



ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION

**POSTABORTION CARE TRAINING
COURSE FOR DISTRICT AND GENERAL
HOSPITALS**

TRAINER'S GUIDE

Draft

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The CATALYST Consortium is a global reproductive health activity initiated in September 2000 by the Office of Population and Reproductive Health, Bureau for Global Health, U.S. Agency for International Development (USAID). The Consortium is a partnership of five organizations: the Academy for Educational Development (AED), Centre for Development and Population Activities (CEDPA), Meridian Group International, Inc., Pathfinder International and PROFAMILIA/Colombia.



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Introduction to the Trainer's Guide

The *Trainer's guide* is a guide for conducting a postabortion care training course based on manual vacuum aspiration (MVA) and contains all the necessary information for administering the course. The primary focus of this course is treatment of incomplete abortion.

The Trainer's Guide is an adaptation of the IPAS *MVA Trainer's Handbook*

The clinical standards for the provision of manual vacuum aspiration are the same at all sites. However, each site and group of participants also has unique features and needs. This handbook is designed to enable the trainer to provide clinically accurate information while adapting the training process to the needs of the particular site and participants. The authors of this handbook *expect* the trainer to adapt the course to fit the trainees' prior knowledge and experience, scheduling requirements, and local public health priorities.

The trainer should review the introductory material when planning the training session, and review the lesson plan for each module prior to the session.

Each module contains the following sections:

- Introduction
- List of objectives
- Recommended time
- Trainer preparation
- Materials needed
- Trainee materials
- References for trainer

Note: If a datashow is unavailable, the presentations may be made into overhead transparencies for use with an overhead projector.

Course Description

This 6-day clinical training course is designed to prepare participants (Ob/Gyn specialists at the MOHP hospitals) to provide PAC services.

Course Goals

- To influence in a positive way the attitudes of participants towards PAC services
- To provide participants with the knowledge and skills needed to perform MVA and prevent and manage complications related to the MVA procedure
- To provide participants with the counseling skills needed for postabortion FP counseling

Training Methods

- Illustrated lectures and group discussion
- Role plays
- Simulated practice with pelvic models
- Guided clinical activities (performing MVA, FP counseling, inserting postabortion IUD)

Participant Selection Criteria

Participants for this course should be clinicians working in a hospital, which provides women's health services. The facility should support provision of PAC and FP services.

Physicians should be knowledgeable and skilled in the following areas before beginning the MVA course:

Knowledge

- Basic anatomy and physiology of the female reproductive system
- The evolution of pregnancy
- Effectiveness, advantages, disadvantages, contraindications, risks and benefits of all locally available methods of family planning
- Relative risks associated with analgesia, sedation, and anesthesia

Skills

- Perform a general physical exam and take a medical history
- Conduct a thorough pelvic exam
- Administer local anesthetic
- Manage an Ob/Gyn case from presentation through treatment (and possible referral) to follow up

Attitude

- Positive attitude toward patients needing abortion care
- Positive attitude toward educating and counseling patients/clients
- Positive attitude toward training others
-

Nurses should be knowledgeable and skilled in the following areas before beginning the MVA course:

Knowledge

- Basic anatomy and physiology of the female reproductive system
- The evolution of pregnancy
- Communication with patients/clients
- Infection control

Attitude

- Positive attitude toward patients needing abortion care
- Positive attitude toward educating and counseling patients/clients

Course Duration

- 6 training days
- 6 hours in the morning sessions + 3 to 4 hours in the afternoon session
- Total training hours = 54 to 60 hours

Methods of Evaluation

- Pretest and post test
- Guide for Observation of Performance of Provider of Integrated Care of Incomplete Abortion
- Guide for the Observation of the Performance of Nurse Technicians in the Maintenance of MVA Instruments and Equipment

Training Schedule

Postabortion Care Training For Hospital-Based Providers (6 Days)		
Day 1	Day 2	Day 3
08:30 – 10:30 Opening Introduction Pretest Suggestions for participation Module: Strengthening PAC Services in Egypt	08:30 – 10:30 Review of Day 1 activities (10 min) Discussion of pre course questionnaire results (10 min) MVA case studies (30-60 min) from the MVA procedure module Module: Initial assessment of MVA patients (1 hr)	08:30 – 10:30 Review of Day 2 activities Module: Procedure complications (45 min) Module: Complicated abortions (1 hr)
10:30 – 11:30 - Break	10:30 – 11:30 - Break	10:30 – 11:30 - Break
11:30 – 01:00 Module: Medical ethics in physician and nurse practice Counseling Clients	11:30 – 01:00 Module: Initial assessment of MVA patients (1.5 hrs)	11:30 – 01:00 Module: Complication continued
01:00 – 01:30 - Break	01:00 – 01:30 - Break	01:00 – 01:30 - Break
01:30 – 03:30 Module: MVA facts	01:30 – 03:30 Module: Infection control 1.5 hrs	01:30 – 03:30 Module: FP
06:00 – 08:00 pm Module: MVA procedure Homework: Read Infection control chapter	06:00 – 08:00 pm Module: Pain Control	06:00 – 08:00 pm Classroom Practice Training on counseling skills How to assess abortion cases How to do Para cervical block How to do MVA Instrument processing Post-abortion IUD application

Postabortion Care Training For Hospital-Based Providers (6 days)		
Day 4	Day 5	Day 6
08:30 – 10:30 Guided clinical practice If no patients: classroom practice	08:30 – 10:30 Guided clinical practice If no patients: classroom practice	08:30 – 10:30 Guided clinical practice If no patients: classroom practice
10:30 – 11:30 - Break	10:30 – 11:30 - Break	10:30 – 11:30 - Break
11:30 – 01:00 Guided clinical practice If no patients: classroom practice	11:30 – 01:00 Guided clinical practice If no patients: classroom practice	11:30 – 01:00 Guided clinical practice If no patients: classroom practice
01:00 – 01:30 - Break	01:00 – 01:30 - Break	01:00 – 01:30 - Break
01:30 – 03:30 Guided clinical practice If no patients: classroom practice	01:30 – 03:30 Guided clinical practice If no patients: classroom practice	01:30 – 03:30 Guided clinical practice If no patients: classroom practice
06:00 – 08:00 pm Guided clinical practice If no patients: classroom practice	06:00 – 08:00 pm Guided clinical practice If no patients: classroom practice	Course Evaluation Post Test Closing

Course Materials

Equipment needed for training

- 1 MVA kit per trainee, and 2 MVA kits per trainer
- Datashow or overhead projector
- Chalkboard or flipcharts and markers newsprint
- One of the following types of pelvic models is needed for each MVA course:
 - ▶ SIMA Family Planning Educator Model. This model is useful for demonstrating and practicing the MVA procedure and bimanual examination.
 - ▶ The Gaumard Scientific Zoe Model. This model has multiple cervixes and uteri and can be used for demonstrating and practicing the MVA procedure, bimanual examination, IUD insertion, and other procedures.

Notes to the Trainer

All effective training programs have certain characteristics in common which will help the trainees to learn, and will also provide a stimulating and satisfying training experience for the participants and the trainer. The following should be taken into consideration when planning the training session.

The course content is based on skills and knowledge the trainee will need in the clinic to manage MVA cases and perform the MVA procedure.

In order to develop the necessary skills, the active participation of the trainees is necessary. This includes participation in discussions and practice in the classroom and the clinical setting.

Training should be tailored to meet the needs of the individuals. Participants should be encouraged to ask questions and discuss issues relevant to their particular clinical settings. The training should be flexible enough to address the needs of individuals when necessary. A pretest can be helpful to determine whether or not the trainees have the necessary prerequisite skills. If they do not have the basic skills, these should be included in the training.

Training must be well organized to avoid administrative problems and ensure that the training goes smoothly. The trainer should check the materials lists at the beginning of each module to be sure to have the supplies necessary for each session.

The trainer's positive attitude toward the trainees and patients is important in providing an encouraging and supportive learning environment.

During the training session:

The following are specific steps which can be incorporated into each training session to provide a structure for the session.

1. Begin each lesson by focusing the attention of the trainees on the topic in a way that will motivate the class to learn and help them remember. This can be done, for example, by introduction of the topic with a case history, an impressive statistic, an anecdote about a local problem or a way that services were improved, a memorable graphic or an illustration of the lesson.

2. Discuss the objectives of the lesson, or what you will expect the trainee to know or be able to do after the training. It is important to communicate the objectives to the trainee so that they will know what they are supposed to gain from the session. Trainees should also be encouraged to give suggestions of additional topics they wish to cover.
3. Make sure that trainees have the knowledge and skills that are essential to learning the new material that you are teaching. Also, make a transition from material or skills already covered to the new material. New skills and knowledge will be learned more easily when they are related to what the trainee already knows.
4. Present new material in a clear and organized fashion.
5. Use examples and demonstrations, which take into account local conditions. Encourage questions and discussion of the topic.
6. Provide opportunities for practice, for example, clinical practice, exercises, role plays, pelvic model practice, and discussion of case histories.
7. During class time and clinical session, be sure to give feedback, which will help improve the performance of the trainees, and enable them to see their progress.
8. Evaluate the trainees during the course and at the end of the course to be sure that the objectives have been accomplished. Also be sure arrangements are made for supervision of the trainees after the training event.

Special Considerations for Each Training Method

Each of the modules contains an outline for teaching including the information to be covered and sample exercises, role plays, or case studies. However each trainer may wish to develop their own exercises or revise the ones offered. The following are special considerations for the different teaching methods, which are part of the training.

Lecture

Lecture can be an effective way of presenting information to a group. It is a good way to introduce a topic or show the main points. However, presenting information in a lecture format will not guarantee that the trainees will learn the material. It is important to incorporate class participation through discussions or exercises in between short lectures giving the important background information. Below are a few considerations, which can help to make a lecture more effective.

- Plan carefully the topics to include and the order of the topics.
- State objectives at the beginning of the lecture.
- Use discussion and exercises along with lecture.
- Summarize what you have covered at the end of the lecture.
- Present materials visually whenever possible, using slides and/or handouts to illustrate facts and concepts.
- Use local examples whenever possible.
- Do not lecture about things that are better visually demonstrated, such as loading the syringe, or putting on gloves.

Group discussions

Large or small group discussions can be an effective way to talk through issues, identify problems, or practice skills. Discussions can provide for exchange of ideas and experiences. A large group discussion may consist of question-and-answer sessions where the participants ask questions and the trainer provides the answers, or the trainer may ask questions for the group to answer. Small group discussions can have the benefit of allowing more people to participate in the same amount of time.

The following considerations should be taken into account when planning group discussions.

- Structure the discussion by providing a specific topic, case study, questions to answer or an exercise.
- Small groups should have no more than 3-5 people in order to allow participation by all members.
- You may want to have the group pick a leader or you may need to provide leadership if a group is digressing from the topic.
- Have a summarizing or reporting session at the end.

Classroom demonstration

Demonstrations are used to help people learn new skills. The trainer can illustrate the correct procedure, then offer the trainees an opportunity to practice and receive feedback on their performance. Demonstrations work best with small groups; the trainer may need to conduct the demonstration more than once. Using materials that are available to the trainees in their clinical settings is most effective.

To conduct a demonstration:

1. Explain what you will be demonstrating. Show the materials and equipment and pass them around the room.
2. Conduct the demonstration. Make sure that everyone can see what you are doing. Explain the steps clearly. Encourage questions.
3. Give each trainee a chance to practice. Watch the progress of the practice. Give suggestions and encourage trainees to ask questions and express concerns about their performance.

If you are giving a demonstration in a clinical setting, be sure to explain the steps before you go in to the procedure room, and provide the trainees with a handout to follow once in the demonstration. This will provide the trainees with a knowledge base before starting, and make the demonstration less disruptive in the clinical setting.

