through. Mrs. Joko is in tears throughout the session, but is eager to know how to prevent another miscarriage. As with the previous losses, she plans to become pregnant again immediately.

While preparing the patient for the MVA procedure, the midwife discusses with Mr. and Mrs. Joko the importance of waiting at least 6 months before trying to become pregnant again. She introduces the idea of family planning to help space the next pregnancy. Though Mr. Joko was reluctant at first, he agreed to continue the discussion about family planning after the MVA procedure.

The procedure has gone well and Mrs. Joko is recovering. She will be discharged in a few hours. The midwife returns with teaching aids to discuss the various available family planning methods with the couple. After a long discussion with many questions, Mr. Joko decides that his wife should use oral contraceptives. The midwife makes sure that they understand the instructions and provides the method. She is to return to the midwife in 2 weeks for a follow-up visit.

Postabortion Care: Values and Attitudes

Summary

This session will discuss values and attitudes and their importance in postabortion care. Many providers are from similar backgrounds, but may have very different experiences leading to different conclusions during daily work interactions or when discussing a common issue. Awareness of our own values and attitudes helps health care professionals to provide care in a respectful and non-judgmental manner regardless of our values, social status or personal condition.

Acknowledgments: Information from EngenderHealth's Postabortion Counseling Curriculum and JHU/PCS's – Put Yourself in Her Shoes curriculum has been adapted for use in this session.[2]

Session Objectives

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

1. Define the terms value and attitudes
2. Explain the importance of being aware of our own values and attitudes
3. Explain the importance of respect for all clients, regardless of their values, social status or personal situation, and demonstrate this in an actual counseling session or classroom activity

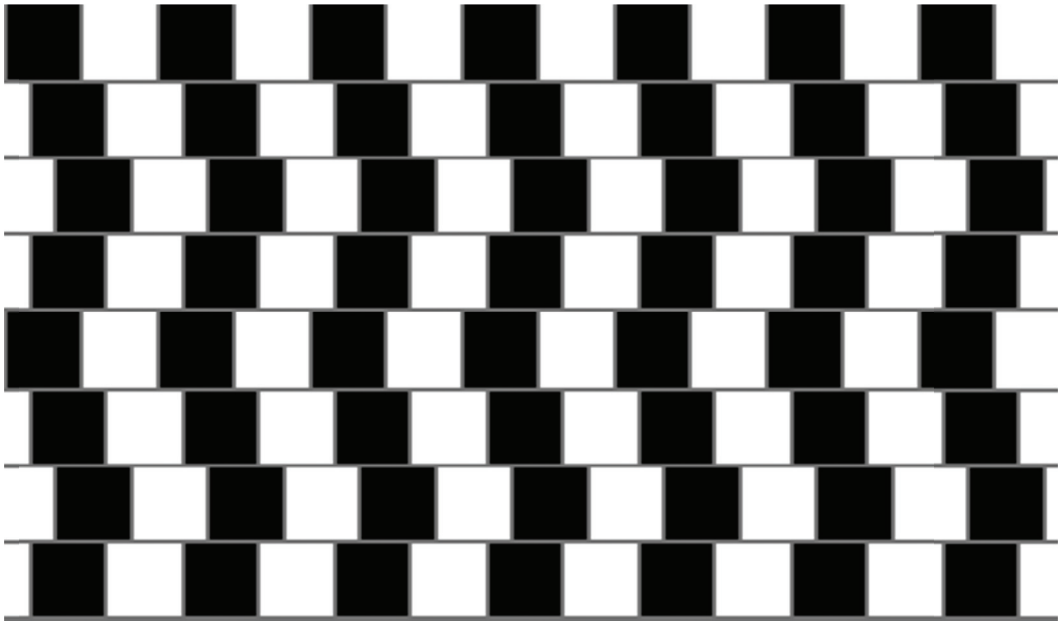
[2] EngenderHealth. 2003. *Counseling the Postabortion Client: A Training Curriculum* and Johns Hopkins Population Communication Services/PATH. 1996*. Put Yourself in Her Shoes: Family Planning Counseling to Prevent Repeat Abortion*.

OTHER EXERCISES IN HOW WE SEE THINGS DIFFERENTLY (20 MINUTES)

Ambiguous Figure

Source: EngenderHealth. 2003. *Counseling the Postabortion Care Client: A Training Curriculum*, EngenderHealth: New York, from Boring, E.G. 1930. A new ambiguous figure. *American Journal of Psychology* July: 444.

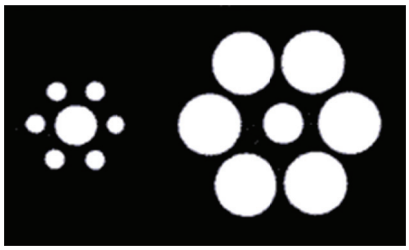
Are the Lines Below Straight or Are They Curved?



All lines are straight—measure against the straight edge of a piece of paper or ruler

Look Carefully at the Center Dots on Both the Left and Right.

Which Dot Is Bigger?



(They are both the same size)

What Do You See Below? A Lady or a Musician?

Do You See a Young Woman or an Old Woman?

What Is in These Images? What Do You See?

Do You See a Man or a Lake with a Boat?

COUNSELING SESSIONS ROLE PLAYS

Instructions for the Two People Playing Clients

Aspects of Empathetic Counseling Include:

- Greeting the client respectfully
- Ensuring privacy and confidentiality
- Asking about the client's feelings
- Listening attentively
- Exploring the clients existing knowledge
- Giving credit for appropriate actions
- Avoiding blame and condemnation

You are a married woman who is having a miscarriage. You have recently had malaria and now you are bleeding heavily and are in pain when you enter the emergency ward. You are frightened as this is your first pregnancy and you are frightened about your health and your baby, and nervous about how the health care provider will respond to your situation.

You are an unmarried teenager who has recently had an unsafe abortion because your trusted boyfriend dissuaded you from using a contraceptive method. You have been bleeding heavily and are in pain when you enter the emergency ward. You are frightened about your health, and nervous about how the health care provider will respond to your situation.

Instruct the two people playing providers:
You are a nurse on the emergency ward where the client is admitted, and you are the first one to speak to her.

Empathetic Provider

The first provider will keep in mind the following questions:

- How would I want to be treated if I were the client in this situation?
- How would I treat the client if she were a guest in my home?

This provider will show empathy to the client by encouraging her to talk about her feelings; keeping the focus on the client, not on his or her own emotions; listening actively and paraphrasing the client's feelings; responding to the client's non-verbal communications: "Tell me how you're feeling. You look very sad."

Non-Empathetic Provider

The second provider will keep in mind the question:

- How would I not want to be treated if I were the client in this situation?
  This provider will show a lack of empathy toward the client, perhaps by scolding, being impatient, not showing respect for the client. Have this provider think of and use comments that he or she has actually heard or said to clients in the course of his/her daily work.

  First have the non-empathetic provider and the first client role play an interaction for 5 minutes or so. Then switch to the empathetic provider and the second client. After both role plays have been completed, have each provider and client comment on how they felt during the experience.

Then ask the group to discuss what they observed. Discuss how empathy affects the client and the interaction. Record the main points of the discussion.

- Describe the concept of empathy. How do you define empathy?

  Empathy is not just feeling sorry for someone. It means putting yourself in the other person's situation in order to understand how the other person might be feeling. Empathy means to show understanding, concern and a desire to help in a way that encourages open, honest and sincere communication.

Provider Emotions

It is normal for providers to experience emotions in the life-and-death encounters of an emergency ward. It is therefore important to raise participants' awareness of their emotional responses to clients and to help them to become aware of specific thoughts and actions that can convey empathy and encourage two-way communication.

Have participants individually generate a list of emotions that they or their colleagues experience during their daily interactions with clients. After a few minutes, ask participants to form pairs and share some of the items on their lists. How do these emotions make them act toward clients? Ask for volunteers to share one or two responses with the larger group.

Additional Role Plays

Below are case studies that can be used as a guide for discussion or role plays. Trainees should feel free to use their local language and local issues to make the role plays more relevant for the participants. Choose at least one or as many as is appropriate for the participants and their learning needs. Create additional case studies as needed or desired. Allow about **10–15 minutes** for each case study. There are no answer keys here as the responses to the questions will come from the participants and depend on the local settings.

Case Study 1.3.1: Meena

Meena is a 28-year-old nurse. She is single and lives in an upper middle class neighborhood with her family. Meena got pregnant with Jai, a pharmaceutical sales representative who calls on the private hospital where she works. Meena told Jai that she was pregnant and that she had decided to keep the baby, regardless of whether he would be involved in raising the child. At 10 weeks gestation, Meena had a spontaneous abortion, and she went to a local public hospital with heavy bleeding. What happens in your facility when an unmarried woman presents with signs of an abortion? When Meena requested birth control pills, the nurses told her that she'd have to visit the family planning clinic next door during its regular operating hours, but they also warned that the clinic did not routinely provide methods to unmarried women. What are the protocols in your facility for providing family planning methods to unmarried women? To youth or adolescents?

Case Study 1.3.2: Marisa

Marisa is 43 years old and the mother of six children. She lives in a lower middle class rural area, and in addition to her work as a wife and mother, she does much of the work to maintain the family farm. Marisa has had eight pregnancies, one of which aborted spontaneously and one of which was a stillbirth. At this point in her life, she does not wish to have any more children, but she has never used any method of family planning. Marisa became pregnant for the ninth time and consulted her husband for advice. He recommended that she obtain an abortion from a traditional birth attendant (TBA) in their community. Marisa visited the TBA and received a vigorous massage intended to terminate the pregnancy. When she began to bleed heavily, Marisa returned to the TBA for help but was instructed to go to the hospital instead. At the hospital, the providers would not treat her until she confessed to inducing an abortion. No one ever talked to her about how to avoid becoming pregnant again in the future. In your facility, what are the protocols/standards for providing contraceptive counseling and contraceptive methods when women miscarry?

RESPONDING TO CLIENTS' FEELINGS ROLE PLAYS (30 MIN.)

- **A 15-year-old girl** who attempted to terminate a pregnancy by inserting a foreign object into her vagina. She had never been to a hospital before and had never seen a doctor. She arrived at the hospital alone and is afraid to return home to her family because they do not know where she has been.
- **A 22-year-old woman** who has come to the hospital with her husband and her mother-in-law. She is worried because she has been pregnant three times in the past year and has not yet had a child. Every one of her pregnancies has ended in a spontaneous abortion.
- **A commercial sex worker** who has come in with a friend. She is anxious to see a doctor and leave as quickly as possible.
- **A 35-year-old married woman** whose sister brought her to the hospital. The trip back home will take 10 hours and she has children waiting. She appears to be very sick.

HANDOUT: VALUES AND ATTITUDES IN POSTABORTION CARE

Adapted from: EngenderHealth. 2003. *Counseling the Postabortion Care Client: A Training Curriculum.* EngenderHealth: New York.

A **value** is a belief that is important to an individual. Values can be influenced by religion, education, culture and personal experiences. Our values shape our **attitudes**, or the way that we think about and act toward particular people or ideas.

Every interaction between a client and health care staff, from the time she enters the health care system until she is discharged, affects the woman's satisfaction with her care, how quickly she recovers and how well she takes care of herself after she leaves the facility.

How we communicate our own values and attitudes (both verbally and nonverbally) is an important part of our interactions with the women we treat. Our values are often so ingrained that we are unaware of them until we are confronted with a situation that challenges them.

Our attitudes, feelings, biases and values will affect how we treat a client's illness. For example, our private reaction to the client's looks, social class, age and marital status affects the gentleness or harshness with which we perform procedures, the delay that we may impose on clients and whether we consider the full range of health care needs of each client.

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

Keep in mind that even two people from similar experiences and backgrounds may see things differently. What do you see in the following image, a lady or a musician?

PAC Core Component One—Emergency Treatment: Preparation and Client Assessment

Summary

Preparation for providing health care starts long before the client arrives. First, health services must be organized to ensure the highest quality of care. This includes not only restructuring the environment, but ensuring providers are trained in all PAC components and that contraceptive methods are available at the site of services when possible. With a supportive policy environment for PAC, a reorganization of services can improve provider attitudes and skills and improve access to contraceptive methods and services. Then, when the woman presents for care, the provider assesses her clinical condition in an environment that increases quality of care and client satisfaction. A thorough assessment is the first step in providing the most appropriate care and treatment.

The next two modules present details of the core components of postabortion care. This session is an introduction to the emergency treatment component. There is a brief discussion of rearranging patient service areas with a focus on client privacy, followed by guidance on gathering information from the history and physical examination.

Session Objectives

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

1. Describe emergency treatment
2. Describe how to rearrange patient service areas to ensure confidentiality, privacy and the ability to counsel a male partner or other companion with the client
3. Perform client assessment and examination according to standards, including:
   a. A rapid assessment to rule out life-threatening conditions, including immediate management as needed
   b. A complete history
   c. A physical examination including:
      - Abdominal examination
      - Assessment of uterine size and position by bimanual examination
      - Assessment of the cervix to determine the degree of cervical dilatation
      - Speculum examination
   d. Determining and obtaining the appropriate laboratory tests needed
4. Explain the different types of miscarriage and abortion, including major signs and symptoms
5. Demonstrate during practice sessions the ability to integrate appropriate counseling in emergency treatment as indicated

EXERCISES/ROLE PLAYS

History-Taking Exercises

Symptom Descriptions: Any information not included can be filled in by the "client."

Symptom Description 1

This 30-year-old woman lives far away from the clinic. Her symptoms are not severe, but her sister persuaded her to seek treatment. She doesn't think she is pregnant.

- Moderate bleeding for 3 days
- Last menstrual period ended about 7 weeks ago
- Some cramping, but not severe
- Two previous births
- One previous miscarriage
- Was using injections for contraception; last injection was 7 months ago

Symptom Description 2

This is a 15-year-old girl who is alone, in considerable pain, and is very anxious that her family should not know about her condition. She has the following symptoms:

- Moderate bleeding for 7 days
- Last menstrual period began about 11 weeks ago
- Severe cramping
- No previous pregnancies
- Seems warm—no thermometer available
- Has sweats and chills
- Has a large amount of vaginal discharge, which is:
  - Brown in color
  - Foul-smelling
- Reports that she has used condoms regularly

REARRANGING PATIENT SERVICE AREAS ROLE PLAYS

Scenario 2.1.1

Crescent Health Center

There are only two providers staffing this health center on each shift. One is a midwife or medical assistant; the other is a junior nurse (enrolled nurse, auxiliary nurse). All senior providers have been trained in PAC, but not the junior staff. There are two exam rooms, one labor/delivery room and a small "ward" with two inpatient beds. Exam rooms are used for all outpatient activities. The waiting

room has several benches with two tables near the front of the room, where staff sit to take histories and blood pressure on outpatient clinic days. The exam rooms are identical in equipment and set-up. Each exam room has a window facing the main road. The feet of the exam tables face the door as this is the way it was set up by the clinic administrators.

Scenario 2.1.2

Triangle Private Maternity

The Triangle Maternity Home is owned and operated by Sarah, a midwife with many years of experience. Sarah has a reliable worker who was trained as a nurse's assistant. The assistant receives most of the client intake information in the waiting area including history, blood pressure, height and weight. There is also a maternal-child nurse from the government hospital nearby who works at the maternity a few days per month. Sarah was trained in MVA along with other private midwives about 5 years ago. She provides PAC services about twice monthly. The nurse gives family planning counseling and supplies to PAC clients at the government hospital where she works. The maternity home has one exam room (which is also the counseling room) and one patient care room (labor/delivery and PAC clients) with two beds. The beds are separated by a curtain and the foot of both beds is away from the door. The general waiting area is separated from the care area by a curtain. There are curtains in the doorway of the exam room because the door hinges are broken.

Scenario 2.1.3

Diamond Hospital

Diamond District Teaching Hospital has many PAC providers—primarily doctors and a few midwives. Other staff members have not been included in PAC training. Currently, any client seeking PAC care must proceed to the gynecology clinic during outpatient hours. Otherwise, clients are directed to the gynecology or postpartum ward, wherever a PAC-trained provider is working during that shift. However, all MVA procedures are done in the operating theater and clients must undergo "preoperative" procedures like any other surgical client. These include history, physical, blood work, etc. PAC clients are then assigned a bed on the ward to wait with other surgical clients until the procedure can be done. During daytime hours (except on weekends), the family planning nurse will come to talk with the PAC clients on the ward about contraceptive options. Clients presenting at nights or weekends are referred to the family planning services clinic on the next clinic day. Most beds have no curtains, but there are some movable screens available. This is the reason that males are not permitted in the wards.

HANDOUT: ADDRESSING THE POSTABORTION CLIENT'S FEELINGS

Addressing the PAC Client's Feelings		
Client's Feelings	**Why**	**Provider Response**
FEAR	**Fear of:** • Feeling pain during the procedure • Experiencing complications resulting from the procedure • Feeling pressure to accept a permanent or long-term family planning method	**Examples:** • Explain what to expect during the procedure and tell the client what pain control medication will be used (if any). • Tell the client about the risk of complications. • Tell the client that she may choose whether to receive a family planning method immediately after the postabortion care procedure.
	Fear of: • Dying • Becoming infertile • Becoming disabled • Being prosecuted • The "unknown" (what will happen at the hospital or facility) • Not receiving treatment because of inability to pay for services	**Examples:** • Listen. • Reassure the client. • Find out why or what the client fears. • Provide information. • Provide or arrange for family planning counseling or referral for other services if needed. • Be aware of one's own feelings toward the client and try not to be judgmental.

Emergency Treatment: Uterine Evacuation Methods

Summary

Because most complications result from retained products of conception, removal of the contents of the uterus, (uterine evacuation), is one of the primary components of emergency treatment. Uterine evacuation can be accomplished by one of several methods, based on type of facility, available equipment, staff and local conditions. The three main methods of evacuation are vacuum aspiration, sharp curettage (also called dilatation and curettage) and pharmacological methods. This session presents an overview and description of each method. The techniques of each method are presented in separate sessions.

Session Objectives

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

1. Describe how each method of uterine evacuation works
2. List the main advantages and disadvantages of each method
3. Identify the instruments (or parts) used in each method as appropriate
4. Describe any indications, contraindications and precautions as applicable for each method
5. Describe the counseling appropriate during any uterine evacuation procedure

Emergency Treatment: Pain Management

Summary

While most health facilities use a general protocol for pain control medication, the service provider must be alert and respond to the individual and particular needs of each woman being treated. Pain management for postabortion care includes not only appropriate medication, but also supportive interaction and gentle performance of procedures. In addition to pain management, other medications or related interventions may be necessary during emergency treatment. This includes, for example, intravenous (IV) fluids and oxytocics. This session covers the types of pain control and the information needed to appropriately select and administer each type.

Session Objectives

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

1. Describe the goal of pain control
2. Describe the main counseling points to include when discussing pain management with the client
3. Describe the types of pain women may experience from incomplete abortion and from the different uterine evacuation procedures
4. List the types of pain control and available methods for each type
5. Describe symptoms of local anesthesia complications, and treatment
6. Demonstrate counseling related to pain management and integrate with care as appropriate

COUNSELING AND DISCUSSING PAIN MANAGEMENT ROLE PLAYS

Role Play 2.3.1

Sarah is a 19-year-old university student who has presented with signs of miscarriage. Her last menstrual period was about 6 weeks ago. Sarah appears very nervous and shy; the midwife heard her say that she was "scared." She is accompanied by her sister, who is an accountant there at the district hospital. They are seated in the examination room when the provider arrives. Sarah is holding her lower abdomen and slouched forward in her seat.

Role Play 2.3.2

Miriam is married with three young daughters at home. She has just experienced a pregnancy loss at nearly 12 weeks LMP and will undergo VA for an incomplete abortion. Miriam is in obvious pain and accompanied by her husband, who seems anxious. He stated to the doctor that he does not want his wife to suffer and does not understand why she lost the pregnancy; he was hoping for a son. Miriam delivered her last baby just over 1 year ago. The husband is pacing around the waiting room when you go to talk with him.

Role Play 2.3.3

You are preparing Mrs. P. for treatment. The physical exam revealed retained products of conception and signs of infection. She has agreed to a sharp curettage and says she does not want to be awake during the procedure. (No providers trained in vacuum aspiration are available at this hospital.) She is allergic to ibuprofen and has said several times, "I can't let this happen again." Mrs. P. is a gravida 8, para 7, and has come to the hospital alone.

Role Play 2.3.4

Thandi is a teacher at a local secondary school. This is her second miscarriage. The first time (6 years ago), she had a VA at the community health center, but did not receive analgesia. Thandi now has many questions about pain medication as she fears the pain she had from the previous experience. Her husband is also a teacher and they have two children. Thandi does not want her mother-in-law, who is in the waiting area, to participate in the counseling session.

Role Play 2.3.5

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

Role Play 2.3.6

For this role play, participants will practice using the pain assessment scales. Involve as many participants as possible. In each scenario, one participant will be the provider and the other will play the client:

Scenario 2.3.1—Mrs. B. has traveled across the border to your facility with signs of an incomplete abortion. The providers do not speak her language very well, but know she is in some pain. Assess Mrs. B.'s pain using the appropriate method.

Scenario 2.3.2—Mr. M. has accompanied his wife to the hospital. He says she is "about 3 months pregnant" but has been bleeding for the past 2 hours. He and his wife are both teachers at the local school. As part of the history, you are trying to assess the level of Mrs. M.'s pain.

Scenario 2.3.3—Ms. P. was taken straight to the operating theater to have a sharp curettage procedure due to excessive bleeding after a miscarriage. You need to discuss pain management with her just prior to the procedure. Ms. P. is 17 years old and this was her first pregnancy.

Scenario 2.3.4—Mrs. G. is being treated for a septic abortion. She told the midwife that she doesn't "hurt much," but is moaning and constantly rubbing her lower abdomen. You need to discuss pain management with her urgently before treatment, but she seems very shy.

Scenario 2.3.5—Ms. R. has had a VA procedure 2 hours ago. Her vital signs are stable and she will be discharged soon. You will be explaining how to take the pain medication and danger signs as part of the discharge counseling and instructions.

HANDOUT: COUNSELING AND PAIN MANAGEMENT

- Arrange the setting so it facilitates a confidential discussion.
- Ask the client if there is anyone else that she would like to have involved in the discussion (e.g., her partner, family members or a friend).
- Be sure the client understands what level of pain and discomfort to expect for the procedure she will undergo.
- Acknowledge that feeling scared, confused or worried are common emotions for most women in the same situation.
- Explain pain management options with simple terms and explanations. Include pre- and post-procedure pain control, benefits and possible side effects.
- Be sure that the client demonstrates understanding of all explanations by having her repeat or summarize the information in her own words.
- Follow local or institutional protocols for documenting informed consent for the procedure and pain control as appropriate.

Emergency Treatment: Uterine Evacuation—Dilatation and Curettage

Summary

This session presents an overview and description of the dilatation and curettage (D&C) (also called sharp curettage or SC) procedure for uterine evacuation. Each step of the procedure is outlined with illustrations for the main steps. Always follow local guidelines or protocols for the procedure, including anesthesia or related care.

Session Objectives

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

1. Identify the instruments used for D&C or sharp curettage procedures
2. Explain the procedure for D&C and sharp curettage and demonstrate it on a model
3. Describe the post-procedure care

Sharp Curettage

While sharp curettage is an effective method for the treatment of incomplete abortion, WHO recommends that it be used only when vacuum aspiration (VA) is not available; WHO recommends VA for incomplete abortion before 12 weeks gestation.

When vacuum aspiration is not available, PAC programs should therefore aim to improve the quality of postabortion care services and ensure the delivery of the complete package of PAC services regardless of whether a woman is treated with VA or sharp curettage. To ensure high-quality sharp curettage care (when VA is not available), periodic updating of skills would, whenever possible, be desirable, as with any other surgical intervention. Sharp curettage can be performed more safely with systemic analgesia rather than general anesthesia. Providing family planning counseling and services to women who have had sharp curettage procedures for emergency treatment will increase the number of women leaving the clinical facility with a family planning method, thereby potentially decreasing the incidence of unplanned pregnancy that may result in repeat abortion.

POST-PROCEDURE COUNSELING ROLE PLAYS

Role Play 2.4.1

Mrs. P. is recovering after a D&C 3 hours ago. Her husband is with her, but is concerned about caring for her at home. They have a small son and want to try for another pregnancy as soon as possible. Mrs. P is still upset about the miscarriage, but is anxious to go home today. Her recovery has been uneventful and she is not experiencing any signs of complications or problems. The midwife has just arrived on her shift and is preparing to counsel Mr. and Mrs. P.

Role Play 2.4.2

Olivia is a first-year university student and was treated for incomplete abortion a few hours ago. She has just asked the midwife for "more pain medication" and wants to know when the bleeding will stop. Olivia is about to be discharged, but is waiting until sunset so "no one will see me." She has told the midwife she does not want to use contraceptive pills or any method that can be seen or discovered by her parents.

Role Play 2.4.3

Yosef has accompanied his wife for treatment of an incomplete abortion. He has been in the waiting room during the procedure and has just been told that he can now proceed to be with his wife in the recovery area. Yosef has confided in the doctor that he feels guilty about causing the miscarriage. He says: "I should not have had sex with her so early in the pregnancy." They have five children at home.

Emergency Treatment: Uterine Evacuation—Vacuum Aspiration

Summary

In the first part of this session, participants become familiar with various vacuum aspiration (VA) procedures (electric, manual and foot pump) and VA equipment and learn how it works. This activity provides an introduction to performing the procedure, which is outlined step by step. A section on recognizing and solving problems that may arise during the procedure completes this session.

Session Objectives

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

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

Emergency Treatment: Postabortion Complications and Management

Summary

Any woman with an incomplete abortion may experience one or more life-threatening complications. Health care providers must recognize these complications and initiate immediate treatment in order to save the woman's life. This session covers an overview of the major postabortion complications of shock, severe vaginal bleeding, intra-abdominal injury and sepsis, as well as the detailed management of each.

Session Objectives

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

1. Identify possible complications and their signs/symptoms
2. Describe initial treatment and other measures for:
    a. Shock
    b. Severe vaginal bleeding
    c. Infection and sepsis
    d. Intra-abdominal injury
    e. Uterine perforation
3. Explain elements of emergency resuscitation/preparation for referral and transport to tertiary care hospital

POSTABORTION COMPLICATIONS CASE STUDIES

Case Study 2.6.1

Mrs. P. is brought to the clinic with vaginal bleeding. Her sister says Mrs. P. has been agitated and confused for the past hour. A quick observation reveals that Mrs. P. is breathing rapidly and perspiring.