Role play

Role plays consist of acting out of real life situations and/or problems. Role plays are useful for applying the knowledge, which is being taught, practicing skills, and generating material for discussion. They allow for practice in a safe setting. Trainees can explore ways of interacting or managing different situations, and may get feedback in important areas where they wouldn't normally receive feedback in the work setting. They can also have the opportunity to reverse roles and see problems from the other perspective.

Role plays may be generated from a problem brought up in class or a concern expressed. You may also have a role play designed ahead of time and give each participant background data

about the role play or a script to follow. You may break the class into small groups and have each group do the same role play and report findings back to the full class, or have one group do the role play in front of the full class. If you do the latter, ask for volunteers, and do not force anyone to take a part if they are uncomfortable.

When planning a role play:

1. Keep the group size small, 3-5 per group.
2. You may want to assign someone to be an observer of each small group, or have trainees write down their observations.
3. Make sure the purpose of the role play is clear to the participants.
4. If the role play demonstrates negative actions, be sure to redo it with positive ones.
5. Keep the role play simple and short.
6. You may want to interrupt the role play to discuss it when some useful material has been generated.
7. Allow plenty of time afterwards for discussion and guide the discussion to cover the important points.
8. Summarize what the group has learned at the end of the session.

Case studies

Case studies are useful for teaching problem-solving skills and case management skills, such as complications or cases that the trainees would not normally see. Case studies are drawn from real life situations and should be adapted when necessary to take into account local practices and conditions.

Case studies can be used before introducing a subject to get the trainees to start thinking about the topic, or they can be used afterwards to have the trainees practice what they are learning. You may discuss the case study in the large group or break into small groups and have them report back to the large group.

Practice with an anatomical model

When trainees practice clinical skills (such as the MVA procedure) on actual patients, their inexperience can increase the patients' risk of complications and physical discomfort. Using an anatomical model allows trainees to reach a minimum level of confidence and proficiency in their clinical skills before facing a live patient. Moreover, model practice need not be limited by patient caseload or clinic schedule.

Simulate the clinic environment as much as possible:

- Set up instruments on table or trays as in clinic.
- Have trainees' practice talking to the patient, explaining the procedure and assessing her pain control needs.
- Have trainees wear gloves during the procedure
- Place the model on the end of a high table if possible; the trainee doing the procedure may sit on a stool.
- Place a bucket next to the table so trainees can practice decontamination of instruments.

- Allow trainees to practice as much as they need to feel comfortable handling the MVA instruments, speculum, and tenaculum, and developing the characteristic technique of the MVA procedure.
- Stop the practice as needed to further explain a step, make corrections in a trainee's technique, or answer questions.
- Point out differences between the model and a real procedure that may not be obvious to trainees, for example, the size of the cervix or position of the uterus.
- Also, it may be necessary to be "rough" with a model (for example, to insert the speculum or dilate the cervix), but a clinician should never be rough with a real patient.

Clinical practice (MVA and postabortion family planning)

After classroom instruction and practice with a model, trainees need practice in the clinic with real patients. Clinical practice is important not only for performing the aspiration, but for the crucial skills of diagnosis and assessing uterine size, as well as for practicing counseling skills. The first session of clinical practice should always begin with trainees watching a competent provider examine a patient and perform the procedure. All clinical practice must be closely supervised; the trainer must be prepared to intervene if the patient experiences unusual pain or is at risk for complications (especially incomplete evacuation or uterine perforation).

Trainer should watch each step of the procedure for correct performance; having a copy of the Observation Guide for Patient Care handy may make this easier.

Trainer should provide both positive and negative feedback, keeping in mind the physical and mental comfort of the patient, as well as the trainee's need for feedback.

Cases in clinical practice should progress from "simple" to more complex, if at all possible. Inexperienced providers should master uncomplicated cases before having to perform any complicated or risky cases.

Trainees should receive as much supervised clinical practice, as they need to master the procedural skills; some trainees may need more practice than others.

Counseling sessions should be observed and evaluated using the learning guide.

Day One/Session One

Part 1: Introduction to the Training Course

Objectives

After this module, participants will:

1. Know each other
2. Know their expectations.
3. Have determined their needs through pretest
4. Provide suggestions for effective participation in the Training of Trainers Course.
5. Understand the agenda

References for trainers

- Brancich C, Farrell B. Advanced Training of Trainers: Nigeria, International Health Programs/Western Consortium for Public Health (IHP/WCPH), 1990. Annex 1

Materials needed

- Newsprint
- Marking pens
- Overhead projector
- Pre test
- Flipcharts
- Pens and paper

Session Dynamics

1. Introduction (10 minutes)

Lecture

- Greet participants; introduce yourself and the participants.
- Discuss the PAC training course objectives.

2. Expectations (20 minutes)

Brain Storming

- Ask the group to pair off.
- Ask each pair to spend 10 minutes interviewing each other to answer the five questions.
 - ▶ What do you hope to accomplish during this course?
 - ▶ Do you anticipate any difficulties during the course?
 - ▶ How do you think this training will help you at work?

- Have each person present her/his partner's expectations to the group.
- Write all participants' expectations in a flipchart paper so that you can refer to them throughout the course.

 **Group Exercise (20 minutes)**

- Divide trainees into 4 groups.
- Ask each group to spend the first 10 minutes discussing what changes they hope will be made in the clinics/hospitals where they work on PAC
- Ask them to record some of the changes they hope to make. They should limit their answers to 5-10 important changes.
- Each group should select one Trainee to record their answers on newsprint and present their answers to the group

3. Pretest (20 minutes)

- Pass out copies of the pretest
- Ask each trainee to fill out the questionnaire.
- Review the trainee's questionnaires

4. Trainer Presentation (10 minutes)

 **The trainer should:**

- Ask trainee for suggestions for effective participation.
- Give trainees additional suggestions.
- Ask a trainee to record the suggestions of the trainee.
- Possible outcomes are:
 - ▶ DO
 - Ask a question when you have one.
 - Feel free to share an illustration.
 - Request an example if a point is not clear.
 - Search for ways in which you can apply a general idea to your work.
 - Think of ways you can pass on ideas to your subordinates and co-workers.
 - Be skeptical - don't automatically accept everything you hear.
 - ▶ DON'T
 - Try to develop an extreme problem just to prove the trainer doesn't have all the answers. (The trainer doesn't.)
 - Close your mind by saying, "This is all fine in theory, but..."
 - Assume that all topics covered will be equally relevant to your needs.
 - Take extensive notes; the handouts will satisfy most of your needs.

5. Agenda (10 minutes)

Lecture

- Review the training goals, objectives, and agenda with trainees.
- Through discussion, determine the clarity of objectives, agreement/ disagreement on objectives, and areas to consider for revision.
- Explain clearly how the clinical practice will work, what times it will be etc.
- Describe the role of the trainers during training

Part 2: Strengthening PAC Services in Egypt

Introduction

Physicians and nurses need to understand the situation of post abortion care services in Egypt, in order to understand the need for improvement and their role in the program.

Objectives

After this module, trainees will be able to:

1. Explain the situation in Egypt regarding PAC program.
2. Explain the strategy for working on PAC at the three health care levels (primary, secondary, and tertiary levels).
3. Identify the conceptual framework

Trainer Preparation

Materials needed

- PowerPoint presentation “PAC Introduction”
- Datashow or overhead

Trainee materials

- Handout: Introduction
- Handout: Course schedule
- Handout: Course objectives

References for trainer

- none

Session Dynamics

Introduction: (30 minutes)

Lecture

- Provide lecture using PowerPoint presentation “PAC Introduction”

Day One/Session Two

Medical and Nursing Ethics

Introduction

The purpose of this session is to orient participants to the principles of medical ethics. The session also aims to enhance positive physicians' and nurses' attitudes toward the practice of medicine.

Learning Objective

By the end of this session each participant will be able to:

1. Identify and explain the meaning of ethics and the importance of the oath in medical practice.
2. Recognize the importance of ethics in medical and nursing practices and in public and private health services.
3. Explain the ethical aspects of a physician's relationship with his/her patients.
4. Explain the physician's duties toward his/her patients.
5. Explain the need to treat PAC clients with high regard and respect
6. Provide proper counseling to PAC clients.

Trainer Preparation

- Browse References for Trainer and read material as needed.

Materials Needed

- PowerPoint presentation "Ethics"
- Flipchart and markers
- Datashow or overhead Projector

Trainee Materials

- Ethics section of the Trainee's Guide

References for Trainer

- Ethics section of the Trainee's Guide

Time: 120 Minutes

Session Dynamics

Lecture (5 minutes)

- Motivate Learning
- The facilitator reviews the, session purpose, learning objectives, and learning activities.

 ***Brainstorming and lecture (25 minutes)***

- The facilitator asks participants to share their ideas about the oath, the meaning of ethics and their importance to the practice of medicine.
- Answers are recorded on a flip chart.
- Facilitator discusses with the participants and explains the meaning and importance of ethics in medical practice, according to the ISOP, using PowerPoint presentation “Ethics”.

 ***Working Groups, Group Presentation, and Discussions (30 minutes)***

- The facilitator divides the participants into three subgroups.
- Each group will be assigned to prepare a presentation on:
 - ▶ The moral values surrounding PAC clients, the effect this has on the status of postabortion clients as compared to other clients and the effect this can have on quality of care

Possible outcomes

- Stigma for PAC clients, feel less feminine, suspected of inducing abortion, feel guilt, demised status, less attention from staff, junior resident do the cases, less privacy, less respect.
- Each group presents its work on a flip chart and listens to feedback from the other participants.
- The facilitator organizes a discussion and presents the main points of each groups’ work.
- A discussion is held to determine what we can do as providers to address the situation.

Counseling Clients

Session Dynamics

 ***Lecture with Discussions (15 minutes)***

- Present the counseling wall chart and discuss briefly the different items to be counseled at different stages of the procedure.
- Discuss the possibility of having one nurse assigned to each client to counsel her and provide moral support
- Discuss where counseling will take place.
- Discuss privacy arrangements in the hospital and if it can be improved.

 ***Role play (30 minutes)***

- The facilitator asks 2 participants to perform counseling role play assuming that one of them is the physician or nurse and the other is the PAC client.
- Counselor use the counseling flipchart and encourage client to express her feelings and discuss her knowledge.

- The facilitator opens the floor for discussion after the role play.

Possible outcomes

- Two way communication is a must in counseling clients
- Listening is very important in counseling
- Clear message and simple language help client's understanding of the message
- Feed back help providers to evaluate the outcome and impact of the counseling session

Summary (15 minutes)

- At the end of the session, the facilitator delegates the responsibility of summarizing the session to one of the participants, using the criteria in the learning objectives. After the participant's summary, the facilitator wraps up the session

Day One/Session Three

Manual Vacuum Aspiration (MVA) Facts

Introduction

Manual vacuum aspiration (MVA) is a safe, effective, and low cost method of uterine evacuation, used for endometrial biopsy, treatment of abortion complications, and early induced abortion or menstrual regulation. MVA can be used in outpatient settings, thus extending women's access to care.

Objectives

After this module, trainees will be able to:

1. Explain the mechanism of MVA.
2. List the advantages of the MVA procedure over other methods of uterine evacuation.
3. Identify MVA indications, contraindications, warnings, and precautions.
4. Identify the parts of the MVA instruments.
5. Experiment handling and using MVA instruments

Recommended Time:

120 minutes (Didactic)

120 minutes (Clinical and Practical in the afternoon session)

Trainer Preparation

- Prepare materials for demonstration
 - ▶ Container of water (colored water or tea optional)
 - ▶ 1 set of MVA instruments
- Prepare materials for exercise
 - ▶ Each team of 3 trainees needs:
 - 1 set of labels for MVA instruments (master included)
 - 1 set of MVA instruments (syringe, cannulae, adapters), container of water (colored water or tea optional)
- Browse References for Trainer and read material as needed.

Materials Needed

- See above
- PowerPoint presentation “MVA Facts”, and datashow or overheads

Session Dynamics

1. Introduction and theory

Lecture (45 minutes)

- Show PowerPoint presentation “MVA Facts”, and display video
- Present material.
- Answer any questions that may arise.

2. PAC Instruments

Demonstration and Re-demonstration (30 minutes)

- Explain that a cannula is inserted through the cervix and attached to the vacuum syringe.
- When the valve is released, the contents of the uterus are emptied by suction into the syringe.
- Demonstrate the vacuum action of the syringe by aspirating a glass of liquid through the cannula (tea or colored water may be more visible, if available).
- Point out to the class that the contents of the uterus don't get aspirated quite as quickly as the glass of water
- Ask participants to re-demonstrate the same procedure under facilitator's observations and instructions

Exercise (15 minutes)

- Divide trainees into groups of three or four.
- Give each group a set of MVA instruments, a glass of water, and set of parts labels, barrel, cannula, adapter, valve set, O-rings, plunger, and collar stop).
- Describe and lead the exercise as follows:
 - ▶ Each person in the group should practice disassembling and reassembling the instruments.
 - ▶ The group should match each part to the labels provided.
 - ▶ Each person in each group should practice charging the syringe (creating the vacuum) and aspirating the liquid, then emptying the syringe back into the glass (this may get a little messy).
 - ▶ The trainer move around trainees to assist them if needed, and to verify correct labeling of parts.
 - ▶ After the groups have finished the exercise, the trainer collects all the instruments, labels, and containers of water.

3. Implementing MVA

Discussion (30 minutes)

- Lead a discussion by asking: **What adaptations/changes in delivery of care can allow a clinic or hospital to take advantage of the benefits of MVA?**
- The following points may arise in discussion:
 - ▶ Clinical changes
 - Paracervical block and analgesia, light sedation for pain control (rather than heavy sedation or general anesthesia)
 - Develop protocols for re-sterilization or high-level disinfection of MVA instruments (not autoclave)
 - ▶ Management changes
 - Modify patient management procedures so abortion patients don't have to wait long for care
 - Structure discharge protocols to allow patients to leave without overnight stay
 - Locate service delivery outside of surgical ward
 - If budget allocations depend on patient overnight stay, alter them to reflect outpatient case numbers
 - ▶ Training changes
 - Train staff to care for awake patients

Day One/Session Four

This session is to be conducted in the afternoon period. The session lasts for 3 - 4 hours according to the needs. Facilitators are responsible for preparing the needed training resources such as models, infection prevention equipments and materials, patients...etc

Applied MVA

Introduction

MVA is a relatively simple procedure. Nonetheless, it requires practice and careful attention to proper technique in order to achieve safe, effective uterine evacuation.

Objectives

After this module, trainees will be able to:

By using models

1. Select syringe and cannula size.
2. Check, assemble, and prepare MVA instruments.
3. Practice gentle cervical dilation (if indicated)
4. Evacuate uterine contents, noting signs of complications
5. Recognize and solve technical problems during the procedure.
6. Inspect aspirated tissue to assure completion of procedure.
7. (Optional) Record complete, accurate case information on patient charts, logbook, and other forms as needed.

Time:

3-4 hours (including break)

Trainer Preparation

- Review Case Studies and make 3 copies for class (masters included).
- Browse References for Trainer and read material as needed.
- Make sure clinical practice has been arranged.

Materials Needed

- Videos:
 - ▶ MVA Procedure - Preparation
 - ▶ MVA Procedure - Evacuation
 - ▶ MVA Procedure - Inspection
- Pelvic model
- MVA instruments: 1 set for every 2 trainees
- Examination gloves: 1 set per trainee
- PowerPoint presentation "MVA Facts"

- Case studies (included in module)
- Learning guides for postabortion care clinical skills

Trainee Materials

- MVA case studies
- Learning guides
- References for Trainer (included in trainer references book)

Session Dynamics

1. Pre-procedure patients' care (Brain Storming)

Brain Storming (10 minutes)

- Review with the participants the pre-procedures patient care.
- Ask the participants the following question: *What are the clinical interventions that must be performed before the MVA procedures?*
- Guide the participants to the following points:
 - ▶ Possible outcomes
 - Patient history has been taken
 - Physical and pelvic exam completed, contraindications were ruled out, precautions taken where appropriate, patient emptied bladder, patient in lithotomic position, draped, pain control administered, complications either ruled out or treated, and patient stable.
 - Infection prevention procedures should have been made (decontamination of instruments, waste disposal, etc.).

2. Preparing MVA Instruments

Demonstration and re-demonstration (30 minutes)

- Demonstrate preparation of MVA instruments according to the reference guide
- Ask the participants to follow the reference guide while facilitator demonstrate preparation of MVA instruments
- Ask one of the participants to re-demonstrate preparation of MVA instruments while facilitator observe the participant by using the reference guide
- Divide trainees into pairs and distribute learning guide and MVA kit to each pair of trainees.
- Have trainees practice preparing instruments (while wearing gloves) by using the learning guide.
- Repeat the steps until all trainees practice preparation of MVA instruments
- Facilitator observe participant's performance and instruct them when necessary

- Answer any participant's questions.
- Display the video Procedure Preparation

3. Performing MVA

Lecture with Discussions (30 minutes)

- Present PowerPoint presentation material up to the case studies.
- Have participants follow along in learning guides.
- Answer any questions that arise.
- Display the videos Procedure Evacuation and Procedure Inspection

4. MVA Procedure

Clinical Practice - Approximately 2 hours

- Arrange clinical practice as permitted by clinic schedule and patient caseload.
- Follow guidelines for clinical practice.
- Allow each participant to attend the available MVA procedures to observe the facilitator while performing MVA to patients
- Ask each participant to review the learning guides during the MVA procedures.
- Explain the procedure to the participants and demonstrate examination of aspirated tissue.
- Allow trainees to practice tissue exam as well.
- Display the videos to reinforce learning: Procedure Evacuation and Procedure Inspection

5. MVA Procedure

Practice on Model (50 minutes)

- Prepare anatomical model for practice of MVA procedure.
- Demonstrate procedure on the model, following the learning guide and using “non-touch” technique.
- Follow guidelines for model practice in "Notes to the Trainer" in this handbook.
- Allow each trainee to re-demonstrate as much as needed to master the competency with the procedures, instruments use on the model.

Possible outcomes

- Participants follow infection prevention guidelines (gloves and non-touch technique)
- Participants use the reference guide properly
- Participants master the skill of using MVA instruments
- Participants perform the procedure of MVA correctly on models

Day Two/Session One

Initial Assessment of MVA Patients

Introduction

Thorough patient assessment, including history, physical exam, pelvic exam, and laboratory tests, is critical to the formulation of a correct diagnosis for the MVA procedure. "Cutting corners" in the assessment may lead to more difficult procedures and higher complication rates.

Objectives

After this module, trainees will be able to:

1. Understand the different causes of bleeding in early pregnancy
2. Complete patient assessment, including:
 - a. Ruling out complications
 - b. Taking complete history
 - c. Performing physical exam
 - d. Performing pelvic exam
 - e. Obtaining appropriate laboratory tests.
3. Assess uterine size and position by bimanual exam.
4. Determine whether cervix is dilated (and how much).
5. Make a correct diagnosis
6. Correctly manage the case

Trainer Preparation

Prepare lecture

- Browse References for Trainer and read material as needed.
- Make sure clinical practice sessions have been arranged; clinical practice is crucial for learning diagnosis and uterine sizing skills.

Materials Needed

- PowerPoint presentation "Patient Evaluation and Assessment"
- Medical history role play exercises (included)
- Pelvic model
- Blackboard and chalk or flipchart and markers
- Datashow or overhead

Trainee Materials

- Handout: patient assessment

References for Trainer

- None

Session Dynamics

1. Review of Day 1 activities

Brain Storming (10 minutes)

- Facilitator asks for a volunteer to summarize the knowledge presented the previous day
- Brain storm other trainees to remind all participants about the most important thing they learned the previous day

2. Patient Assessment and Management

Brain Storming and Lecture (60 minutes)

- Trainer asks participants, "What is the goal of the patient assessment"?
- Possible answers:
- Make accurate diagnosis, including:
 - ▶ Confirmation of pregnancy gestation (weeks LMP) incomplete/inevitable abortion any complications, determine appropriate treatment. MVA or other treatment antibiotic drug therapy, identify constraints on treatment or contraindications: drug allergies chronic illnesses bleeding disorders
- A systematic and thorough patient assessment is the only way to determine patient's condition, appropriate treatment, and any precautions required.
- Present components of the patient assessment, using the PowerPoint presentation "Patient Evaluation and Assessment" as a guide.

3. Taking History

Role play exercise (50 minutes)

- Divide participants into teams of three: each team consists of a "patient" "doctor," and observer.
- For each role play, the "patient" receives a description of 'their' symptoms, which the "doctor" does not see.
- The third trainee acts as observer, and may see the symptom description.
- The patient and doctor role play the assessment interview.
- The doctor's task is to elicit complete, thorough information from the patient while treating her with respect and compassion.
- After the role play, the observer can comment constructively on the doctor's interviewing technique.
- The trainees switch roles for the next role play, and use a new symptom description. Repeat the exercise until all trainees play the role of the "patient" and "doctor."

Role Play #1

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

She complained from:

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

Role Play #2

An 18 year-old girl who is alone, in considerable pain, and very anxious that her family not know about her condition. She has the following symptoms:

She complained from:

- Moderate bleeding for 7 days
- Last period began about 11 weeks ago
- Severe cramping
- Seems warm - no thermometer available
- Chills and sweats
- Vaginal discharge: brown color, foul-smelling, and profuse
- No previous pregnancies using condoms irregularly

Role Play #3

A 34 year-old woman, who brings two children with her to the clinic. She is in severe pain, and very frightened.

She complained from:

- 6 previous births
- 2 previous miscarriages
- Last menstrual period about 8 weeks ago
- Moderate cramping for last 12 hours
- Heavy bleeding
- Severe abdominal pain began in lower belly suddenly - now hurts all over right shoulder hurts
- Using withdrawal for contraception

Role Play #4

A 26 year-old woman, who is very concerned because she and her husband were looking forward to a third child.

She complained from:

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

Day Two/Session Two

Pain Control

Introduction

Using MVA outside a hospital's major surgical theaters encourages the use of local anesthesia with mild tranquilization rather than riskier general or regional anesthetics.

Lighter levels of pain control medication are not only appropriate for MVA, but also safer for patients and require fewer health system resources.

Because the woman is awake during the MVA procedure, clinicians must be very attentive to the management of pain through supportive interaction and proper medication. While each health facility needs an overall protocol for pain control medication, the individual provider must respond to the particular needs of each woman treated.

Objectives

After this module, trainees will be able to:

1. Describe the goal of pain control, especially for the MVA procedure.
2. List types of pain control and available methods in each type.
3. Describe the types of pain that women may experience from incomplete abortion, possible complications, and from the MVA procedure.
4. Select and administer appropriate pain control to meet the patient's needs.
5. Monitor the patient's status, make corrections in pain control medication if required, recognize symptoms of complications of anesthesia, and treat if necessary.

Time: 2 hours

Trainer Preparation

- Browse References for Trainer and read material as required.
- Make sure clinical practice sessions have been arranged.

Materials Needed

- PowerPoint presentation "MVA Pain Management"
- 22 gauge spinal needle and syringe for Para cervical block demo
- Learning Guide for Verbal Anesthesia

Session Dynamics

1. Introduction to *Local Anesthesia and Light Sedation*

Lecture with discussions (30 minutes)

- Trainer may present one or more of these facts:
 - ▶ Levels of Pain Experienced: MVA is not a painless procedure. In a study of almost 2,300 women undergoing MVA, most rated the pain as less than a toothache, and menstrual cramping.