1. What other information will you gather to assist in your assessment of Mrs. P.?
   Vital signs reveal the following:
   B/P—80/50; pulse 120; respiration 40

   According to her sister, Mrs. P married about 3 months ago and suspected that she was pregnant. She is not sure when the bleeding started, but thinks it was at least 4 hours ago after Mrs. P walked home from the market about 3 km away. The amount of blood observed appears less than 500 ml.

2. Based on this rapid assessment, what is your initial diagnosis?
3. What initial actions will you take to address this?
4. What other steps will you take to manage her problems?

Case Study 2.6.2

Ms. B. was admitted to the hospital 3 hours ago with a diagnosis of incomplete abortion. She is scheduled for a D&C when the doctor arrives. She calls for the midwife to say that she is bleeding "down there." You inspect her vaginal area and discover blood-soaked pads with several clots.

1. What information will help you determine the severity of Mrs. B.'s blood loss?
   Vital signs reveal the following:
   B/P—100/60; pulse 100; respiration 24

   Ms. B. says she had fallen asleep 30 minutes ago after the nurse took her vital signs and does not know when the bleeding started. She complains of dry lips and feeling "light-headed."

2. Based on these findings, what is your initial diagnosis?
3. What initial actions will you take to address this?

Case Study 2.6.3

Amina is a 21-year-old university student. Only she and her boyfriend know of her miscarriage 3 days ago. Last night, Amina awoke with a fever and chills. She presents to the clinic today complaining of a bad-smelling vaginal discharge. She begs the midwife not to reveal her recent pregnancy to her parents.

1. What are the main signs of infection/sepsis in a postabortion patient?

   Vital signs reveal the following:
   Temperature: 39° Celsius (102.2° Fahrenheit); B/P—130/80; pulse 100; respiration 30

2. What initial actions will you take to address this?
3. Disseminated intravascular disorder (DIC) is a bleeding disorder that is sometimes seen with severe cases of sepsis. What are the main signs if DIC?

Case Study 2.6.4

Mrs. Y. presents to the health center with signs of an incomplete abortion. The PAC-trained medical assistant performed an MVA, but noticed that there was still bleeding after the uterus was empty. The medical assistant monitored Mrs. Y.'s vital signs for the next 30 minutes.

Temperature of 38° Celsius (100.4° Fahrenheit); B/P—160/80; respiration 28; pulse 100; decreased bowel sounds

Though he denied it at first, Mr. Y. admitted that she had attempted to terminate the pregnancy earlier that day through a traditional healer.

1. Based on this assessment, what is the likely diagnosis?
2. What initial actions will you take to address this?
3. The medical assistant recognized an important sign of perforation. During the VA procedure, what other signs might indicate a perforation?

Family Planning Counseling and Provision, STI Evaluation and Treatment, and HIV Counseling and/or Testing

Family Planning Counseling and Provision

Summary

A woman's fertility can resume almost immediately—as soon as 2 weeks after an incomplete abortion. She should carefully consider, therefore, whether or not she wants to become pregnant again, and when. Some clients who have experienced miscarriage may soon be ready for another pregnancy. For others, their experience with incomplete abortion represents a desire not to be pregnant at this time. In either case, every PAC client and her partner, if she desires, should be offered counseling and information about her return to fertility and available contraceptive options. Throughout counseling, it is important to emphasize healthy timing and spacing of pregnancy. Delaying pregnancy for at least 6 months after an abortion or miscarriage reduces the chances of low birth weight, maternal anemia and preterm birth in the next pregnancy.[3] As emphasized throughout this document:

Postabortion care is incomplete without the inclusion of family planning services.

Full information about all available contraceptive methods and related counseling are not included in this module.[4] However, resources that include the most recent evidence-based information are readily available. Recommended materials include:

Family Planning: A Global Handbook for Providers, 2007, USAID/JHU/WHO

Medical Eligibility Criteria for Contraceptive Use, 4th edition, 2010, World Health Organization

Counseling the Postabortion Client: A Training Curriculum, 2003, EngenderHealth

Contraceptive Technology, 19th edition, 2007, Hatcher, et al.

Family Planning: A Key Component of Post Abortion Care, 2009, FIGO/ICM/ICN/USAID

IUD toolkit: www.iudtoolkit.org

These publications include training resources such as learning guides, checklists and other learning tools.

[3] Report of a WHO Technical Consultation on Birth Spacing, June 2005; WHO: Geneva.
[4] For detailed information, also refer to: *Contraceptive Technology*, 19th Edition, 2007 by Hatcher, et al. and *Family Planning: A Global Handbook for Providers*, 2007 USAID/JHU/WHO.

Session Objectives

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

1. State the essential information about family planning that all postabortion clients must have before they leave the service site
2. Explain the importance of informed choice for effective family planning services
3. Describe personal and clinical factors that should be considered in family planning counseling for postabortion clients
4. Demonstrate appropriate family planning counseling during different phases of care
5. State one consensus point of the consensus statement by the International Federation of Gynecology and Obstetrics (FIGO), International Confederation of Midwives (ICM), International Council of Nurses (ICN) and United States Agency for International Development (USAID) on postabortion family planning

CHOICE OF METHODS CASE STUDIES

Case 3.1.1

A 17-year-old woman was treated for incomplete abortion and will be released later today. You check the client's chart and find that she has been treated with MVA and there were no complications. The client's uterus was approximately 8 weeks size before treatment and her overall health status is good. The client says that she does not want to get pregnant again and would like to talk about family planning. She says that she does not want anyone, even her boyfriend, to know that she is using family planning.

Case 3.1.2

A 30-year-old woman was treated for incomplete abortion and is recovering. Her medical chart indicates that fragments of plastic were found in her vagina during her pelvic examination. When asked about her incomplete abortion, she says that she did nothing to provoke it. She says that she does not want more children for a few years. She had been using progestin-only pills since her last child was born 1 year ago. She is also interested in "the injection" because she has heard that it is a good method.

Case 3.1.3

A 20-year-old woman who has two living children has just been treated for incomplete abortion and says that she does not want to be pregnant until her youngest child starts school in 2 years. She says that she want to use the IUD because her sister has one and likes it. The client has no signs of infection but may have some anemia since she bled for 5 days before coming in for treatment. When you asked her about the incomplete abortion, she just shrugged her shoulders, looked at the floor and said it was surely a shame.

Case 3.1.4

A 28-year-old woman is treated for incomplete abortion with MVA followed by surgery to repair damage to the uterus and bowel that were discovered during the MVA procedure. She has been hospitalized for several days but is now recovering. She says that she is interested in taking the pill. When you check the client's chart, you find that her blood pressure has been slightly elevated throughout her stay. When obtaining her medical history, you find out that her father had a heart attack as a young man and one sister is on anti-hypertensive medication. The client's blood pressure today is 140/86.

Case 3.1.5

A 30-year-old woman was treated for incomplete abortion 2 weeks ago and has returned to the family planning clinic. She has two children and seems to be in a hurry, being very concerned about getting home in time to complete her chores. You find out that the family does not know where she is and she knows that her mother-in-law and husband want her to have many more children. She wants more children too, but not for a year or two. Her medical history is unremarkable except for iron deficiency anemia.

Case 3.1.6

A 31-year-old woman was diagnosed with a miscarriage and treated this afternoon. She is very interested in becoming pregnant again "as soon as possible." She has three female children, but says she "must have a male child." She is diabetic and weighs 73 kg. This is the first time she experienced spontaneous abortion.

Case 3.1.7

A 19-year-old girl is treated for incomplete abortion with no complications, but reports treatment for chlamydia 1 year ago. You suspect that she is a commercial sex worker but cannot confirm the suspicion. She says that she is interested in the IUD, because she does not really trust methods with hormones. She has opted out of counseling and testing for HIV.

Case 3.1.8

A 40-year-old woman with seven children tells you that she and her husband have decided not to have any more children and she would like to be sterilized. When you check her medical chart, you see that she has just been treated for incomplete abortion with a uterine size of 12 weeks, but there is no consent form signed. You advise her that you cannot do the operation today because of the Ministry of Health requirements to obtain consent 30 days before the procedure. She begins to cry because she lives so far from the hospital and does not know when she will be able to come back.

Case 3.1.9

A 27-year-old woman treated for incomplete abortion tells you that this is the third time she lost pregnancy in the last 5 years. She asks you how to make sure that her next pregnancy is not lost. She does not have any living children. Other than "occasional migraines," she reports an unremarkable medical history.

Case 3.1.10

A 26-year-old married woman was treated for incomplete abortion without complications. She said that she was taking injections before she became pregnant but has stopped because it took so long to walk to the nearest clinic for injections, and when she was able to go, the clinic has run out of supplies. Besides, she really couldn't afford the shots. She does not want any more children right now because of the eclampsia she experienced postpartum after her first baby.

THE COUNSELING PROCESS ROLE PLAYS

Role Play Instructions

This may be done as small group exercises, with each group acting out the role play and the observers commenting on the content. To make the role plays realistic, at least one group may omit some of the important points as a stimulus for discussion. During counseling, remember the GATHER or REDI method as a guide.

Each group should consider the following key points as they demonstrate what needs to be included in care:

- Contraceptive methods appropriate to the client's situation, needs and reproductive intention/desire
- Demonstration of emotional support and empathy
- Involvement of the male partner whenever appropriate and with the client's permission
- Return to fertility
- Offer of family planning services in the same place as emergency treatment

Role Play 3.1.1

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

My husband and I had talked and he would like us to complete our family. However, I wanted one more child before completing our family, but after resting for 2 years. Since my last delivery 18 months ago, I have been trying to practice what my friends call "child spacing" by using oral contraceptive pills regularly, according to the MCH nurse's advice. I like the pills and have not had any of the side effects my friends talk of. Sometimes I do forget to take the pill but when it happens, I take two immediately when I remember, according to what I was taught by the nursing sister.

Though my husband supports my use of family planning, I am afraid of being seen by the neighbors who may even tell my mother-in-law. I received the initial supply of pills from the clinic when I took the baby for a check-up and immunization, but since then I have been buying the pills from the nearest chemist that belongs to my friend's husband. However, due to the poor economy, the chemist is not able to maintain a continuous supply of pills. Three months back, I used the last pills I had but the chemist did not have any in stock, and it took me 1 week to find another source. However, I guess this was too long a break because I soon learned that I was pregnant. I was happy with the pregnancy, though it came much sooner than we had planned. My husband and I were looking forward to having the baby to complete our family.

Last Sunday, I began to bleed heavily and had terrible pains in my tummy. My husband desperately looked for a taxi to take me to the hospital without success; fortunately a neighbor with a car returned to his house just in time and kindly rushed me to hospital. At the hospital they told me that I had lost my baby.

Role Play 3.1.2

My name is Mrs. Perez. I am 33 years old and a mother of six children. My husband works as a truck driver and is away most of the time. He returns home every 3 months or so for a few days. I live in a small village many kilometers from the nearest market town. I support our family by growing yams to sell by the roadside. However, times are hard and we barely have enough to eat.

My husband is very proud of the number of children he has. The last time that he returned home he left me pregnant. I really felt weak, tired, and could not imagine having another baby soon, but my husband did not seem to notice or be bothered. My children went hungry because I could not fetch and prepare food for them. I was really afraid of terminating this pregnancy because of my last experience but I have no means for supporting another child.

One week ago, I felt very bad and started to bleed. I was carried to the hospital 2 days ago and the doctor cleaned my womb. I feel much better now though I am still bleeding a little, have some pain and feel very weak. I do not understand much of what is happening in this big hospital—it is so large. The doctors talk too fast. However, I know they are talking about me and they think I intentionally terminated my pregnancy. But secretly I believe that I could not have survived through the pregnancy, had no means of taking care of the newborn and do not want any more children ever.

Role Play 3.1.3

My name is Rani. I am a 15-year-old student in a girls' secondary boarding school in the capital city. I am the oldest in a family of four children, and my parents, who live in the village with my younger brothers and sisters, have high hopes of my performing well in school and helping them bring up the others. Life in the city without my family has been difficult because everything happens too fast and makes me nervous but I am managing well so far.

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

When I discovered I was pregnant, my man-friend, who is rich with plenty of money, took me to a doctor he knew who could terminate the pregnancy in confidence to enable me to continue with my education. The procedure was very expensive but that was not a problem to my man-friend so long as I kept quiet. The doctor told me that what he was doing would make me start to bleed and that I should go to the hospital immediately after the procedure. However, what he did was very painful and made me scream. My womb felt very hot and even now I am still bleeding. The doctors in this hospital informed me that I had an infection and gave me some pills to make the pain go away. I am glad that they have assured me that I will be able to have children in the future, but I now know better that I am not ready for pregnancy.

I have heard about family planning methods such as pills that can protect clients from pregnancy but I am afraid to use them. I cannot even consult the school nurse on family planning for fear of being expelled from school … what would my father say? Besides, people will have very bad ideas about me if they knew I was using family planning methods. However, I urgently want to learn more about family planning … I wonder whom I can ask?

Role Play 3.1.4

My name is Ajay. I am on my way to the hospital to get my wife, who was treated for something called "incomplete abortion." I am very worried about her and don't want her to be pregnant again until she is better, but I don't know what to do. My mother tells me to be careful of these modern birth control methods as they can cause infertility or prevent conception of a male child. I think I will take my wife to the traditional healer next week as he has much success in treating hard cases.

HANDOUT: SIMPLE ANSWERS TO CLIENTS' QUESTIONS ABOUT POSTABORTION FAMILY PLANNING

When can I resume sexual activity?
After your bleeding has stopped (bleeding stops in about 5 to 7 days).

How soon can I become pregnant?
Almost immediately—even before your next period. It is possible to become pregnant as soon as 11 days after this treatment.