- ▶ Pain can be reduced with paracervical block, and further reduced with appropriate analgesics and/or anxiolytics.
- ▶ Effects of anxiety on pain experienced: Women with greater feelings of anxiety and/or depression before an abortion procedure report feeling more pain than women with less anxiety or depression.
- Ask participants the following question:
What are the advantages that might be gained by using local anesthesia and light sedation versus heavy sedation for MVA?
- Facilitator records participant's answers on a flipchart following three categories:
 - ▶ Advantages for the woman? Such as shorter recovery time ...etc
 - ▶ Advantages for the health workers? Such as more responsive patient...etc
 - ▶ Advantages for the health system? Such as less use of hospital resources...etc
- Facilitator presents the advantages of local anesthesia and light sedation and compare it with general anesthesia and heavy sedation for MVA

2. Use of Pain Control Medication with MVA

Lecture with discussions (30 minutes)

- PowerPoint presentation “MVA Pain Management”
- Present material.
- Answer any questions that may arise.
- Distribute and discuss the “Learning Guide For Verbal Anesthesia”

Model Demonstration and Practice on Pelvic Models (30 minutes)

- Depending upon the type of the available anatomical model, the trainer demonstration and practice of placement of paracervical block.
- The trainer will probably need to repeat the demonstration several times so that all trainees can view the technique.
- Trainer divides trainees into teams of three:
 - ▶ One to play the role of the patient, standing next to the model
 - ▶ One to play the role of the nurse (she will practice verbal anesthesia)
 - ▶ One to play the role of the doctor who will practice local anesthesia and verbal anesthesia)
- Each trainee should have a chance to simulate administering the injections and perform verbal anesthesia.
- Close supervision is needed to make sure that trainees:
 - ▶ Know correct dosages to use and maximum allowable dose
 - ▶ Place injections around (not in) the cervix, at 3, 5, 7, and 9 o'clock
 - ▶ Withdraw plunger slightly before each injection to guard against intravenous injection

- ▶ Place anesthetic just under the epithelium, not deeper than 2-3 mm.
- ▶ The trainee who practice verbal anesthesia will do so using *the learning guide for verbal anesthesia*

 ***Clinical Demonstration and Practice (30 minutes)***

- As allowed by case load, trainer demonstrates assessment of patient's needs for pain control, proper technique for administering paracervical block, and verbal anesthesia and monitoring for complications.
- Under close, direct supervision, have trainees practice these skills until mastery.

Day Two/Session Three

Infection Prevention

Introduction

Infection control is vitally important to prevent disease transmission in the clinical setting and minimize risk to patients, health care workers, and the community. In this module, participants will be introduced to infection control procedures including universal precautions, no touch technique, glove use, and use of barriers. Participants will learn how to clean and disinfect IPAS MVA instruments for reuse in a later module.

Objectives

After this module, trainees will be able to:

1. Explain "universal precautions" for infection control.
2. Describe and demonstrate use of infection control barriers (masks, aprons, etc.)
3. Explain and demonstrate proper glove use for the MVA procedure and instrument processing.
4. Explain and demonstrate safe needle disposal
5. Describe and demonstrate no-touch technique.

Time: 2 hours

Trainer Preparation

- Browse References for Trainer and read material as needed.
- Preview exercises.

Materials Needed

- Pelvic model: One set of infection prevention barriers per trainee (gown, apron, gloves, mask, and goggles (if possible)).
- If these items are not readily available, they can be shared (except masks should not be shared).
- PowerPoint presentation "Infection Control"

Trainee Materials

- References for Trainer

Session Dynamics

1. Infection Prevention Overview

 **Lecture / Discussion with PowerPoint presentation (45 minutes)**

- Present material and PowerPoint presentation “Infection Control”
- Answer any questions that may arise.
- Stress that there is much more material in the reference guide that is worth reading.

2. Glove use

 **Demonstration and Re-demonstration (15 minutes)**

- Demonstrate putting on and taking off gloves, and proper glove use for MVA procedure
- Demonstrate instrument processing.
- Include the following:
 - ▶ Putting on gloves without touching outer glove surface,
 - ▶ Rolling gloves off,
 - ▶ Keeping hands above waist to prevent contamination.
- Clarify that after using gloves in a pelvic bimanual exam, the provider cannot use the same gloves to touch sterile instruments. He/she must remove the gloves, wash hands, and put on a fresh pair.

3. No-touch technique in MVA

 **Demonstration with pelvic model (30 minutes)**

- Demonstrate non-touch technique
 - ▶ Demonstrate picking up instrument (dilator) and using with pelvic model.
 - ▶ Emphasize being deliberate in action; think about what you will touch before doing it.
- Remind trainees of these cautions:
 - ▶ Don't let instrument touch vagina, speculum, or external body surfaces
 - ▶ Place instrument on tray away from other items; don't contaminate other items on tray
 - ▶ Keep dilators in series from small to large on tray
 - ▶ Don't drag sleeve across tray or instruments

 **Problem-solving exercise (30 minutes)**

- Trainees have read infection control chapter
- Divide trainees into groups of 3 (be sure that nurses are presented in all groups).
- Ask each group to discuss an infection prevention problem that exist in their hospital and ask them how to solve the problem.
- After 10 minutes, ask each group to explain their problem and the possible solutions that they reached.

Day Two/Session Four

Complicated Abortion and MVA Procedure Complications

Introduction

Any woman with an incomplete abortion may also be experiencing one or more life threatening complications: shock, severe vaginal bleeding, intra-abdominal injury, or sepsis. Health care providers must recognize these complications and initiate immediate treatment in order to save the woman's life.

Objectives

After this module, trainees will be able to:

1. Describe possible complications and their signs and symptoms.
2. Describe management of uterine perforation (with and without laparotomy).
3. Describe treatment for shock, severe vaginal bleeding, intra-abdominal injury, and sepsis.
4. Determine when uterine evacuation is the most effective treatment step.
5. Explain elements of emergency resuscitation/preparation for referral and transport to tertiary care hospital.

Recommended Time: 3-4 hours

Trainer Preparation

- Make copies of “MVA Possible Complications List” for every three trainees
- Browse References for Trainer and read material as needed.

Materials Needed

- PowerPoint Presentation “Complications of MVA”
- MVA Possible Complications List
- Blackboard and chalk or flipchart and markers

Trainee Materials

- Trainee's reference book
- Complications case studies

Session Dynamics

1. *Introduction to abortion complications*

Lecture (15 minutes)

- Estimates based on death certificates from 24 countries reveal that up to 46% of all reported maternal deaths can be attributed to complications from all types of abortion. (Liskin, 1980)

- The most common complications from spontaneous and unsafe induced - sepsis, uterine perforation, hemorrhage, and cervical perforations - are also four of the five leading causes of maternal mortality. (WHO)
- These complications are also a leading cause of maternal morbidity in developing countries; resulting in infertility and chronic disability for many women.
- Fortunately, in many cases, these complications can be managed if treatment is initiated promptly. Delay is often the most dangerous risk factor.

2. *MVA Procedure Complications*

Lecture (30 minutes)

- Provide lecture with PowerPoint presentation "Complications of MVA"

3. *Signs, Symptoms, and Treatment of Complications*

Working Group (60 minutes)

- Divide trainees into teams of 3.
- Explain and conduct the exercise "Identifying and Treating Complications" as follows:
 - ▶ Each team gets three lists: (1) signs/symptoms, (2) complications, and (3) initial treatment steps
 - ▶ The team's task is to match the signs/symptoms with the relevant complication, and with the appropriate initial treatment.
- Allocated (30) minutes for the group's work and then (10) minutes for each group presentation
- At the end of the exercise, discuss the groups presentation and clarify as needed
- Discuss with the groups their presentation and summarize the complication of abortion and MVA procedures
- Answer any questions that may arise.

Case Studies (45 minutes)

Case Studies may be used as an adjunct exercise to reinforce case management principles, or reserved for times when patients for clinical practice are unavailable. The trainer may use the case studies supplied with this module, or may create additional case studies relevant to local caseloads and trainee experience.

- Divide trainees into 3 teams.
- Give each team one or two case studies to read and write comments for.
- After 15-20 minutes, have each team present the cases and their conclusions for class discussion.

Case 1: A patient arrived at the hospital having aborted at home after 4 months of pregnancy. She reported having lost a lot of blood. When she arrived at the

hospital she was very pale and febrile. The pelvic examination revealed a 12 week sized uterus and a few pieces of placental remains which were removed by MVA. She was advised to have a blood transfusion and was given antibiotics (ampicillin IM). An IV line was started but no blood was available for the transfusion. One hour after the MVA procedure she complained of a headache and became agitated. One half hour later, in spite of being given adrenaline and cardiac massage, the patient died.

1. Was the case managed adequately?

Answers may include the following points:

- ▶ The time lag between her arrival and treatment
- ▶ Probability of shock from blood loss
- ▶ Probability of intra-abdominal hemorrhage
- ▶ Severe anemia

2. What additional steps could the practitioner have taken to manage the case?

Answers may include the following points:

- ▶ Was she placed in head down position to maximize venous return to the heart?
- ▶ Did she receive adequate IV fluids (since blood was unavailable)?
- ▶ Was there any possibility of referral to a better equipped health center?
- ▶ Should the MVA have been delayed until the patient was stabilized?

3. What was the most likely cause of the death?

Answers may include the following:

- ▶ Hypovolemic shock caused by hemorrhage septic shock

Case 2: *You are called by the nurse to see a patient who had an MVA procedure yesterday. She is in significant pain, the uterus is enlarged, firm, tense and tender, and she is a-febrile. She is not bleeding and has hardly bled at all since the procedure.*

1. What is the likely diagnosis?

Answers may include the following:

- ▶ Post-abortal syndrome (acute hematometra)
- ▶ May occur from a few hours to several days after evacuation procedure
- ▶ Blood flow from uterus is blocked

2. What additional information is useful before treatment?

Answers may include the following points:

- ▶ Any sign of infection or intra-abdominal injury?
- ▶ What was the gestation at the time of MVA?
- ▶ Did aspirated tissue include villi?

3. How should this case be managed?

Answers may include the following:

- ▶ Re-evacuation

4. What may have caused this condition?

Answers may include the following:

- ▶ Excessive bleeding behind a closed cervix
- ▶ Patient anxiety

Case 3: *A woman presents to casualty with a history of 5 or 6 weeks of amenorrhea, mild abdominal tenderness and cramping during the last few days, and breast swelling and tenderness. She reports having spotting for a few days. The patient appears healthy but anxious. The examination reveals mild vaginal bleeding, a soft but closed cervix, a slightly enlarged, mobile, minimally tender uterus, and abdominal tenderness but no rebound.*

1. What is the possible working diagnosis for her symptoms?

Answers may include the following:

- ▶ Possibility of ectopic pregnancy
- ▶ Possibility of threatened abortion

2. How would you ascertain the presence of a viable pregnancy prior to making a clinical decision on management?

Answers may include the following:

- ▶ Latex agglutination (or 2-minute) pregnancy test
- ▶ Ultrasound (for intrauterine pregnancy of 6 weeks or more)
- ▶ RIA (radioimmunoassay) or monoclonal antibody-based test for b-HCG.

Case 4: *A 26 year-old Para 6+0 (6 live births, no abortions) presents to casualty with the following history: LMP - 8 weeks ago, but with bleeding for the last 2 days. The blood is dark and mixed with clots. Pain - moderate pain in both lower quadrants, confined to pelvis. Fever - mild fever since yesterday. On examination the clinician finds mild pallor and abdominal tenderness with mild rebound in the lower quadrants. The patient's temperature is 38.1°C. The pelvic exam reveals a moderate amount of dark blood in the vagina; the uterus is slightly tender and 8 weeks size. There are no adnexal masses and the cervix appears open. You diagnose an incomplete abortion and begin MVA immediately. As you place the cannula into the uterus, you cannot feel the fundus.*

1. Discuss further management of this case.

Answers may include the following:

- ▶ Uterine perforation probably occurred before patient came to the hospital

- ▶ MVA should not be continued without visualization (laparoscopy)
- ▶ If laparoscopic control available, MVA can continue to insure that the uterus is empty; if the uterus is to be saved, it must be emptied of any infected tissues
- ▶ Treatment with broad-spectrum antibiotics is important
- ▶ Uterine perforation may occur even to skilled providers, and should be treated promptly

Case 5: *A patient has presented to casualty with abdominal pain and vaginal bleeding. The casualty officer suspects incomplete abortion. On your examination, there is mild abdominal tenderness, a low grade temperature (37.8^oC) but no vaginal bleeding or uterine enlargement. Instead, you noticed a grayish yellow discharge coming from the cervix.*

1. What is the most likely diagnosis?

Answers may include the following:

- ▶ Pelvic infection (most likely)
- ▶ Septic abortion (less likely but possible)

2. How should this case be managed?

Answers may include the following:

- ▶ Once pregnancy is ruled out (by history and/or pregnancy test), administration of appropriate antibiotics for gonococcal and chlamydial infection
- ▶ If pregnancy is confirmed, stabilize the patient with antibiotic therapy before uterine evacuation
- ▶ If low grade fever and no sign of peritonitis, outpatient treatment is probably adequate
- ▶ If infection related to sexually-transmitted disease, partner should be treated
- ▶ Implication for contraception and future fertility

Case 6: *A woman presents at the hospital at 4 pm with vaginal bleeding and low fever. (LMP 10 weeks, uterus 6 weeks size). The hospital is very crowded that day and she is unable to be treated until the next morning. By then her fever was (39^oC), and her abdomen quite tender with pain limited to the lower abdomen. The attending physician decided that because the patient was septic, she should be treated in the OR with a D&C. Finally at 11:30 am, the operating theatre and an anesthesiologist were available and a D&C was performed. After the D&C, the patient was admitted and remained in the hospital for three days until her fever was again normal.*

1. Could MVA have been used to manage this patient? Are any steps other than uterine evacuation required to manage the patient?

Answers may include the following:

- ▶ MVA would be appropriate for this patient even though the uterus is septic.
 - ▶ MVA is gentler to uterine lining than D&C.
 - ▶ Pain limited to lower abdomen, so infection probably limited to pelvis (rather than generalized peritonitis)
 - ▶ Broad spectrum antibiotics should be administered pre-operatively when there is manipulation of an infected uterus, because the manipulation always results in dissemination of bacteria into the blood stream. Tetanus toxoid should be given
2. What advantages would MVA have afforded the patient?
- Answers may include the following:
- ▶ Prompter treatment would have prevented further sepsis
 - ▶ Flexible cannulae are less likely to damage the uterus (perforation, Asherman's syndrome) than either rigid cannulae or the instruments used in sharp D&C
3. What disadvantages would have been experienced in using MVA on the patient?

 ***Clinical practice (90 minutes)***

- If circumstances allow, use clinical practice time to review signs, symptoms, and treatment of complications.

NB: clinical practice is far preferable to case studies, so if the abortion case load in the hospital is sufficient to the number of trainees, re-allocate the time of case studies to give clinical practice more weight

Day Three/Session One and Session Two

Family Planning Counseling After Abortion

Introduction

In many instances, the emergency post-abortion care setting may be one of the few contacts a woman has with the health care system. Therefore, the time when she receives post-abortion care potentially is an important opportunity for her to receive contraceptive information and services.

Some women may want to become pregnant soon after having an incomplete abortion, and there is no reason to discourage them from doing so, barring medical reasons.

However, recent research has shown that those who delay another pregnancy by at least 6 months have better pregnancy outcomes. For some, postponing the next pregnancy may be wise.

Most women receiving post-abortion care, however, do not want to be pregnant at this time. Furthermore, a woman who has risked the dangers of unsafe abortion has clearly expressed a desire to control her fertility and a need for help in preventing unwanted pregnancy.

At a minimum, all women receiving post-abortion care need counseling and information to ensure that they understand:

- They can become pregnant again before the next menses,
- There are safe methods to prevent or delay pregnancy, and
- Where and how they can obtain family planning services and methods.

Objectives

After this module, trainees will be able to:

- Explain the return of fertility after abortion
- Explain the GATHER Approach to counseling in family planning
- Rank the contraceptive priorities in the post abortion period
- Formulated and disseminate simple messages about contraceptive methods
- Describe the terms "informed choice", and two-way communication"
- Discuss the FP methods specific counseling
- Counsel post abortion women on family planning
- Describe the benefits of Optimal Birth Spacing Interval (OBSI) to post abortion care women

Time: 4 hours

Trainer Preparation

- PowerPoint Presentation "Postabortion Family Planning and Counseling"
- Review Postabortion Contraception from Trainee's manual

Materials Needed

- Overhead projector or data show
- Blackboard and chalk or flipchart and markers

Trainee Materials

- Trainee's manual

1. Introduction

Lecture with discussions (30 minutes)

- Facilitator explains and discusses with the participants the return of fertility after abortion.
- Ask the participants the following questions:
 - ▶ When the post abortion women regain their fertility if the abortion is during the 1st trimester and during the 2nd trimester?
 - ▶ What are the best contraceptive choices for PAC women? Rank the choices
- Summarize the discussion and present the PowerPoint presentation “Postabortion Family Planning and Counseling”

2. GATHER

Brain Storming (45 minutes)

- Ask the participants the following question:
 - ▶ What does the word GATHER stand for?
 - Greet patients/clients
 - Ask patients/clients about themselves and their family
 - Tell patients/clients about available FP/RH services
 - Help patients/clients to decide about the needed FP/RH services and choices
 - Explain the selected method
 - Return follow-up recommendations and make appointment if possible

3. Contraceptive priorities in the postabortion period

Brain Storming (15 minutes)

- Ask participants to rank contraceptive choices for postpartum women
- Open the discussion to highlight:
 - ▶ When to start each method after abortion?
 - ▶ Side effects, complications (if any)
 - ▶ How to use the method after abortion

4. Formulate and disseminate simple messages about contraceptive methods

Working Groups (45 minutes)

- Divide trainees into teams of 3.
- Explain and conduct the group's assignment "formulate health messages about the different contraceptive methods suitable for postabortion women" as follows:

Group 1. Postabortion IUDs

Group 2. Hormonal methods (COCs, POPs, injectables, sub-dermal implants)

Group 3. Other methods such as (tubal ligation, condom, spermicidal, LAM and other natural methods, pilling methods)

- Allocated (30) minutes for the group's work and then (10) minutes for each group presentation
- Discuss with the groups their presentation and summarize.
- Answer any questions that may arise.

Role plays (30 minutes)

- Ask each group to select two trainees (one physician and one nurse) to perform the role plays
- Ask the selected trainees to perform role plays by using the messages they formulated in the working group
- Repeat with all groups
- Open the discussion after each role play to emphasize the following:
 - ▶ Informed Choice
 - ▶ Two-way communication
 - ▶ Steps of counseling "GATHER"

5. FP method-specific counseling

Lecture with Discussions (45 minutes)

- Discuss with the groups the specific counseling for each group that include:
 - ▶ What the method consists of
 - ▶ How the method works
 - ▶ Effectiveness
 - ▶ How to use the method
 - ▶ Initiation
 - ▶ Schedule
 - ▶ Advantages
 - ▶ Disadvantages
 - ▶ Side effects

- ▶ Follow up
- Facilitator ask one of the participants to summaries method specific counseling for each method after group discussion

6. *Counseling post abortion women on family planning*

 ***Role play (30 minutes)***

- Ask participants to select two trainees (one physician and one nurse) to perform the role plays
- Ask the selected trainees to perform role plays by using the PAC Wall charts
- Give feedback after the role play to highlight the proper use of the wall charts.

Day Three/Session Four

Reuse of IPAS MVA Instruments

Introduction

This section of the module will outline the procedures for reuse of MVA instruments.

These procedures need to be followed closely to protect health workers and their patients from the spread of infection. Many microorganisms (such as the HBV virus) can live in dry blood. Local or general infections can be caused by bacteria, fungi, or parasites. HIV and hepatitis are caused by viruses. Tetanus and gangrene are caused by bacterial endospore. If instruments are not properly cleaned and disinfected, blood in the crevices of syringes, tenacula, etc. can dry and flake off on a patient or onto a health worker the next time the instruments are used. Instruments must be processed safely in order to protect doctors, nurses, housekeeping staff, and patients from infection.

Safe processing of instruments does not require expensive, high-tech equipment.

Objectives

After this module, trainees will be able to:

- List the 4 steps in processing instruments for reuse, and explain rationale for each.
- Describe the difference between sterilization, HLD, LLD, and when each is appropriate.
- Demonstrate the 4 steps of processing instruments for reuse, using either sterilization or HLD.

Time: 4 hours

Trainer Preparation

- Prepare materials for demonstration in clinic
 - ▶ 1 set of MVA instruments
 - ▶ Sink basin
 - ▶ 5% chlorine solution
 - ▶ Storage containers
 - ▶ Waste disposal facilities
- Browse References for Trainer and read material as needed.

Materials Needed

- PowerPoint presentation “Processing MVA Instruments for Reuse”
- Wall chart
- Equipment and materials for instrument reuse

Trainee Materials

- Infection prevention practices

1. Introduction

Lecture (10 minutes)

- Many microorganisms (such as the HBV virus) can live in dry blood. If instruments are not properly cleaned and disinfected, blood in crevices of syringe, tenaculum, etc. can dry and flake off the next time they are used - into a patient or onto a health worker. Instruments must be processed safely in order to protect doctors, nurses, housekeeping staff, and patients from getting infected. Safe processing of instruments does not require expensive, high-tech equipment. IPAS cannulae can be decontaminated with chlorine and disinfected by boiling in a pot of water
- The 4 steps in processing instruments are:
 1. Soaking
 2. Cleaning with detergent and water
 3. High-level sterilization or disinfection
 4. Safe storage
- Soaking in chlorine makes soiled objects safer to touch: kills HBV and HW.
- Cleaning removes up to 80% of the microbes
- High-level disinfection destroys all bacteria, viruses, fungi, parasites, and some endospores (up to 95% of microbes)
- Sterilization destroys all microorganisms, including all endospores.

2. Processing instruments for reuse

Video, Discussion, and Demonstration (90 minutes)

- The trainer should:
 - ▶ Discuss the purpose of safe instrument processing, including definitions of the 4 steps in processing instruments.
 - ▶ Show the remaining portions of the JHPIEGO video, Infection prevention for Family Planning Programs.
 - ▶ Focus on the Training Demonstration Segments (TDSs)
- Demonstrate decontamination, cleaning, and if possible, high level disinfection and chemical sterilization.
- Ask participants to return the demonstration.
- Discuss some of the problems frequently encountered in processing MVA equipment, such as:
 - ▶ How to clean the cannulae, especially the small ones.

Day Four, Five, and Six

Clinical Practicum

Clinical practicum sessions are an important part of this training because they ensure that material learned in the classroom setting will be appropriately applied to clinical practice. During the clinical practicum, trainees will demonstrate the following:

- Counseling
- History taking
- Physical examination, including general physical examination, bimanual and pelvic examination.
- Paracervical block (where used) and pain management techniques.
- Manual Vacuum Aspiration (MVA) procedure.
- Examination of aspirated tissue for evidence of completed procedure.
- Proper infection prevention procedures.

Length of the Practicum (3 training days)

- The ideal clinical practicum site will be a high volume setting that offers participants frequent repetition of skills.
- It is important to take as much time as necessary for each participant to demonstrate proficiency.
- Each participant should perform a minimum of 5 MVA procedures in a model before performing the procedure in patients
- Each participant should perform a minimum of 5 MVA procedures. However, some trainees may need more practice than others to become proficient; therefore, it is important to individualize the practicum sessions in order to allow as much practice as each trainee requires.
- To further enhance the experience, the trainer should aim to have the smallest number of trainees possible at each session.