How can I avoid becoming pregnant again?
Start using a modern family planning method right away.

Which method can I use right away?
Discuss all available methods with your provider (include your partner, if you wish) to decide which methods may be right for you. If you are otherwise healthy and free of infection, the family planning methods that are safe immediately after incomplete abortion include:

- Condoms
- Oral contraceptives ('the pill")
- Injectables
- Implants
- Diaphragm or cervical cap
- IUD
- Male or female voluntary surgical contraception

Note: Only condoms and abstinence provide protection against STIs and HIV. For this reason, it is advisable to use condoms with all other methods to protect against both pregnancy and STIs (dual method use).

I had a miscarriage and want to become pregnant again soon—which methods are right for me?
In order to give your body the rest it needs and to make sure the next pregnancy is healthy, it is strongly recommended that you wait at least 6 months before becoming pregnant again. You can use any temporary or long-acting method to space your pregnancies and help reduce the risk of repeat miscarriage. However, with some methods there may be a delay in the return of fertility once you stop using them, so you may want to take that into consideration when selecting your method and/or when timing your next pregnancy. Short-acting temporary methods include barrier methods, pills and injectables. Long-acting methods that can be used include implants and the IUD.

The GATHER Method of Counseling

Counseling about family planning and other reproductive health matters often has six elements. You can remember the six elements with the letters in the English word GATHER. Or you can find words in other languages to help you remember.

Remember that all PAC counseling should suit each client. Not all clients need to be counseled in this order and not all clients need all six GATHER elements. Some will need an element repeated. Counseling should change to fit the client's needs.

Counseling often has six elements or steps. Each letter in the word GATHER stands for one of these elements. Effective counseling, however, is more than covering the GATHER elements. A skilled counselor also understands the client's feelings and needs. With this understanding, the counselor adapts counseling to suit each client.

G — Greet (Greet clients)

- Give clients your full attention as soon as you meet them.
- Be polite, friendly and respectful: greet clients, introduce yourself and offer them seats.
- Ask how you can help.
- Tell clients that you will not tell others what they say.
- Explain what will happen during the visit.
- Conduct counseling where no one else can hear.

A — Ask (Ask clients about themselves)

- Ask clients about their reasons for coming.
- Help clients decide what decisions they face.
- Help clients express their feelings, needs, wants and any doubts, concerns or questions.
- Ask clients about their experience with the reproductive health matter that concerns them.
- Keep questions open, simple and brief. Look at your client as you speak.
- Ask clients what they want to do.
- Listen actively to what the client says. Follow where the client leads the discussion.
- Show your interest and understanding at all times. Express empathy. Avoid judgments and opinions.
- Ask for any information needed to complete client records.

T — Tell (Tell clients about their options)

- Help clients understand their possible options.
- Information should be tailored—that is, important to the client's decision.
- Information should be personalized—that is, put in terms of the client's own life.
- If clients are choosing a family planning method:

- Ask which methods interest them. Clients should get the methods they want if available and no medical reason prevents it.
- Ask what they know about these methods. (If a client has important information wrong, gently correct the mistake.)
- Briefly describe the client's preferred method. Be sure to talk about:
  - Effectiveness as commonly used,
  - Briefly, how to use the method,
  - Characteristics, including possible side effects and complications, and
  - Danger or caution signs.
- Use samples and other audiovisual materials if possible.
- Mention other available methods that the client might want to use now or later.
- Explain that condoms are the only family planning method that offers reliable protection against STIs.

H — Help (Help clients choose)

- Tell clients that the choice is theirs. Offer advice, but avoid making the clients' decisions for them.
- To help clients choose, ask them to think about their plans and family situations.
- Help clients think about the results of each possible choice.
- Ask what the client's partner might want.
- Ask if the client wants anything made clearer. Reword and repeat information as needed.
- Explain that some family planning methods may not be safe for clients with certain medical conditions. Once a client makes a choice, ask about these conditions or perform clinical exam if necessary and share the results with the client. If a method would not be safe, clearly explain why. Then help the client choose another method.
- Check whether the client has made a clear decision. Specifically ask, "What have you decided to do?" Wait for the client to answer.

E — Explain (Explain what to do)

- After the client has made a choice:
  - Give supplies, if appropriate.
  - If the method or services cannot be given at once, tell the client how, when and where they will be provided.
  - For voluntary sterilization, the client may have to sign a consent form. The form says that the client wants the method, has been given information about it and understands that information. Help the client understand the consent form before signing.

- Explain how to use the method or follow other instructions. As much as possible, show how and have the client return the demonstration to confirm understanding.
- Describe possible side effects and what to do if they occur.
- Explain when to come back for routine follow-up or more supplies, if needed.
- Explain any medical reasons to return.
- Ask the client to repeat instructions. Make sure the client remembers and understands.
- If possible, give the client printed material to take home.
- Tell clients to come back whenever they wish, if they develop side effects or danger signs for their method, or if there are medical reasons to return.

R — Return (Return for follow-up)

- At a follow-up visit:
  - Ask if the client has any questions or anything to discuss. Treat all concerns seriously.
  - Ask if the client is satisfied. Have there been problems?
  - Help the client handle any problems.
  - Ask if any health problems have come up since the last visit. Check if these problems make it better to choose another method or treatment. Refer clients who need care for health problems.
  - Check if the client is using the method or treatment correctly.
  - Check whether the client might need STI protection now or voluntary counseling and testing for HIV.
- If a client is not satisfied with a temporary family planning method, ask if she or he wants to try another method. Help the client choose another method, and explain how to use it. Remember—changing methods is normal. No one really can decide on a method without trying it. Also, a person's situation can change, making another method a better choice.
- If a woman wants her IUD or implants taken out, arrange for this. If she plans pregnancy, suggest where to get prenatal care and VCT to prevent possible mother-to-child transmission of HIV.

The REDI Model of Family Planning Counseling

The REDI framework was initially developed to avoid losing family planning content during counseling when integrating with other services (such as HIV/AIDS). The four main components are:

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

The REDI framework is suitable for sexual-reproductive health/PAC counseling in the following ways: it emphasizes the client's responsibility for making a decision and for carrying it out; it provides guidelines for considering the client's sexual relationship(s) and social context; and it addresses the challenges that a client may face in carrying out this decision and offers skills development to help clients meet these challenges.

A crucial point to remember about counseling models is that the client is more important than the framework. Frameworks can be helpful to providers in giving you a structure for talking with the client so that you do not miss critical steps. Too often, though, the provider may focus more on following the steps than on responding to what the client is saying. The most important aspect of counseling is to figure out first what the client needs and then how to help him or her meet those needs.

REDI provides a useful framework, but that does not mean it must be followed exactly or in sequential order during a counseling session. REDI is merely a suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client's needs, desires and method eligibility.

REDI Framework (Short Version)

Phase 1: Rapport-Building	**Phase 3: Decision-Making**
• Welcome the client	• Identify what decisions the client needs to make in this session
• Make introductions	• Identify the client's options for each decision
• Introduce the subject of sexuality	• Weigh the benefits, disadvantages and consequences for each action
• Assure confidentiality	• Assist the client to make her own realistic decisions
Phase 2: Exploration	**Phase 4: Implementing the Decision**
• Explore the client's needs, risks, sexual life, social context and circumstances and reproductive intentions/desires	• Make a concrete, specific plan for carrying out the decision
• Assess the client's knowledge and give information as needed	• Identify skills that the client will need to carry out the decision
• Assist the client to perceive or determine her own pregnancy or HIV/STI risk	• Practice skills as needed with the provider's help
	• Make a plan for follow-up

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds).1995. *Postabortion Care: A Reference Manual for Improving Quality of Care*. Postabortion Care Consortium.

Family Planning Counseling and Provision, STI Evaluation and Treatment, and HIV Counseling and/or Testing

STI and HIV Service Provision

Summary

This chapter provides an overview for PAC providers about STI evaluation, treatment using the syndromic approach and referral. The section on HIV/AIDS focuses on information for counseling and referral to appropriate services for testing, care and treatment.

Acknowledgment: Much of the information in this session (and related appendices) was adapted or used directly from EngenderHealth's *Sexually Transmitted Infections* Online Minicourse (EngenderHealth 2005), the World Health Organization's *Guidelines for the Management of Sexually Transmitted Infections* (WHO 2003) and *Sexually Transmitted and Other Reproductive Tract Infections* (WHO 2005).

Session Objectives

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

1. Describe the symptoms and complications of common STIs and HIV/AIDS
2. List the essential information that all postabortion clients must have about STIs before they leave the health facility
3. Explain how to evaluate, treat and follow up clients with STIs using the syndromic approach
4. Provide counseling within the context of STI/HIV risk

HANDOUT: SYNDROMIC APPROACH IN STI MANAGEMENT

Rationale

- Providers lack time and resources to diagnose and treat in the conventional way.
- Providers lack equipment or skills to diagnose STIs using laboratory tests:
  - Lab tests or reagents may be unavailable.
  - Clients need relief of symptoms immediately or may not return for test results or treatment.
  - Diagnoses based on clinical judgment can be inaccurate or incorrect.

Success Depends On

- A reliable drug supply
- Referral clinics
- A structure to support STI services in primary health centers
- Epidemiologic surveillance to identify the most cost effective antibiotics
- Condoms readily and cheaply available and promoted to the public
- Mass media communication to alert people to STIs, encourage them to seek treatment, promote condoms and support mutual monogamy
- Contact tracing and treatment
- National standardized treatment protocols for STIs based on international guidelines including syndromic approach (that help to ensure adequate treatment at all levels, facilitate training and supervision)

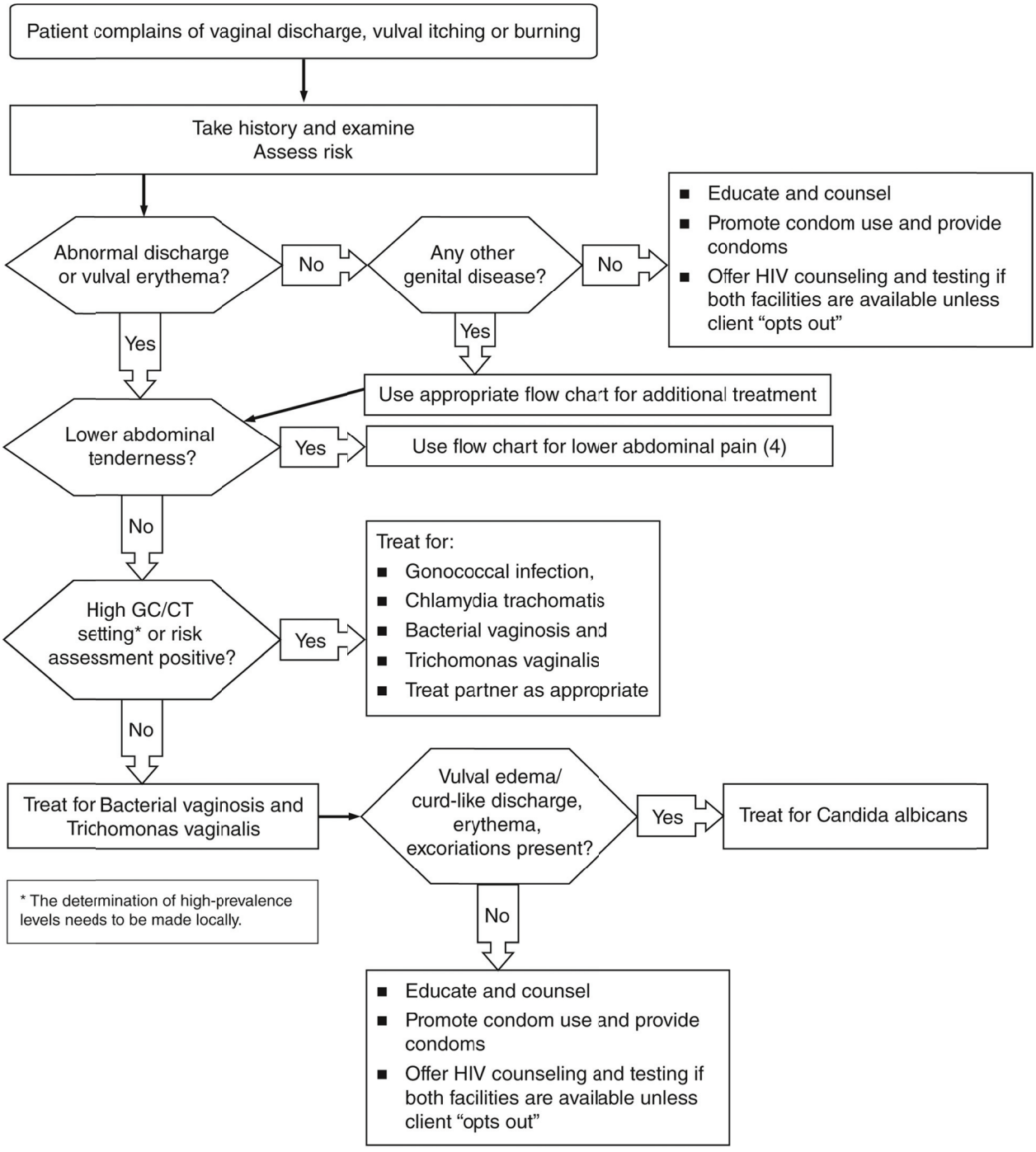
Advantages of Syndromic STI Management

- Improves clinical diagnosis by avoiding wrong diagnosis and ineffective treatment
- Can be learned by a variety of providers including primary health workers, clinical officers, medical assistants, nurses or midwives
- Allows treatment of symptomatic clients in one visit
- Effective for urethral discharge in men and genital ulcers