Qualification

- The number of procedures each trainee will need to perform will depend on his/her previous training and experience. There is no ideal number of procedures. Both the trainee and the clinical trainer determine when the participant is proficient enough to perform clinical skills without supervision.
- The clinical trainer using the Competency Based Training (CBT) skills checklists should evaluate the satisfactory performance of clinical skills.
- In order to determine competency, the trainer will observe and rate each step of the skill or activity.
- The participant must attain a satisfactory rating on each skill or activity to be evaluated as competent.

Demonstration Technique

- The Five-Step Method of Demonstration and Return Demonstration is a training technique useful in the transfer of skills.
- The technique is used to make sure that participants become proficient in certain skills.
- It can be used to develop skills in performing a counseling, general physical examination, paracervical block, MAV procedures, examination of aspirated contents, and infection prevention
- The following are the five steps:

Step 1: Overall Picture: Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed according to the steps in the skills checklist, on models in the classroom and practiced until participants become proficient in each skill and before they perform them in a clinical situation.

Step 2: Trainer Demonstration: The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role playing participant as s/he would to a real client.

Step 3: Trainer/Participant Talk-Through: The trainer performs the procedure again while the participant verbally repeats the step-by-step procedure.

Note: The trainer does **not** demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.

Step 4: Participant Talk-Through: The participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.

Step 5: Guided Practice: In this final step, participants are asked to form pairs. Each participant practices the demonstration with his or her partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.

Learning Guides for Postabortion Care Clinical Skills and Family Planning Counseling Skills

Using the Learning Guides

The learning guides for postabortion care clinical skills and family planning counseling skills are designed to help the trainee learn the steps or tasks involved in:

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

There are three learning guides in this handbook:

- 1. Learning Guide for Postabortion Care Clinical Skills**
- 2. Learning Guide for Verbal Anesthesia**
- 3. Learning Guide for Postabortion Family Planning Counseling Skills**

Each learning guide contains the steps or tasks performed by the counselor and clinician when providing PAC services. These tasks correspond to the information presented in relevant chapters of Postabortion Care: A Reference Manual for PAC in Egypt as well as in the training presentations. Use of the manual will help the trainee review essential information.

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

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

Before using the Learning Guide for Postabortion Care Clinical Skills and Learning Guide for Verbal Anesthesia, the clinical trainer will review the entire MVA procedure with the trainee. In addition, the trainee will be able to witness an MVA procedure, including the use of verbal anesthesia, during a demonstration session with the ZOE pelvic model and/or to observe the activity being performed in the clinic with a patient.

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

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

- | |
|--|
| <ol style="list-style-type: none">1 Needs Improvement: Step or task not performed correctly or out of order (if necessary) or is omitted2 Competently Performed: Step or task performed correctly in correct order (if necessary) but trainee does not progress from step to step efficiently3 Proficiently Performed: Step or task efficiently and precisely performed in the correct order (if necessary) |
|--|

The Learning Guides are designed to be used during both training, and during training follow up in the clinical setting.

Initially, the trainee can use the learning guides to follow the steps as the clinical trainer demonstrates the MVA procedure using a training model or role plays verbal anesthesia. Later, during the classroom practice sessions, they serve as step-by-step guides for the trainee as s/he performs the skill using the pelvic model, practices verbal anesthesia or counsels a volunteer "patient." Lastly, they will be used by the trainer in follow up visits to assist in becoming proficient. The score on the learning guide will be part of the "INDIVIDUAL TRAINEE FOLLOW UP REPORT"

Learning Guide for Postabortion Care Clinical Skills

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

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

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

Learning Guide For Postabortion Care Clinical Skills					
Step/Task	Cases				
Initial Assessment					
1. Assess patient for shock and other life-threatening conditions.					
2. If any complications are identified, stabilize patient and transfer if necessary.					
Medical Evaluation					
1. Treat the patient respectfully and with kindness.					
2. Ensure the necessary privacy and confidentiality.					
3. Take a reproductive health history.					
4. Wash hands thoroughly with soap and water and dry them with a clean, dry cloth or allow them to air dry.					
5. Perform limited physical (heart, lungs and abdomen) and a pelvic examination.					
6. Give the woman information about her condition and treatment plan.					
7. Perform indicated laboratory tests.					
8. Discuss her reproductive goals and concerns, as appropriate. Note any reproductive health issues that should be discussed with the patient after the MVA procedure.					
9. If she is considering the IUD: <ul style="list-style-type: none"> • 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.					

Learning Guide For Postabortion Care Clinical Skills					
Step/Task	Cases				
3. Ask about allergies to antiseptics and anesthetics.					
4. Determine if necessary equipment and consumables are available.					
5. Determine if required sterile or high-level disinfected instruments are present.					
6. Make sure that the appropriate size cannulae and adapters are available.					
7. Check the MVA syringe and charge it (establish vacuum).					
8. Check that patient has recently emptied her bladder.					
9. Check that patient's perineal area is clean. If not, have patient thoroughly wash and rinse her perineal area.					
10. Put on clean plastic or rubber apron. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
11. Put new examination or high-level disinfected or sterile surgical gloves on both hands.					
12. Prepare table for metal phase					
13. Insert ring forceps in "rigid zone"					
14. Place speculum, tenaculum forceps, ring forceps, and MVA instruments (aspirator, cannulae, and adaptors).					
15. Prepare local anesthetic: 10 cc Lidocaine 1% or xylocaine 1%					
Start procedure					
1. Insert speculum smoothly and at an oblique angle					
2. Using speculum, identify cervical lacerations and/or trauma and signs of infection and inform patient of findings					
3. Clean cervix and vagina with antiseptic solution					
4. Place the tenaculum correctly and delicately					
Paracervical block					
5. Fill a 10 ml syringe with local anesthetic (1% without epinephrine).					
6. 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.					
7. 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.					
8. 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.					
9. Wait a minimum of 2 to 4 minutes for the anesthetic to have maximum effect.					

Learning Guide For Postabortion Care Clinical Skills					
Step/Task	Cases				
Prepare table for plastic phase					
<ul style="list-style-type: none"> Request cannula(s) necessary based on size of uterus and place them in vertical position, inside the "rigid zone." The cannula should be a number equal to or smaller than the size of the uterus. Make note of whether cannula 6 is available for final exam. 					
<ul style="list-style-type: none"> If necessary (incomplete abortion), request dilators and place them in horizontal position in superior part of rigid zone. Dilators should be from number 5 up to a number larger than the number of the cannula being used. 					
<ul style="list-style-type: none"> Request syringes, check that they are functional (they retain vacuum) and place them in semi rigid zone 					
<ul style="list-style-type: none"> Request adaptors and place on respective cannulas 					
1. Gently apply traction on the cervix to straighten the cervical canal and uterine cavity.					
2. If necessary, dilate cervix using progressively larger cannulae. Begin with number 5 up to a number larger than the number of cannula being used.					
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, close the valves and 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 after measuring the volume.					
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.					
Conduct final exam using cannula number 6 in STRICT clockwise motion					
8. Re-insert the speculum and check that the patient is not bleeding.					
9. If uterus is still soft or bleeding persists, repeat steps 3–10.					
10. If patient requests, insert IUD					

Learning Guide For Postabortion Care Clinical Skills					
Step/Task	Cases				
Post-MVA Tasks					
1. Let the patient lie on her side in a comfortable position.					
2. Before removing gloves, dispose of waste materials in a leak proof container or plastic bag.					
3. Place speculum and metal instruments in 0.5% chlorine solution for 10 minutes for soaking.					
4. 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.					
5. Attach used cannula to MVA syringe and flush both with 0.5% chlorine solution.					
6. Detach cannulae from syringe and soak them in 0.5% chlorine solution for 10 minutes for decontamination.					
7. Empty POC into utility sink, flushable toilet, latrine or container with tight-fitting lid.					
8. 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.					
9. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.					
10. Allow the patient to rest comfortably for at least 30 minutes where her recovery can be monitored.					
11. Check for bleeding at least once and ensure that cramping has decreased before discharge.					
12. Instruct patient regarding postabortion care and warning signs.					
13. Tell her when to return if follow up is needed and that she can return anytime she has concerns.					
14. Discuss reproductive goals and, as appropriate, provide family planning.					

Learning Guide for Verbal Anesthesia

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

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

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

Learning Guide For Verbal Anesthesia					
Step/Task	Cases				
Getting Ready					
1. Greet woman respectfully and with kindness.					
2. Assure the necessary privacy and confidentiality.					
3. Tell patient what you are going to do and encourage her to ask questions.					
4. Tell patient she may feel discomfort during some of the steps and you will tell her in advance.					
5. Assess need for pain management medication.					
Procedure					
1. Explain each step of the procedure prior to performing it.					
2. Ask the patient throughout the procedure if she is experiencing any pain.					
3. Wait after performing each step or task for patient to prepare for next one.					
4. Move slowly, without jerky or quick motions.					
5. Use instruments with confidence.					
6. Avoid saying things like, "This won't hurt" when it will hurt or, "I'm almost done" when you're not.					
7. Talk with the patient throughout the procedure.					

Learning Guide for Postabortion Family Planning Counseling Skills

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

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

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

Learning guide for postabortion family planning Counseling skills					
Step/Task	Cases				
Initial interview					
1. Greet woman respectfully and with kindness.					
2. Assess whether counseling is appropriate at this time (if not, arrange for her to be counseled at another time).					
3. Assure necessary privacy and confidentiality.					
4. Use effective interpersonal communication: <ul style="list-style-type: none"> • Two-way communication • Listening • Includes non-verbal communication 					
5. Encourage patient to talk (e.g., ask questions, express feelings).					
6. Obtain biographic information (name, address, etc.).					
7. Ask if she was using contraception before she became pregnant. If she was, find out if she: <ul style="list-style-type: none"> • 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 and identify individual needs.					
7. Explore any attitudes or religious beliefs that either favor or rule out one or more methods.					

Learning guide for postabortion family planning Counseling skills					
Step/Task	Cases				
10. Give the woman information about the contraceptive choices available that are appropriate for her, and the benefits and limitations of each: <ul style="list-style-type: none"> • Show where and how each is used • Explain how the method works and its effectiveness • Explain possible side effects and other health problems • Explain the common side effects 					
11. Discuss the patient's needs, concerns and fears in a thorough and sympathetic manner.					
12. Help the patient begin to choose an appropriate method.					
Screening					
1. Screen the patient carefully to make sure there is no medical condition that would be a problem (complete Patient Screening Checklist).					
2. Explain potential side effects and make sure that each is fully understood.					
3. Perform further evaluation (physical examination), if indicated. (Non-medical counselors must refer patient for further evaluation.)					
4. Discuss what to do if the patient experiences any side effects or problems.					
5. Provide follow 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 questions.					

List of MVA Possible Complications

1. Syringe full
2. Cannula withdrawn prematurely
3. Cannula clogged
4. Syringe does not hold vacuum
5. Less than expected tissue
6. Incomplete evacuation
7. All POC Passed before the MVA
8. Vaginal bleeding not due to pregnancy
9. Post-abortal syndrome (acute hematometra)
10. Fainting (vagal reaction or neurogenic shock)
11. Uterine perforation
12. Cervical perforation
13. Shock, severe vaginal bleeding and post-MVA infection
14. Air embolism

Attachment A

Postabortion Care Training Course for Ob/Gyn Pre and Post-Test

Participant Name: _____

Specialty: _____ Hospital _____

Date: _____

Instructions: Circle all the answers that apply. Some questions have more than one correct answer.

1. The return to fertility following a first trimester abortion is:

- a. 2–3 weeks after the abortion.
- b. 30 days after the abortion.
- c. Following the first menstruation after the abortion.
- d. All of the above.
- e. None of the above.

2. The following aspects must be taken into account to provide information on contraception for postabortion patients:

- a. Reproductive risk.
- b. Effectiveness of method.
- c. Patient preference for a particular method.
- d. Availability of a wide range of contraceptive options.
- e. All of the above.

3. The family planning counseling process may be described as:

- a. A one-way communication process in which the provider asks the questions and the client answers them.
- b. A onetime process in which a client learns everything about the family planning methods.
- c. A process of interpersonal communication through which emotional support is given to the client to help her make a decision.
- d. An ongoing communication process that takes place at every health center and family planning service encounter.

4. Informed choice means that a family planning client:

- a. Has been informed about all methods and agrees to use the contraceptive method the provider recommends.
- b. Has informed the provider about the method s/he wants.
- c. Has been informed about the side effects of the method s/he has chosen.
- d. Has the right to choose any method s/he wants (including the right not to choose any method), based on full information about the benefits and risks of all the methods available; and has been counseled on all aspects of the method chosen.

5. Which of the following are good examples of nonverbal communication?

- a. Stating instructions clearly
- b. Looking directly at the patient
- c. Using simple language
- d. Making encouraging gestures

6. Which of the following statements related to general anesthesia is true?

- a. Provides high level of safety and maximum participation of patient
- b. Increases the risk of complications, lengthens time of recovery, and has negative physiologic effects on the patient
- c. Produces a minimum of physiologic disorders allowing firm contraction of uterus
- d. Is followed by a prompt recovery

7. Which of the following strategies is/are applicable for pain management during the MVA:

- a. Showing breathing techniques to the patient to help her relax during the procedure.
- b. Telling her that the procedure is “simple” and “it won’t hurt.”
- c. Explaining that during the procedure she might experience a discomfort similar to a menstrual cramp.
- d. Telling the patient that you want her to ask for additional pain medication if the pain becomes too strong.

- 8. Which are some of the ways to reduce anxiety in a patient during the MVA procedure?**
- Good communication and supportive attitude of the service providers
 - Use of sedatives
 - Clear explanation of each step of the procedure
 - Telling her the procedure won't hurt
- 9. Which are the elements to be considered in the selection of the diameter of the cannula in the treatment of incomplete abortion?**
- The age of the patient and the LMP
 - The position of the uterus and the degree of cervical dilation
 - Sign of infection and the size of the uterus
 - The type of anesthesia used and the degree of dilation
 - The size of the uterus by bimanual examination and the degree of cervical dilation
- 10. What is the best way to determine the size of the uterus before MVA?**
- Examining the cervix
 - History of amenorrhea
 - Bimanual examination
 - Speculum examination
- 11. Which of the following are contra-indications to the use of MVA for treatment of incomplete abortion?**
- Uterus over 12 weeks LMP in size
 - Urinary tract infection
 - Acute cervicitis or pelvic infection, without treatment
 - Anemia
- 12. Which of the following are appropriate High Level Disinfection (HLD) methods for disinfecting MVA cannula?**
- Autoclave for 10 minutes
 - Soaking in enzymatic soap for 20 minutes

- c. Soaking in 2% glutaraldehyde (Cidex) for 20 minutes
- d. Soaking in 0.5% chlorine solution for 20 minutes

13. Which of the following is the most appropriate method for sterilizing MVA equipment?

- a. Soaking in 2% glutaraldehyde (Cidex) for 10 hours
- b. Soaking in Savlon for 1 hour
- c. Autoclaving for 1 hour
- d. Soaking in alcohol 70% for 20 minutes

14. A woman comes for treatment of incomplete abortion and on vaginal examination, has an infection. She requests to have an IUD inserted. The service provider should:

- a. Tell her an IUD is not the method for her.
- b. Insert the IUD and give her an antibiotic.
- c. Not insert the IUD, wait for resolution of the infection (3 months), and suggest the use of another method during those 3 months.
- d. Tell her to return for family planning after her next menstrual period.

15. A postabortion patient is experiencing anemia. Which contraceptive method may be the most appropriate for her?

- a. IUD
- b. Minilaparotomy
- c. Combined oral contraceptives
- d. A Norplant implant

16. Which of the following are signs that the MVA procedure is complete?

- a. Walls of the uterus feel smooth
- b. Walls of the uterus feel gritty
- c. Uterus contracts around the cannula
- d. The cervix relaxes

17. Which of the following statements are true about the use of a local anesthetic (paracervical block) when performing a MVA procedure?

- a. The paracervical block reduces the pain from dilating the os.
- b. Local anesthesia can stop the pain completely.
- c. The best local anesthetic to use is 1% lidocaine without epinephrine.
- d. The local anesthetic stops the pain caused by uterine contractions related to the emptying of the uterus.

18. When MVA is used for treatment of incomplete abortion, women are likely to feel pain from:

- a. Headache.
- b. Cervical movement/manipulation.
- c. Leg cramps.
- d. Uterine cramps.

19. What is the best way to determine uterine size?

- a. Looking at the cervix
- b. Palpating the abdomen
- c. Bimanual examination
- d. Calculating the LMP (Last Menstrual Period)

20. Which of the following are signs of infection following an unsafe abortion?

- a. High blood pressure
- b. Foul-smelling vaginal discharge
- c. Chills, fever, sweats
- d. Severe bleeding

Instructions: Read the statements below and place a mark in the true or false space provided.

	True	False
21. In the presence of infection, the MVA procedure should be done under antibiotic cover.		
22. During the MVA procedure, counseling reduces anxiety and therefore lessens pain		
23. The following are elements, which should be incorporated into each counseling session: privacy, confidentiality, and technical jargon		
24. During the counseling/orientation process the service provider must:		
25. Insist that the client express her feelings.		
26. Inquire about reproductive and family planning history.		
27. Offer information about what to expect during and after the MVA procedure.		
28. Show a preference for a particular method.		
29. If the cervix is open, you do not need to do a paracervical block.		

Pre- and Post-Test Answer Key

1. The return to fertility following a first trimester abortion is:

- a. 2–3 weeks after the abortion.
- b. 30 days after the abortion.
- c. Following the first menstruation after the abortion.
- d. All of the above.
- e. None of the above.

2. The following aspects must be taken into account to provide information on contraception for postabortion patients:

- a. Reproductive risk.
- b. Effectiveness of method.
- c. Patient preference for a particular method.
- d. Availability of a wide range of contraceptive options.

e. All of the above.

3. The family planning counseling process may be described as:

- a. A one-way communication process in which the provider asks the questions and the client answers them.
- b. A onetime process in which a client learns everything about the family planning methods.

c. A process of interpersonal communication through which emotional support is given to the client to help her make a decision.

- d. An ongoing communication process that takes place at every health center and family planning service encounter.

4. Informed choice means that a family planning client:

- a. Has been informed about all methods and agrees to use the contraceptive method the provider recommends.
- b. Has informed the provider about the method s/he wants.
- c. Has been informed about the side effects of the method s/he has chosen.

d. Has the right to choose any method s/he wants (including the right not to choose any method), based on full information about the benefits and risks of all the methods available; and has been counseled on all aspects of the method chosen.

5. Which of the following are good examples of nonverbal communication?

a. Stating instructions clearly

b. Looking directly at the patient

c. Using simple language

d. Making encouraging gestures

6. Which of the following statements related to general anesthesia is true?

a. Provides high level of safety and maximum participation of patient

b. Increases the risk of complications, lengthens time of recovery, and has negative physiologic effects on the patient

c. Produces a minimum of physiologic disorders allowing firm contraction of uterus

d. Is followed by a prompt recovery

7. Which of the following strategies is/are applicable for pain management during the MVA:

a. Showing breathing techniques to the patient to help her relax during the procedure.

b. Telling her that the procedure is "simple" and "it won't hurt."

c. Explaining that during the procedure she might experience a discomfort similar to a menstrual cramp.

d. Telling the patient that you want her to ask for additional pain medication if the pain becomes too strong.

8. Which are some of the ways to reduce anxiety in a patient during the MVA procedure?

a. Good communication and supportive attitude of the service providers

b. Use of sedatives

c. Clear explanation of each step of the procedure

d. Telling her the procedure won't hurt

9. Which are the elements to be considered in the selection of the diameter of the cannula in the treatment of incomplete abortion?

- a. The age of the patient and the LMP
- b. The position of the uterus and the degree of cervical dilation
- c. Sign of infection and the size of the uterus
- d. The type of anesthesia used and the degree of dilation
- e. The size of the uterus by bimanual examination and the degree of cervical dilation

10. What is the best way to determine the size of the uterus before MVA?

- a. Examining the cervix
- b. History of amenorrhea
- c. Bimanual examination
- d. Speculum examination

11. Which of the following are contra-indications to the use of MVA for treatment of incomplete abortion?

- a. Uterus over 12 weeks LMP in size
- b. Urinary tract infection
- c. Acute cervicitis or pelvic infection, without treatment
- d. Anemia

12. Which of the following are appropriate High Level Disinfection (HLD) methods for disinfecting MVA cannula?

- a. Autoclave for 10 minutes
- b. Soaking in enzymatic soap for 20 minutes
- c. Soaking in 2% glutaraldehyde (Cidex) for 20 minutes
- d. Soaking in 0.5% chlorine solution for 20 minutes

13. Which of the following is the most appropriate method for sterilizing MVA equipment?

- a. Soaking in 2% glutaraldehyde (Cidex) for 10 hours
- b. Soaking in Savlon for 1 hour
- c. Autoclaving for 1 hour
- d. Soaking in alcohol 70% for 20 minutes

14. A woman comes for treatment of incomplete abortion and on vaginal examination, has an infection. She requests to have an IUD inserted. The service provider should:

- a. Tell her an IUD is not the method for her.
- b. Insert the IUD and give her an antibiotic.
- c. Not insert the IUD, wait for resolution of the infection (3 months), and suggest the use of another method during those 3 months.
- d. Tell her to return for family planning after her next menstrual period.

15. A postabortion patient is experiencing anemia. Which contraceptive method may be the most appropriate for her?

- a. IUD
- b. Minilaparotomy
- c. Combined oral contraceptives
- d. A Norplant implant

16. Which of the following are signs that the MVA procedure is complete?

- a. Walls of the uterus feel smooth
- b. Walls of the uterus feel gritty
- c. Uterus contracts around the cannula
- d. The cervix relaxes

17. Which of the following statements are true about the use of a local anesthetic (paracervical block) when performing a MVA procedure?

- a. The paracervical block reduces the pain from dilating the os.
- b. Local anesthesia can stop the pain completely.
- c. The best local anesthetic to use is 1% lidocaine without epinephrine.
- d. The local anesthetic stops the pain caused by uterine contractions related to the emptying of the uterus.

18. When MVA is used for treatment of incomplete abortion, women are likely to feel pain from:

- a. Headache.
- b. Cervical movement/manipulation.
- c. Leg cramps.
- d. Uterine cramps.

19. What is the best way to determine uterine size?

- a. Looking at the cervix
- b. Palpating the abdomen
- c. Bimanual examination
- d. Calculating the LMP (Last Menstrual Period)

20. Which of the following are signs of infection following an unsafe abortion?

- a. High blood pressure
- b. Foul-smelling vaginal discharge
- c. Chills, fever, sweats
- d. Severe bleeding

Instructions: Read the statements below and place a mark in the true or false space provided.