Disadvantages of Syndromic STI Management

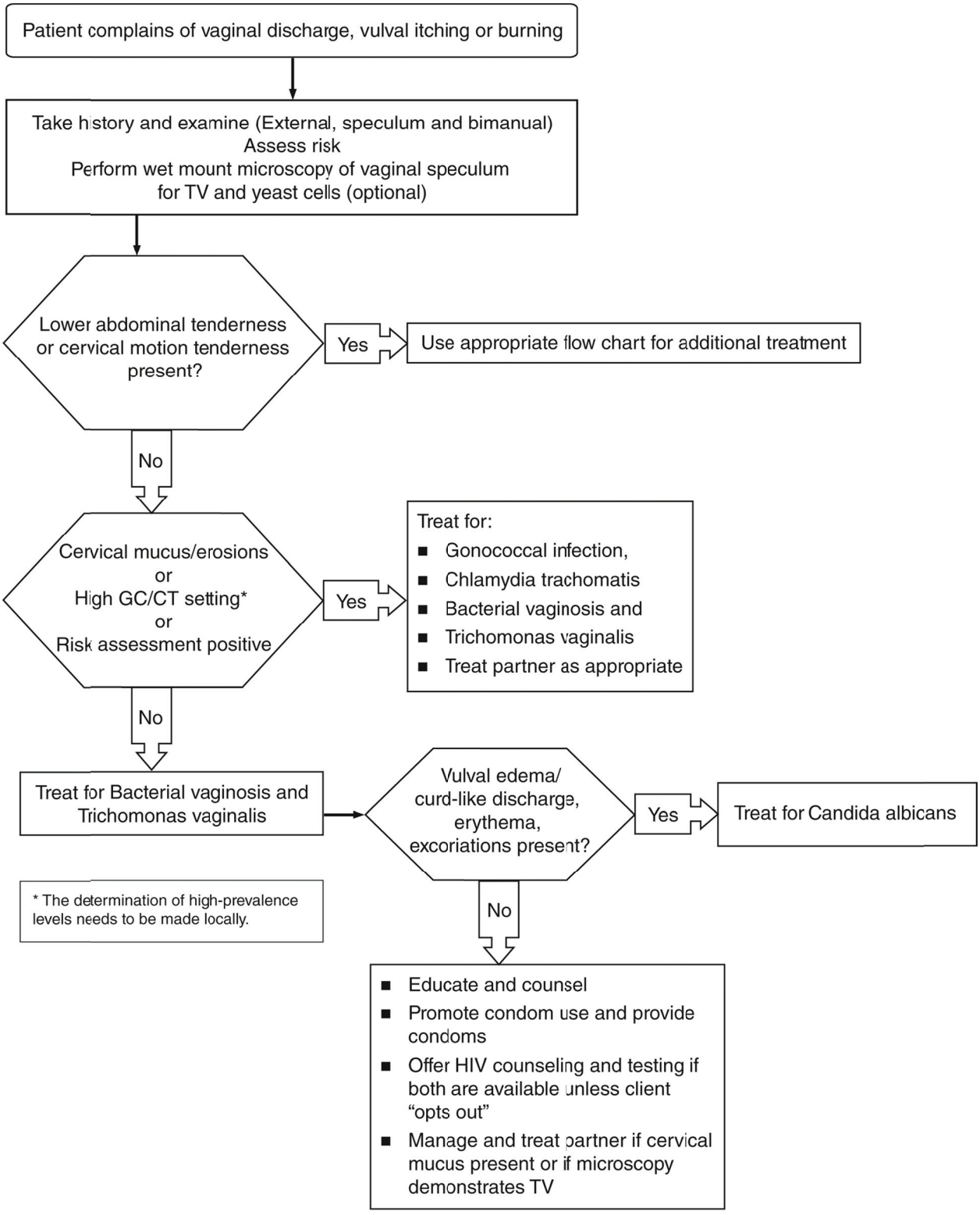
- Not adequately treating those with no symptoms
- Women take up to 2 weeks to show symptoms
- Wasting of drugs, which are often scarce in developing countries
- Works well for vaginal infections, but not designed to detect the more serious and often asymptomatic cervical infections
- Potential for over-treatment:
  - Clients are treated for multiple infections, although some will have no infection or only one. This is costly in terms of unnecessary drug use and the potential for microorganisms to develop resistance to antimicrobial drugs

Syndromic STI Management: Flow Chart 1: Vaginal Discharge



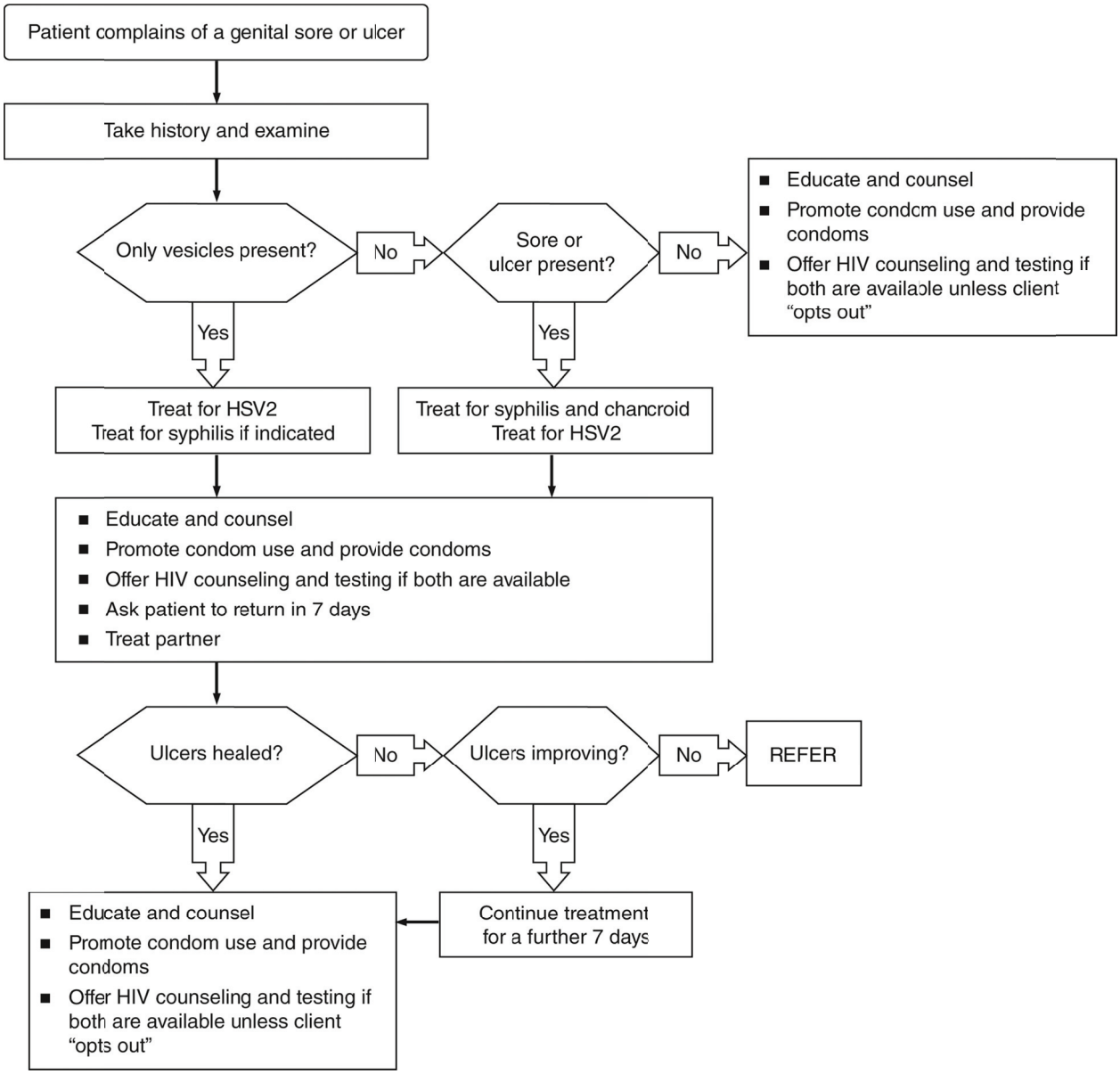
Source: World Health Organization (WHO). 2003. *Guidelines for the Management of Sexually Transmitted Infections*. WHO: Geneva.

Syndromic STS Management: Flow Chart 2: Vaginal Discharge: Bimanual and Speculum With or Without Microscope



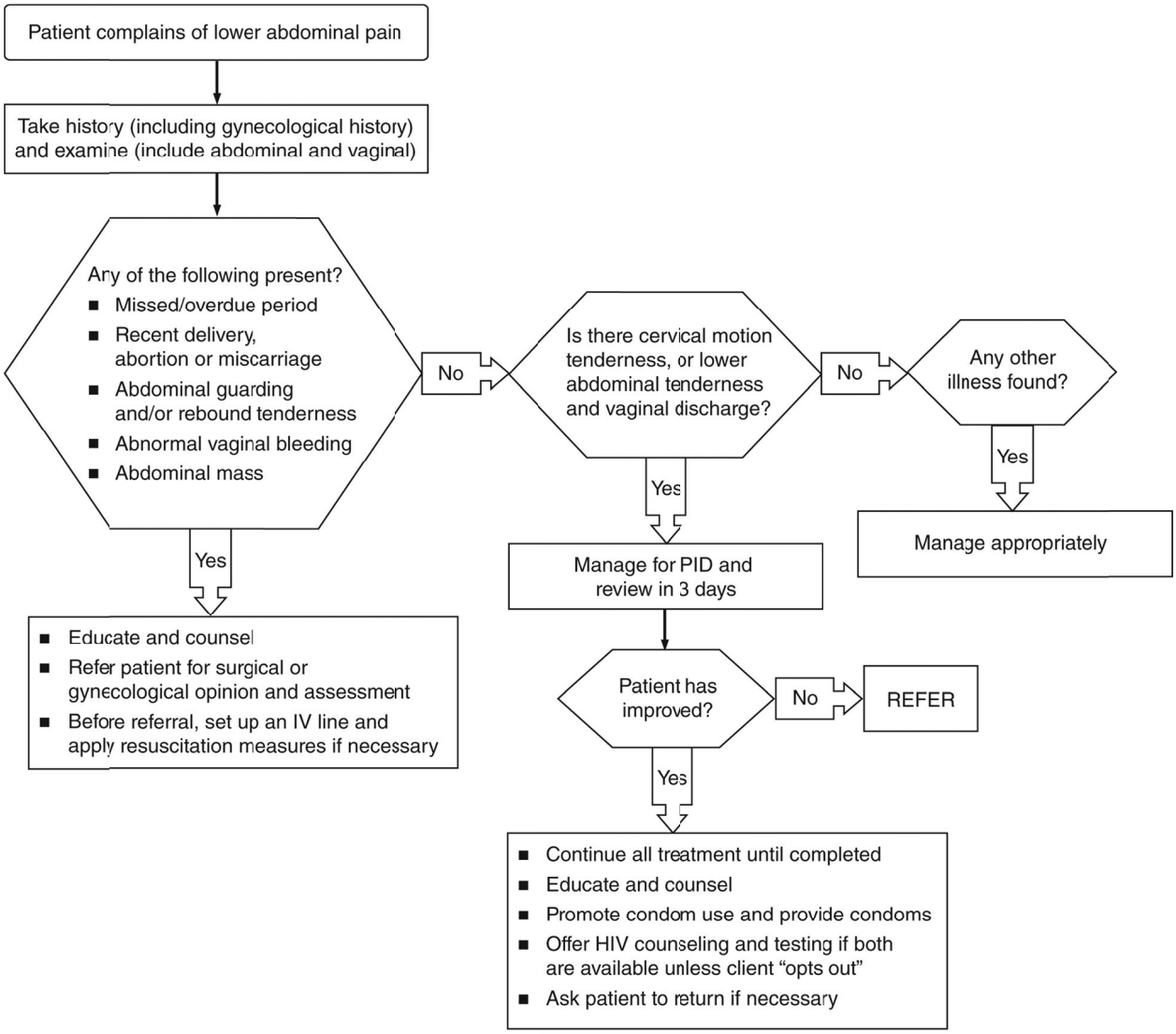
Source: World Health Organization (WHO). 2003. *Guidelines for the Management of Sexually Transmitted Infections*. WHO: Geneva.

Syndromic STI Management: Flow Chart 3: Genital Ulcers



Source: World Health Organization (WHO). 2003. *Guidelines for the Management of Sexually Transmitted Infections*. WHO: Geneva.

Syndromic STI Management: Flow Chart 4: Lower Abdominal Pain



Source: World Health Organization (WHO). 2003. *Guidelines for the Management of Sexually Transmitted Infections*. WHO: Geneva.

HANDOUT: STIS AND ADOLESCENTS

Generally, youth have higher rate of STIs than older adults do. The many reasons for this include:

- Young people tend to have more partners and shorter relationships so there is more opportunity for STIs to spread.
- They may find it difficult or embarrassing to use condoms.
- They may find it difficult to refuse sex in some situations (within the family or in exchange for goods such as school supplies, food or clothes).
- They may not recognize situations and sexual partners where risk of infection is high.
- They may lack knowledge about the symptoms of STIs and when to seek care.
- They may feel uncomfortable about using family planning or other reproductive health services for fear of critical and judgmental responses from staff.
- They may not be aware of places to go for private and confidential services.
- They may be unable to afford health services.

Safer behaviors that should be encouraged for young people include:

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

Source: World Health Organization (WHO). 2005. *Sexually Transmitted and Other Reproductive Tract Infections*. WHO: Geneva.

HANDOUT: COUNSELING THE CLIENT ABOUT SEXUALITY AND STI/HIV RISK—GETTING STARTED

Adapted from: EngenderHealth. 2003. *Counseling the Postabortion Client: A Training Curriculum.* EngenderHealth: New York.

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

Getting Started

It is best to get the conversation started with general, open-ended questions. Asking open-ended questions, such as about a client's reasons for coming to the service site or about her general health will help pave the way for the more sensitive questions you will ask. Later, you can probe with more explicit questions to obtain specific information. You may introduce the discussion in your own way, depending on the setting, the client and the type of service she seeks or needs.

Examples

- Assure the client that the questions are routine and that everyone is asked the same questions. For example:
  - "I am going to ask some very personal questions now. We ask these questions of everyone because we believe that a person's sexual life is an important part of health."
- Assure the client that the questions will have a direct bearing on her health care and the decisions made during the visit:
  - "It is important for me to ask you these types of questions so that I can help you to make health decisions that are right for you."
- Be sure that she feels comfortable:
  - "If there are any questions you do not feel comfortable answering, feel free to let me know."
- Introduce the questions within the context of STI/HIV risk:
  - "As you may know, HIV and other sexually transmitted infections occur a lot in this area. I would like to talk with you more about your situation so that we can determine if you might be at risk. We discuss this with all of our clients to make sure everyone gets the information and family planning method that best meets their needs. I will need to ask you some very personal questions, but I'm asking these questions so I will know how best to help you."

General Questions

- Here are some very general questions to get the conversation started. You may use one or more of these as appropriate:

- Can you tell me about your husband, sexual partner or partners?
- Are you happy with your sex life? Why or why not? Do you talk with your partner about it?
- Tell me about your first sexual experience (this is especially important for adolescents).

Getting Specific

More pointed questions can often be integrated into a discussion of medical history, demographics or risk factors pertinent to the service being provided. If the information does not emerge through general discussion, ask probing questions on HIV and STI risk, family planning or other relevant issues.

Probing: Asking Specific Questions

This list of issues is not to be used as a checklist; it is merely a guide to help you remember the key issues when obtaining a sexual history. Questions about a client's sexual life, sexual practices, sexual risks and social context should be worked into a two-way conversation about her individual situation.

HIV/STI Risk

- During the discussion, try to obtain information about key issues so you can assist the client to perceive and determine her risk for STIs, including:
  - Number (and gender) of current and past sexual partners
  - Knowledge of her partner's sexual practices
  - Condom use
  - History of STIs, RTIs and other related infections
  - Sexual practices and behaviors

Family Planning Concerns

- In addition to obtaining information about contraceptive history and needs, reproductive intentions and potential contraindications, explore factors associated with sexuality that may affect contraceptive choice and continuation, including:
  - Fear of becoming pregnancy or fear of disease
  - Concerns about the negative impact of the method on sexual pleasure
  - Diminished sexual response due to the use of hormonal methods
  - HIV and STI risk (see above)

Other Possible Issues

- Past surgery or diseases related to sexual functioning
- Sexual concerns with the onset of menopause
- Sexual dysfunction in the client or her partner
- Pain during sex

- Lack of desire, orgasm or sexual satisfaction
- Insufficient lubrication
- Age at first intercourse
- Experience of recent or past sexual coercion or violence
- Impact of drug or alcohol use on sexual activity and risks
- Partner's use of, support for and communication about contraceptive use or disease prevention

HANDOUT: COUNSELING THE CLIENT ABOUT SEXUALITY AND STI/HIV RISK: SAMPLE QUESTIONS

Adapted from: EngenderHealth. 2003. *Counseling the Postabortion Client: A Training Curriculum,* citing EngenderHealth 2001. *Sexuality and Sexual Health Online Minicourse.*

The following are some of the questions you may use in discussion or counseling about STIs/HIV. Choose or adapt questions as needed. Avoid those questions that are not culturally or socially appropriate in your setting. Some questions may not be appropriate or needed in an emergency PAC or individual client situation.

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

HANDOUT: STEPS IN THE MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

See "Counseling the Client about Sexuality and STI/HIV Risk: Sample Questions" for specific questions to ask.

History Taking

Careful Abdominal and Pelvic Examinations

When doing the abdominal and pelvic exams for the PAC visit (initial PAC assessment or follow-up visit), pay close attention to the following:

- Presence of:
  - Lower abdominal pain or tenderness;
  - Genital ulcers, sores or swellings (buboes) in the groin;
  - Presence of a purulent (containing muco-purulent) discharge, friable (easily bleeds) cervix or unrecognized vaginal discharge;
  - Pain or tenderness on cervical motion; and
  - Suprapubic, adnexa or pelvic mass.

Use of Appropriate STI Treatment Flow Charts

Vaginal Discharge
Figure 3.2.1: Syndromic STI Management: Flow Chart 1: Vaginal Discharge

Vaginal Discharge: Bimanual and Speculum
Figure 3.2.2: Syndromic STS Management: Flow Chart 2: Vaginal Discharge: Bimanual and Speculum With or Without Microscope

Genital Ulcers
Figure 3.2.3: Syndromic STI Management: Flow Chart 3: Genital Ulcers

Lower Abdominal Pain
Figure 3.2.4: Syndromic STI Management: Flow Chart 4: Lower Abdominal Pain

Use of the 4 C's:

1. Compliance
2. Condoms
3. Counseling/Education
4. Contact Tracing

1. Compliance

Once clients understand the information regarding their care, they play an important part in making decisions about that care and in completing the agreed-upon treatment, including follow-up care.

Provider and Client Roles in Compliance

Provider	Client
Give clear simple instructions regarding any drugs or treatment in a language the client understands.	Take all drugs for the full time prescribed and in the right dosage.
Emphasize importance of keeping to the course of treatment.	Complete the course of treatment prescribed.
Explain side effects and any danger signs associated with the treatment and the appropriate response.	Be aware of danger signs and seek care accordingly.
Encourage the client to ask questions. Be sure the client demonstrates understanding of information given. Ask the client to repeat information.	Ask questions to be sure you understand the treatment.
Schedule follow-up appointment.	Keep follow-up appointments.

2. Condoms

As well as prevent pregnancy, condoms can prevent the spread of STIs and HIV if used properly. It is important to feel comfortable talking about condoms and showing how they are used. Get the help of a male co-worker, if needed, to discuss and demonstrate the correct use of condoms to clients. During the demonstration, show the client how to:

a) Ensure that the condom is not expired

b) Ensure that the package/condom is not punctured

c) Properly open the package

d) Pinch the tip to remove residual air and create a reservoir for semen

e) Properly roll the condom on the erect penis

f) Safely remove the condom without self-contamination

g) Safely dispose of the used condom

3. Counseling/Education

Counseling includes giving health education messages. Listening to what clients say and how they say it can help you to give them the information they need. Although each encounter with a client is short, it is important to inform every client of the risks of HIV/AIDS. See the sections "STIs and Adolescents," "HIV Counseling and Referral" and "Basic Facts about HIV Infection and AIDS" to guide your counseling of clients about STIs and HIV.

4. Contact Tracing

Contact tracing first requires a good rapport between the provider and the client. Clients need to understand the importance of advising their partners about the risk and encouraging them to seek treatment. Known contacts should be treated for the STI even if they have no symptoms. Help clients think about how they will discuss the issue with their partners. This can be a very difficult task for some women and they may fear stigma or physical abuse. Providers can increase the number of contacts who come for treatment by giving clients appointments for their contacts and offering to discuss the risk with them and their contacts.

HANDOUT: HIV COUNSELING AND REFERRAL

HIV prevention counseling should focus on the client's own unique circumstances and risk and should help the client set and reach an explicit behavior-change goal to reduce the chance of acquiring or transmitting HIV. HIV counseling is usually, but not always, conducted in the context of HIV testing. The main role of the PAC provider is to provide HIV/AIDS information and prevention counseling to all PAC clients (as appropriate) and refer to other services for testing and treatment unless the client "opts out." The provider should be familiar with facilities that offer these other services and related information such as cost. During HIV counseling for PAC clients, providers should:

- Explain HIV and AIDS and the ways HIV is spread
- Discuss ways to prevent the spread of HIV
- Offer specific information on how to access testing and/or treatment

Detailed information on testing methods will be a part of the pre-test counseling at the test site. Post-test counseling provides the client with notification of the HIV test results, deals with the client's reaction to the test results and individualized information related to those results. It is critical to counsel clients about HIV in a nonjudgmental way. Imposing guilt or voicing disapproval rarely helps people deal responsibly with HIV or any STI. Help clients learn how to prevent transmission to others and to protect themselves from other future infections. See sections on "Counseling the Client about Sexuality and STI/HIV Risk: Getting Started," "Sample Questions," and "STIs and Adolescents." The following section outlines basic information about HIV/AIDS that will be useful in providing counseling and health messages to PAC clients.

HANDOUT: BASIC FACTS ABOUT HIV INFECTION AND AIDS

What Is HIV?

The human immunodeficiency virus (HIV) is the virus that causes AIDS.

H: Human
I: Immunodeficiency
V: Virus

- The HIV virus is found in the body fluids (particularly blood, semen and vaginal secretions) of infected persons.
- HIV breaks down the body's defenses against infection and disease—the body's immune system—**by destroying specific white blood cells (CD4 cells) and weakening the immune system**.
- When the immune system becomes weak or compromised, the body loses its protection against illness.
- HIV infection is for life. Although there are life-prolonging drugs, *there is no cure.*
- As time passes, the immune system is unable to fight the HIV infection and the person may develop serious and deadly diseases, including other infections and some types of cancer.

Types of HIV

HIV-1 and HIV-2 are types of HIV. Both types are transmitted the same way, and both are associated with similar opportunistic infections and AIDS. HIV-1 is more common worldwide. HIV-2 is found predominantly in West Africa, Angola and Mozambique.

Differences between HIV-1 and HIV-2

HIV-2 is less easily transmitted than is HIV-1, and it is less pathogenic, meaning that the period between initial infection and illness is longer. In some areas, a person may be infected with both HIV-1 and HIV-2. While HIV-2 can be transmitted from an infected mother to her child, this appears to be rare (0% to 5% transmission rate in breastfed infants in the absence of any interventions).

What Is AIDS?

AIDS is an acronym for *acquired immunodeficiency syndrome* and refers to the most advanced stage of HIV infection.

A: Acquired—(not inherited) to differentiate from a genetic or inherited condition that causes immune dysfunction
I: Immuno—the immune system
D: Deficiency—inability to protect against illness
S: Syndrome—a group of symptoms or illnesses that result from the HIV infection

Almost all people who are HIV-positive will ultimately develop HIV-related disease and AIDS, the end stage of HIV infection. As HIV infection progresses, the infected person becomes susceptible to opportunistic infections.

An *opportunistic infection (OI)* is an illness caused by a germ that might not cause illness in a healthy person, but will cause illness in a person who has a weakened immune system. For example, co-infection with tuberculosis (TB) is very common in people infected with HIV.

People living with advanced HIV infection suffer from opportunistic infections of the lung, brain, eyes and other organs. Other common opportunistic infections in persons diagnosed with AIDS are *pneumocystis carinii* pneumonia (PCP); cryptosporidiosis; histoplasmosis; other parasitic, viral and fungal infections; and some types of cancers, such as Kaposi's sarcoma.

Differences between HIV, HIV Infection and AIDS

- HIV is the virus that causes infection.
- The person who is HIV-infected may have no signs of illness but can still infect others.
- Most people who are HIV-infected will develop AIDS after a period of time, which may be several months to more than 15 years.
- AIDS is a group of serious illnesses and opportunistic infections that develop after a person has been infected with HIV for a long period of time.
- A diagnosis of AIDS is based on specific clinical criteria and laboratory test results.
- The CD4 count and viral load are two measures of the progression of HIV:
  - CD4 count is the number of CD4 T-lymphocyte cells in the blood. CD4 cells are the type of white blood cell that is the immune system's key infection fighter. The CD4 count reflects the "health" of the immune system.
  - Viral load refers to the amount of HIV in the blood. The viral load can be measured by PCR testing. The test can be used to check the person's response to antiretroviral (ARV) therapy.

- When HIV actively multiplies, it infects and kills CD4 cells. The CD4 count is usually expressed as the number of cells per cubic millimeter. The normal CD4 count in a healthy adult is between 500 and 1,400 cells/mm^3. As the CD4 count of an adult falls below 200 cells/mm^3, the risk of opportunistic and serious HIV-related infections becomes higher. The viral load is very high shortly after the person first becomes infected with HIV. A high viral load leads to a higher transmission risk. Viral load falls steeply when the body develops antibodies to HIV and rises again after a number of years as the immune system weakens and CD4 count drops. A high viral load can also be a sign of more severe disease progression.
- People infected with HIV usually develop antibodies 4–6 weeks after becoming infected, but it may take as long as 3 months for antibodies to develop. The period of time between infection with HIV and testing positive for HIV is called the "window period." Some people experience a

flu-like illness (fever, rash, joint pains and enlarged lymph nodes) at the time of seroconversion. This is referred to as Acute Retroviral Syndrome (ARS).

- The terms HIV-positive or HIV-negative are used to describe the HIV status of someone who has been tested:
  - A person whose blood test result is HIV-positive has been infected by HIV; this person is said to be seropositive, HIV-positive or HIV-infected.
  - A person whose blood test result is HIV-negative is said to be seronegative, HIV-negative or not infected with HIV. If a person with an HIV-negative test result has engaged in behavior that places him or her at risk for HIV in the past three months, then the HIV-negative test result may not be an accurate indication of the person's HIV status because the person might be in the window period and should be re-tested.

Asymptomatic HIV Infection

- A person who is HIV-infected but looks and feels healthy is asymptomatic. None of the physical signs or symptoms that indicate HIV infection is present. Whether they have symptoms or not, people who are HIV-infected can still pass the virus to others. The duration of the asymptomatic phase varies greatly from person to person. Some adults may develop symptoms of HIV as quickly as a few months after primary infection; others may take up to 15 years to develop symptoms.

Symptomatic HIV Infection

- A person who has developed physical signs of HIV and reports symptoms related to HIV is symptomatic. The immune system weakens and CD4 count decreases during this phase. The progression of HIV depends on the type of virus and specific host characteristics including general health, nutritional and immune status.

AIDS

- Almost all people who are HIV-infected will ultimately develop advanced HIV infection and AIDS, the end stage of HIV infection. As HIV infection progresses, the CD4 count continues to decrease and the infected person becomes more likely to develop OIs and other HIV-related infections.

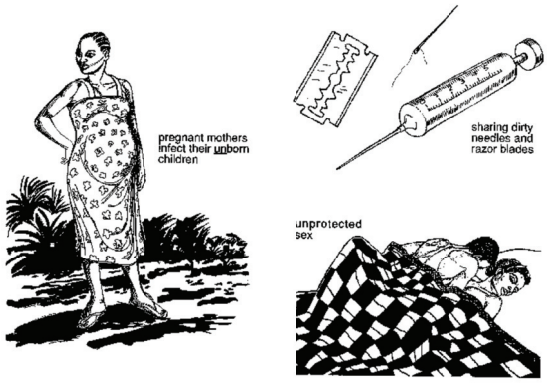
- Even if the symptoms of AIDS develop and then subside for a while, the virus that causes them is still present, and the infected person can still transmit the disease.

How Is HIV Contracted?

HIV is contracted:

- Through sexual contact (vaginal, anal or oral intercourse) with an infected person, during which semen or vaginal fluids and sometimes blood come into contact with the penis, the lining of the

vagina, the rectum or the mouth. HIV in these fluids can then get into the blood stream. HIV can enter the blood through open genital or oral sores, or cuts.



- Through transfusions or treatments with infected blood products.
- Through skin-piercing instruments that have been in contact with infected blood or body fluids and have not been properly disinfected (for example, needles, syringes, razor blades and instruments used to provoke an abortion, or circumcision instruments used previously on another client who was HIV-positive).
- In infants, from an infected mother during pregnancy or childbirth. If the mother is infected with HIV, there appears to be a 15–30% chance that the newborn child will be infected. According to recent evidence, a breastfeeding child may have a higher risk of HIV infection through breast milk if the child's mother becomes infected with HIV while she is breastfeeding. However, the child's risk of HIV infection must be weighed against the risk of the child dying from other causes if it is not breastfed. Diarrheal disease, which can be fatal, is often attributed to the use of contaminated water and food in place of breastfeeding. If a woman is HIV-positive, or suspects that she is, and wishes to breastfeed, encourage her to consult a skilled provider for up-to-date information and counseling.

How Is HIV NOT Contracted?

- HIV is not contracted through any of the following:
  - Ordinary social contact
  - Sharing clothes
  - Touching or sharing food or dishes
  - Kissing, hugging or shaking hands
  - Toilet seats
  - Insect bites
  - Tears
  - Saliva
  - Sweat
  - Living with an infected person

What Are the Symptoms of HIV Infection and AIDS?

- Persons infected with HIV may be asymptomatic. It can take 8 years or more between HIV infection and the diagnosis of AIDS. Once symptoms begin to develop, they may include:
- An unexplained 10% loss of body weight within 1 month
- Diarrhea for 1 month or more
- A white coating on the tongue
- Enlarged or sore glands in the neck and/or armpit
- A cough that persists for more than 1 month
- Persistent fever of unknown origin
- Persistent symptoms of vaginitis

Since these symptoms characterize other diseases (a persistent cough may be a symptom of tuberculosis; diarrhea may indicate an intestinal illness), a blood test must be done to confirm the presence of HIV.

COUNSELING ADOLESCENTS ON HIV PREVENTION

Goals:
- Change health behavior
- Nurture leadership skills
- Link information to services
- Help adolescents to be proactive
- Foster responsible decision-making, for example:
  - Abstaining from sex before marriage
  - Using condoms
  - Resisting peer pressure

Special Counseling Tips:
- Encourage and praise behavior that lessens the risk of infection.
- Assist the client in finding alternatives to high-risk behavior.
- Be nonjudgmental.
- Explain risks and dispel myths in an objective manner.

HIV-positive persons, especially those who have not yet developed AIDS, normally look as healthy as any other person does. A fat person can be HIV-positive and will pass on the virus before she/he becomes thin.

Who Is at Risk?

- Anyone can become infected with HIV, but only through the means described above. Clients who are at high-risk include:
  - Commercial sex workers
  - Persons who have multiple sexual partners or whose sexual partners have had sexual relations with others
  - Users of intravenous drugs
  - Persons who have received unscreened blood products
  - Health care workers who have direct contact with infected blood

Can HIV Infection and AIDS Be Prevented?

- Strategies to promote HIV prevention include:
  - Blood-to-blood transmission
  - Screening of all blood and blood products for HIV.
  - Following universal precautions, which include:

- Use of protective equipment
- Safe use and disposal of sharps
- Sterilization of equipment
- Safe disposal of contaminated waste products

Sexual Contact

- Promote abstinence or being faithful to one uninfected partner.
- Provide instruction on the consistent and correct use of barrier methods:
  - Male or female condoms for vaginal intercourse
  - Non-lubricated condoms for oral intercourse on a male
  - Dental dams, plastic wrap or latex panties for oral intercourse on a female
  - Condoms for anal intercourse
- Prevent, identify and provide early treatment for STIs.
- Provide access to HIV testing and counseling.

Condoms provide protection from HIV transmission, as well as other STIs when used correctly and consistently.

Drug Use

- Educate about the risks of infection through drug use with contaminated needles and syringes.
- Provide referral for treatment of drug dependence.

Can HIV Be Treated?

Though there is no known cure, several different types of drugs exist to treat HIV infection. These drugs attack various aspects of the process used by the virus to replicate itself. Because HIV quickly mutates to become resistant to any single drug, patients must take a combination of drugs to achieve maximum suppression of HIV.

Combination anti-HIV therapy is known as antiretroviral therapy, or ART. ART changes the natural course of HIV infection, significantly extending the period between initial infection and the development of symptoms. To achieve these results, it is important to start therapy before AIDS symptoms develop. However, even patients who start on therapy after being diagnosed with AIDS often receive major and long-lasting health benefits. Although effective in slowing the progression of HIV-related disease, ART is not a cure.

In addition to treatments for HIV infection itself, therapies exist to prevent and/or treat many HIV-related opportunistic infections.

Choice of Contraceptive Methods for Clients with a History of STI and/or HIV/AIDS

It is critical to emphasize dual-method protection for all clients to protect against both STIs and pregnancy. This means that condoms should be used with all methods. When condoms are the primary method, a spermicide should also be used at all times. A woman with chlamydia, gonorrhea, purulent cervicitis or PID should not have an IUD inserted until the infection is resolved. A woman at **very high** risk of STIs should use an IUD only if no more appropriate contraceptive method is available or acceptable to her; if she does decide to have an IUD inserted, she should then use condoms as well.

Infection Prevention and Processing MVA Equipment for Re-Use

Summary

Infection prevention is of critical importance in minimizing risk to clients, health care workers and the community while providing health services. In this module, participants will be introduced to infection prevention procedures, including a review of standard precautions, the no-touch technique, glove use and the use of barriers. There is also a section on how to clean and disinfect instruments and other materials for re-use.

Note that several programs are using MVA equipment that can be autoclaved. If this is the case, adapt the content of this session accordingly.

Session Objectives

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

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

INFECTION PREVENTION CASE STUDIES[5]

Case Study 4.1.1

When sisters Marie and Nathalie were hired to clean a local maternity hospital, they were only told to clean the floors of the hospital and the operating theaters daily. Every day they sweep the floors with straw brooms and then dust and sweep the surgical theaters. If an operating theater was not used the day before, they did not bother to clean it again. No one said anything about their cleaning habits so they thought they were doing a good job. Did the sisters practice appropriate cleaning methods? Why?

Case Study 4.1.2

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

Case Study 4.1.3

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

Case Study 4.1.4

Each morning, Mr. Pierre, a technician in the operating theater of a district hospital, prepares the 0.5% chlorine solution for each of the three operating theaters. This morning, however, he decides to prepare only enough solution for two of the rooms, because yesterday no surgeries were performed

[5] *Adapted from*: EngenderHealth Infection Prevention Online Course, 2004.

in the third room, and the bucket of chlorine solution he prepared for the third room remained unused. He figures that this bucket of solution can be used today. Is he correct? Why or why not?

Case Study 4.1.5

Nurse Indira assists the surgical team of a large hospital and is responsible for cleaning the instruments and other items used during surgery. To make sure that she is always available to assist the team, Nurse Indira cleans the instruments and other items used during the prior surgery in the operating theater while the next surgery is going on. The new head nurse asks her to discontinue this practice. Why would the new head nurse ask Nurse Indira to discontinue this practice? What should be done instead?

Case Study 4.1.6

You have just drawn blood from a patient. As you are placing the used needle and syringe in the sharps box, you stick yourself on a needle that is protruding from the sharps box, which is very full. What should you do? How can you prevent this from happening again?

HANDOUT: FORMULAS FOR PREPARATION OF DILUTE CHLORINE SOLUTION

Using Liquid Bleach

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

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

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

$$\frac{\text{3.5\% chlorine bleach}}{\text{0.5\% chlorine desired}} - 1 = (7) - 1 = 1 \text{ part of bleach to 6 parts water}$$

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

Using Bleach Powder (such as calcium hypochlorite 35%)

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

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

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

$$\frac{\text{0.5\% chlorine desired}}{\text{35\% chlorine in bleach powder}} \times 1{,}000 = 0.0143 \times 1{,}000 = 14.3 \text{ grams/liter}$$

Note: When using bleach powder, the solution often looks cloudy and the smell is not as strong as it is when liquid bleach is used.

HANDOUT: RECOMMENDED DILUTIONS OF BLEACH

Brand of Bleach (country)	Percent Available Chlorine	Dilution Necessary to Achieve 0.5% Concentration (for decontamination, blood spills, soiled equipment)	Dilution Necessary to Achieve 0.1% Concentration (for high-level disinfection of cannulae)
JIK (Africa), Robin bleach (Nepal), Ajax (Jamaica)	3.5%	1 part bleach to 6 parts water, or 160 ml bleach to 1 liter water	1 part bleach to 34 parts water, or 30 ml bleach to 1 liter water
Household bleach, Clorox (USA, Canada), ACE (Turkey), Jif, Red & White (Haiti), Odex, (Jordan), Eau de Javel (France, Vietnam) (15°chlorum), Clorox (Peru)	5%	1 part bleach to 9 parts water, or 110 ml bleach to 1 liter water	1 part bleach to 49 parts water, or 20 ml bleach to 1 liter water
Blanqueador, cloro (Mexico), Hypex (Jordan)	6%	1 part bleach to 11 parts water, or 90 ml bleach to 1 liter water	1 part bleach to 59 parts water, or 17 ml bleach to 1 liter water
Lavandina (Bolivia)	8%	1 part bleach to 15 parts water, or 70 ml bleach to 1 liter water	1 part bleach to 79 parts water, or 13 ml bleach to 1 liter water
Chloros (UK), Liguria (Peru)	10%	1 part bleach to 19 parts water, or 50 ml bleach to 1 liter water	1 part bleach to 99 parts water, or 10 ml bleach to 1 liter water
Extrait de Javel (France) (48°chlorum), Chloros (UK)	15%	1 part bleach to 29 parts water, or 30 ml bleach to 1 liter water	1 part bleach to 149 parts water, or 7 ml bleach to 1 liter water

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

Adapted from: Tietjen, L., Bossemeyer, D., and McIntosh, N. 2003. Infection Prevention: *Guidelines for Healthcare Facilities with Limited Resources*. Jhpiego: Baltimore, Maryland

HANDOUT: RECOMMENDED DILUTIONS OF CHLORINE-RELEASING COMPOUNDS

Dilution is necessary when using a pre-made bleach solution, because bleach sold by commercial brands is more than 0.5% concentrated. The following chart shows how to obtain a 0.1% and a 0.5% solution from pre-made solutions.

Available Chlorine Required	0.5% Solution (e.g., for blood spills, soiled equipment, dilution made with contaminated water)	0.1% Solution[b] (e.g., for cleaning medical equipment)
Calcium hypochlorite (70% available chlorine)	7.1 g/liter[a]	1.4 g/liter
Calcium hypochlorite (35% available chlorine)	14.2 g/liter	2.8 g/liter
NaDCC[c] (60% available chlorine)	8.3 g/liter	1.5 g/liter
Chloramine **tablets**[d] (1 g of available chlorine per tablet)	20 g/liter (20 tablets/liter)[d]	4 g/liter (4 tablets/liter)[d]
NaDCC-based **tablets** (1.5 g of available chlorine per tablet)	4 tablets/liter	1 tablet/liter

[a] For dry powders, read x grams per liter (example: Calcium hypochlorite—7.1 grams mixed with 1 liter water).

[b] Use boiled water when preparing a 0.1% chlorine solution for HLD because tap water contains microscopic organic matter that inactivates chlorine.

[c] Sodium Dichloroisocyanurate.

[d] Chloramine releases chlorine at a slower rate than does hypochlorite. Before using the solution, be sure the tablet is completely dissolved.

Adapted from: Tietjen, L., Bossemeyer, D., and McIntosh, N. 2003. *Infection Prevention: Guidelines for Healthcare Facilities with Limited Resources*. Jhpiego: Baltimore, Maryland.

HANDOUT: HIGH-LEVEL DISINFECTION OF INSTRUMENTS

High-Level Disinfection of Instruments							
Equipment	**Disinfecting Agent**	**Advantages**	**Disadvantages**	**Solution Strength**	**Minimum Time Required for Disinfection**	**Steps**	**Precautions**
Cannulae	Boiling Water	Easily available; will provide HLD up to 5,500 meters (18,000 ft)		N/A	20 minutes at rolling boil	Fill large (at least 25 cm/10" diameter) pot 3/4 full with clean water; deposit instruments; cover pot; bring to boil again; boil for 20 minutes; remove items gently with HLD forceps; air-dry on a HLD tray or in a HLD container.	Grasp cannulae gently when removing from water. Grasping hot cannulae with forceps may flatten the cannulae. Do not leave cannulae in previously boiling water.
Metal Instruments and Cannulae	Glutaralde-hyde (2–4%)	Not easily inactivated by organic materials	Skin, eye respiratory irritant	Use full strength, never dilute; follow manufacturer's instructions for mixing	20 minutes	Submerge items completely, making sure solution fills cannula interior; soak; remove with HLD forceps; rinse with boiled water; air-dry on a HLD tray or in a HLD container.	Discard solution (7–28 days) after mixing or sooner if cloudy. (Follow manufacturer's instructions.)
Instruments, Cannulae and Syringes	Chlorine (0.1%)	Fast-acting, very effective against HBV and HIV	Corrosive to metal	Dilute to 0.1% for clean equipment using boiled water; 0.5% if tap water used	20 minutes	Submerge items completely in a non-metal container, making sure solution fills cannula interior; soak; remove with HLD forceps; rinse with boiled water; air-dry on a HLD tray or in a HLD container.	Change solution daily or sooner if cloudy.

High-Level Disinfection of Instruments							
Equipment	**Disinfecting Agent**	**Advantages**	**Disadvantages**	**Solution Strength**	**Minimum Time Required for Disinfection**	**Steps**	**Precautions**
Cannulae	Hydrogen Peroxide (6%)	Not easily inactivated by organic materials	Corrosive to copper, zinc, aluminum, and brass; inactivated by prolonged exposure to heat (over 30°C) or light	Mix 1 part 30% hydrogen peroxide with 4 parts boiling water to make 6% solution	30 minutes	Submerge items completely in a non-metal container, making sure solution fills cannula interior; soak; remove with HLD forceps; rinse with boiled water; air-dry on a HLD tray or in a HLD container.	Store hydrogen peroxide in opaque container away from light and heat. Change solution daily or sooner if cloudy.

HANDOUT: ANTISEPTIC EFFECTIVENESS

Group	Activity against Bacteria						Recommended Use				
	Gram-positive	Most Gram-negative	TB	Viruses	Fungi	Endospores Speed	Relative Speed of Action	Affected by Organic Matter	Surgical Scrub	Skin Preparation	Comments
Alcohol (60–90%) (Ethyl or isopropyl)	Very Good	Very Good	Good	Good	Good	None	Fast	Data Varies	Yes	Yes	Not for use on mucous membranes
Chlorhexidine (4%) (Hibitane, Hibiscrub)	Very Good	Good	Fair	Fair	Fair	None	Slow	Slight	Yes	Yes	Has good persistent effect
Hexachlor-ophene (3%) (pHisoHex)	Good	Poor	Poor	Poor	Poor	None	Slow	Slight	Yes	Yes	Rebound growth of bacteria may occur
Iodine preparations (3%) (Iodine and alcohol tincture of Iodine)	Very Good	Very Good	Good	Good	Good	Poor	Intermediate	Slight	Yes	Yes	Not for use on mucous membranes
Iodophors (1.2.500) (Betadine)	Very Good	Good	Good	Good	Good	None	Slow	Yes	Yes	Yes	Can be used on mucous membranes

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

Using the Learning Guides and Practice Checklists

The learning guides and practice checklists are designed to help the participant learn the steps or tasks involved in:

- Screening a potential client for serious complications and further evaluating her if medical problems are identified
- Talking with clients before and during the uterine evacuation procedure
- Treating complications of incomplete abortion
- Counseling a client about postaborion family planning

The practice checklists are the same as the Checklist for Postabortion Care Clinical Skills and the Checklist for Postabortion Care Family Planning Counseling Skills, which the clinical trainer will use to evaluate each participant's performance at the end of the course.

The participant 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 participant in learning the correct steps and sequence in which they should be performed (skill acquisition)
- Measure progressive learning in small steps as the participant gains confidence and skill (skill competency):
  - The clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g., video).
  - While being supervised, the participant should practice the required skills and client interactions using the model and actual instruments in a simulated setting that is as similar as possible to the real situation. The participant practices until skill competency is achieved and the individual feels confident performing the procedure.
  - **Only when skill competency has been demonstrated with models, however, should participants have their first contacts with clients.**

Used consistently, the learning guides and practice checklists enable each participant 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 participant and clinical trainer easier and more helpful. When using either learning guide, it is important that the participant and clinical trainer work together as a team. For example, before the participant attempts the skill or activity (e.g., MVA) the first time, the clinical trainer (or person rating the participant, if not the clinical trainer) should briefly review the steps involved and discuss the expected outcome. In addition, immediately after the skill or activity has been completed, the clinical trainer or rater should debrief with the participant. 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 participant'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 participant 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

Initially, participants can use the learning guides to follow the steps as the clinical trainer demonstrates the procedure or skill using a training model or role plays. Subsequently, during the classroom practice sessions, they serve as step-by-step guides for the participant as s/he performs the skill using the pelvic model, practices client support or counsels a volunteer "patient." During this phase, participants work in teams with one "service provider" participant performing the skill or activity while the other participant uses the learning guide to rate the performance or prompt the "service provider" as necessary. During this initial learning phase, clinical trainer(s) will circulate to each group of participants to oversee how the learning is progressing and check to see that the participants are following the steps outlined in the learning guides.

Using the Practice Checklists

As participants progress through the course and gain experience, dependence on the detailed learning guides decreases, and they advance to using the condensed Practice Checklist for Postabortion Clinical Skills and the Practice Checklist for Postabortion Care Family Planning Counseling Skills. These guides focus on key steps in an entire procedure.

Once participants become confident in performing a procedure using the pelvic model, they can use the practice checklist to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference before the participants begin providing services to patients.

For clinic practice sessions with patients, participants again are paired. Here, one "service provider" participant performs the procedure while the other observes and uses the practice checklist to remind the "service provider" of any missed steps. During this phase, the clinical trainer(s) is always present in the clinic to supervise the initial patient encounter for each participant. Thereafter, depending on the circumstances, s/he circulates from group to group of participants to be sure that there are no problems, coaching them as they perform the skill/activity.

Remember: It is the goal of this training that every participant perform every task or activity correctly with clients by the end of the course.

LEARNING GUIDE FOR POSTABORTION CARE *Clinical Skills*

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

1. **Needs Improvement:** Step or task is performed incorrectly or out of sequence (if sequence necessary) or is omitted
2. **Competently Performed:** Step or task is performed correctly and in proper sequence (if sequence necessary) but participant does not progress from step to step efficiently
3. **Proficiently Performed:** Step or task is performed efficiently and precisely and in the proper sequence (if sequence 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.					
6. If she is considering an IUD: • She should be fully counseled regarding IUD use. • The decision to insert the IUD following the MVA procedure will be dependent on the clinical situation.					
GETTING READY					
1. Tell the patient what is going to be done and encourage her to ask questions.					
2. Tell her she may feel discomfort during some of the steps of the procedure and you will tell her in advance.					
3. Ask about allergies to antiseptics and anesthetics.					
4. Determine that required sterile or high-level disinfected instruments are present.					
5. Make sure that the appropriate size cannulae and adapters are available.					
6. Check the MVA syringe and charge it (establish vacuum).					
7. Check that patient has recently emptied her bladder.					
8. Check that patient has thoroughly washed and rinsed her perineal area.					
9. Put on clean plastic or rubber apron. Wash hands thoroughly with soap and water and dry with clean cloth or allow them to air dry.					
10. Put new examination or high-level disinfected or sterile surgical gloves on both hands.					
11. Arrange sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.					

LEARNING GUIDE FOR POSTABORTION CARE *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
PRE-MVA TASKS						
1. Perform bimanual pelvic examination, checking the size and position of uterus and degree of cervical dilatation.						
2. Insert the speculum and remove blood or tissue from vagina using sponge forceps and sterile gauze.						
3. Remove any 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 anesthetic (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 anesthetic 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 anesthetic 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.						
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.						

LEARNING GUIDE FOR POSTABORTION CARE *CLINICAL SKILLS*					
STEP/TASK	**CASES**				
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.					
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.					

CHECKLIST FOR POSTABORTION CARE *MVA CLINICAL SKILLS*

(To be used by the **Learner** 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.

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 or task or skill not performed by learner during evaluation by clinical trainer

CHECKLIST FOR POSTABORTION CARE *CLINICAL SKILLS*						
STEP/TASK	**CASES**					
GETTING READY						
1. Tell patient what is going to be done and encourage her to ask questions.						
2. Tell patient she may feel discomfort during some of the steps and that you will tell her in advance.						
3. Check that patient has thoroughly washed her perineal area and has recently emptied her bladder.						
4. Determine that required equipment and sterile or high-level disinfected instruments and cannulae are present.						
5. Check MVA syringe and charge it (establishes vacuum).						
6. Put on apron, wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.						
7. Put new examination or sterile or high-level disinfected gloves on both hands.						
8. Arrange sterile or high-level disinfected instruments on sterile tray or in high-level disinfected container.						
MVA PROCEDURE						
1. Explain each step of the procedure prior to performing it.						
2. Perform bimanual pelvic examination to confirm uterine size, position and degree of cervical dilatation.						
3. Check the vagina and cervix for tissue fragments and remove them.						
4. Apply antiseptic solution two times to the cervix (particularly the os) and vagina.						
5. Put tenaculum or vulsellum forceps on posterior lip of cervix.						
6. Correctly administer paracervical block (if necessary).						
7. Dilate the cervix (if needed).						
8. While holding the cervix steady, insert the cannula gently through the cervix into the uterine cavity.						
9. Attach the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other.						
10. Evacuate 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. Inspect tissue removed from uterus and ensure it is POC.					
12. When the signs of a complete procedure are present, withdraw the cannula and MVA syringe and remove forceps or tenaculum and speculum.					
13. Perform bimanual examination to check size and firmness of uterus.					
14. Re-insert speculum and check for bleeding.					
15. If uterus is still soft or bleeding persists, repeat steps 5–11.					
POST-MVA TASKS					
1. Before removing gloves, dispose of waste materials and soak instruments and MVA items in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Immerse both gloved hands in 0.5% chlorine solution and 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.					
3. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
4. Check for amount of bleeding and if cramping has decreased at least once before discharge.					
5. Instruct patient regarding postabortion care (e.g., when patient should return to clinic).					
6. Discuss reproductive goals and, as appropriate, provide family planning.					

CHECKLIST FOR POSTABORTION FAMILY PLANNING
COUNSELING SKILLS

(To be used by the **Learner** 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.

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 or task or skill not performed by learner during evaluation by clinical trainer

CHECKLIST 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.						
4. Obtain biographic information (name, address, etc.).						
5. 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						
6. Provide general information about family planning.						
7. Explore any attitudes or religious beliefs that either favor or rule out one or more methods.						
8. Give the woman information about the contraceptive choices available and the risks and benefits 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						
9. Discuss patient's needs, concerns and fears in a thorough and sympathetic manner.						
10. Help patient begin to choose an appropriate method.						
PATIENT SCREENING						
1. Screen 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.						

CHECKLIST FOR POSTABORTION FAMILY PLANNING *COUNSELING SKILLS*						
STEP/TASK	**CASES**					
5. Provide follow-up 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's questions.						

POSTABORTION CARE COURSE EVALUATION

(To be completed by Participants)

Please indicate your opinion of the course components using the following rate scale:

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

1. The Pre-Course Questionnaire helped me to study more effectively.	
2. The role play sessions on communication and counseling skills were helpful.	
3. There was sufficient time scheduled for practicing communication skills and counseling through role play and with volunteers and patients.	
4. The curriculum materials helped me get a better understanding of the uterine evacuation procedures for treating incomplete abortion prior to practicing with the ZOE model.	
5. The practice sessions with the ZOE model made it easier for me to provide postabortion care for patients.	
6. There was sufficient time scheduled for practicing postabortion care with patients who had an incomplete abortion.	
7. I feel confident in providing postabortion care.	
8. I feel confident in using the infection prevention practices recommended for postabortion care.	
9. The interactive training approach used in this course made it easier for me to learn how to provide postabortion care.	
10. Six days were adequate for learning how to provide emergency postabortion care services.	

ADDITIONAL COMMENTS (use reverse side if needed)

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

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