	True	False
1. In the presence of infection, the MVA procedure should be done under antibiotic cover.	X	
2. During the MVA procedure, counseling reduces anxiety and therefore lessens pain	X	
3. The following are elements, which should be incorporated into each counseling session: privacy, confidentiality, and technical jargon		X
During the counseling/orientation process the service provider must:		
4. Insist that the client express her feelings.		X
5. Inquire about reproductive and family planning history.	X	
6. Offer information about what to expect during and after the MVA procedure.	X	
7. Show a preference for a particular method.		X
8. If the cervix is open, you do not need to do a paracervical block.	X	

Attachment B

Counseling Wall Chart

خطوات المشورة لحالات ما بعد الإجهاض

بعد العملية

- التحدث مع المريضة بطريقة ودية وطمأنتها على صحتها مع توضيح الآتي:
 - الحاجة إلى الراحة
 - التغذية السليمة
 - عودة الخصوبة في خلال أسبوعين
 - أهمية استخدام وسيلة لتنظيم الأسرة
 - علامات الخطر
 - مواعيد وأهمية المتابعة



أثناء العملية

- التحدث إلى المريضة بطريقة ودية وتهنئتها
- شرح مبسط لما يحدث أثناء العملية
- مساعدة المريضة على الاسترخاء والتخفيف من آلامها



قبل العملية

- طمأننة المريضة وتشجيعها
- أخذ موافقة المريضة على إجراء العملية
- شرح مزايا المخدر الموضعي مقارنة بالمخدر الكلي
- وصف مبسط لخطوات العملية
- الرد على تساؤلات المريضة ومخاوفها
- بدء المشورة بخصوص تنظيم الأسرة









Diagnosis Wall Chart



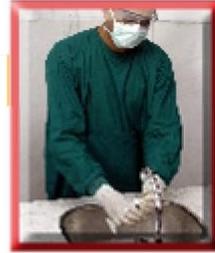
MVA Disinfection Wall Chart

إجراءات إعادة استخدام أدوات الشفط اليدوي ومنع انتشار العدوى

١- إزالة التلوث بواسطة وضع الآلات في محلول كلورين ٠,٥%
بعد الاستعمال مباشرة لمدة ١٠ دقائق



٢- غسل الآلات والحقن بعد تفكيكها بماء فاتر
مضاف اليه منظف سائل



٣- وضع الآلات والسرنجات والكانيونات في محلول
سيدكس (جلوترالديهايد ٢%)
لمدة ٢٠ دقيقة ← تطهير فائق المستوى
لمدة ١٠ ساعات ← تعقيم



٤- تشطف الآلات والأدوات (الكانيونات والسرنجات)
بماء مقطر أو ماء سبق غليه (لمدة عشرون دقيقة) ثم تم تجفيفه.
(يجب التأكد من أن التعامل مع الآلات المعقمة يتم باستخدام جفث معقم)



٥- توضع الآلات في وعاء معدني سبق تعقيمه
أو تلف بظوطة معقمة لحين إعادة الاستخدام.
(يجب وضع تاريخ التعقيم على الوعاء المعدني)

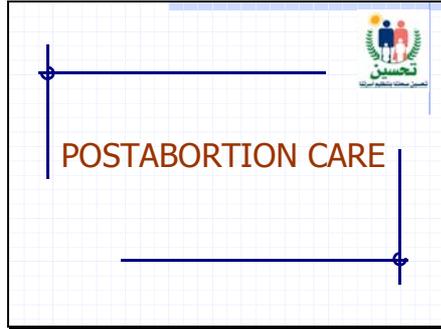


Attachment C

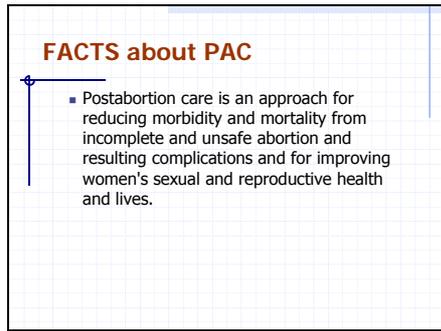
PowerPoint Presentations

1. PAC Introduction
2. Ethics
- 3a. Postabortion Family Planning and Counseling
- 3b. Postabortion Counseling Wall Charts
4. MVA Facts
5. Patient Evaluation and Assessment
6. Infection Control
7. MVA Pain Management
8. Complications of MVA
9. Processing MVA Instruments for Reuse

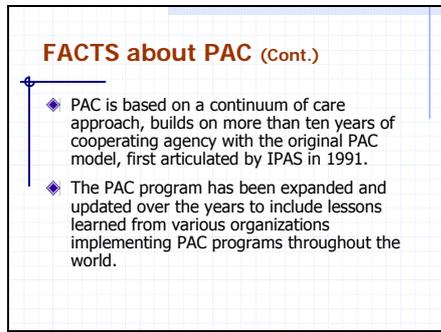
Slide 1



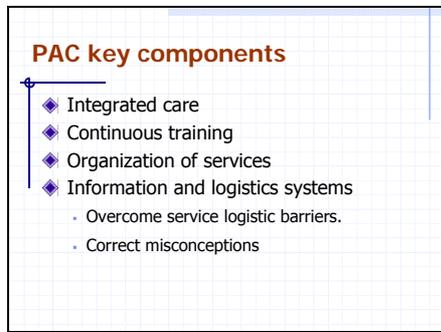
Slide 2



Slide 3



Slide 4



Slide 5

The problem of abortion

- ◆ Abortion is interruption or termination of pregnancy before the age of medico-legal viability.
- ◆ The incidence of spontaneous abortion is about 20%. The incidence of induced abortion is extremely difficult to determine, for that reason it is often estimated.

Slide 6

Problem Worldwide *

- ◆ Abortion is one of the causes of maternal death, mainly due to hemorrhage, sepsis and general anesthesia complications.
- ◆ The WHO estimates that:
 - Almost 500,000 women die in pregnancy and child birth every year.
 - Approximately 15-30% of these deaths (about 200,000) are due to complications of abortion
 - The majority of these deaths (90%) occur in developing countries
 - Moreover, an estimated 60 percent of pregnancies are unwanted, half of which are terminated, often in unsafe conditions.

* Preventing Maternal Deaths . WHO, Geneva , 1989 :30.

Slide 7

Problem in Egypt

- ◆ Abortion represents 19 % of total Ob/Gyn hospital admissions. Annually approx 340,000 women present for PAC, of whom 85% present < 12 weeks.
* The Egyptian Fertility Care Society February 1997:11-17.
- ◆ Abortion represents 4.5% of all maternal mortality. About 60% of them are spontaneous and about 40% are probably induced.
* National Maternal Mortality Study 1992-93

Slide 8

Problem in Egypt (Cont.)

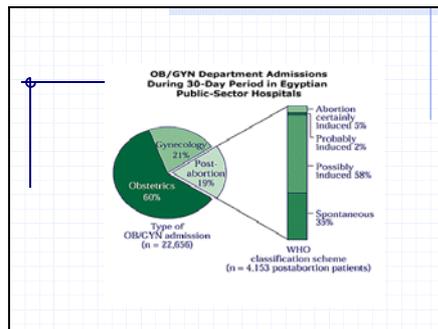
- ◆ The Cairo Demographic Center 1996 study found that one-third of 1,300 Egyptian women surveyed had tried to terminate a pregnancy
* Cairo Demographic Center (CDC)

Slide 9

Problem in Egypt (Cont.)

- ◆ In 1994, the Egyptian Fertility Care Society (EFCS) and the Population Council International (PCI) carried out a pilot study that demonstrated the feasibility of improving PAC services in Egypt.
- ◆ In 1997, the EFCS and PCI introduced a short trial to use MVA in some hospitals, but it failed to establish the procedure as a modality for treatment of incomplete abortion.
- ◆ In 2000, the EFCS extended the trial to three years and succeeded to establish PAC services.
- ◆ Sustainability of PAC in Egypt is continuing through the efforts of ANE OR/TA, FRONTIERS, MOHP, and the TAHSEEN Project.

Slide 10



Slide 11

PAC STRATEGY FOR EGYPT

- ◆ **USAID PAC model to include the following three essential elements:**
 - Emergency treatment for complications of spontaneous or unsafe abortion;
 - Family planning counseling, service provision, and referral for selected reproductive health services; and
 - Community awareness and mobilization.

Slide 12

Lessons learned

- ◆ A high demand for family planning services exists among postabortion clients
- ◆ Postabortion family planning acceptance is highest when services, including both counseling and methods, are provided at the same location where treatment is offered
- ◆ Postabortion family planning services can reduce subsequent unplanned pregnancies and the incidence of repeat abortions

Slide 13

Lessons learned (Cont.)

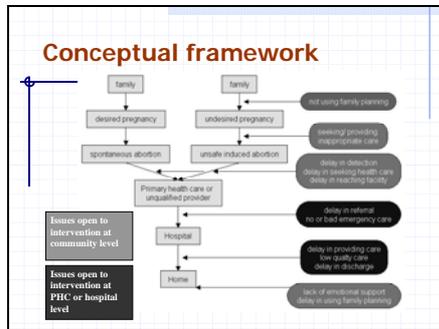
- ◆ MVA does not equal PAC. Where MVA is not available, dilation and curettage (D&C) is life-saving and is a legitimate practice to provide life-saving emergency care
- ◆ MVA is safer, less costly, and as effective as D&C for treating postabortion complications
- ◆ PAC training can effectively change provider attitudes to be less judgmental towards PAC patients
- ◆ The comprehensive PAC strategy for Egypt is based on these three essential elements and key lessons learned.

Slide 14

Access to care is often impeded by “the 3 delays.”

1. Delays in deciding to seek care
2. Delays in reaching care
3. Delays in receiving care

Slide 15



Slide 16

Program structure

- ◆ Mobilize the community and providers around PAC as an obstetric emergency, and emphasize the need for family planning counseling and provision and the importance of husband involvement in postabortion support and counseling.
- ◆ Training of PHC
- ◆ *Clinical training for hospital staff.*

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Challenges to the program

- ◆ the woman's belief that fertility will not return immediately.
- ◆ the need to return immediately to daily routines, without a chance to rest and recuperate
 - BUT: A 1999 study in Egypt showed that counseling husbands in postabortion care and contraception has a positive impact on the support that husbands provide to women postabortion, on women's postabortion recovery, and when counselors have been thoroughly trained, on contraceptive use.

Slide 18

Challenges to the program (Cont.)

- ◆ A new study: Intervals shorter than 6 months between spontaneous or unsafe induced abortion and pregnancy are independently associated with increased risks of adverse maternal and perinatal outcomes in the next pregnancy
 - Conde-Agudelo, A. et al. 2004. Effect of the interpregnancy interval after an abortion on the maternal and perinatal health in Latin America. Article in press International J Gynec Obstet.

Slide 19

Challenges to the program (Cont.)

- ◆ Thus, provision of counseling to reduce anxiety and fears, accurate and easily comprehensible information about miscarriage, unsafe induced abortion, future fertility, and support for the women's need to rest are important aspects of postabortion care.

Slide 1

Overview

Ethics in Medical Practices

Session Overview

Purpose

The purpose of this session is to orient participants to the principles of medical ethics in general and in the FP/MCH field, in particular. The session also aims to effect a positive change in physicians' attitudes toward the practice of medicine.

Slide 2

Session 1

Learning Objectives

By the end of this session, each participant should be able to:

1. Identify and explain the meaning of ethics and the importance of the oath in medical practice.
2. Recognize the importance of ethics in medical practice and in public and private health services.
3. Explain the ethical aspects of a physician's relationship with his/her patients.

Slide 3

Session 1

Learning Objectives (Cont.)

4. Explain the physician's duties toward his/her patients.
5. Explain the need to treat PAC clients with high regard and respect.

Slide 4

Session 1

Ethics and Medical Practices

Ethics are concerned with the distinction between right and wrong and the moral consequences of human actions.

Slide 5

Session 1

Medical ethics are related specifically to the principles of proper professional conduct relative to the rights and duties of physicians, patients and fellow practitioners, as well as patient care and interactions with patient families.



Slide 6

Session 1

تسعم الطبيب

أقسم بالله العظيم

- * أن أراقب الله في مهنتي .
- * وأن أصون حياة الإنسان في كافة أدوارها. في كل الظروف والأحوال بإدلة وسعي في استنقاذها من المالك والمرض والألم والقلق.
- * وأن أحفظ للناس كرامتهم، وأستر عورتهم، وأكتم سرهم.
- * وأن أكون على الدوام من وسائل رحمة الله، بإدلة رعايتي الطبية للزبيب واليهيد، والعالم والناطئ، والصديق والعدو.
- * وأن أثار على طلب العلم، وأسخره لنفع الإنسان .. لا لأداءه.
- * وأن أؤثر من علمي، وأعلم من يصغرنني، وأكون أنا لكل زميل في المهنة الطبية متعاونين على البر والتقوى.
- * وأن تكون حياتي معداق إيماني في سري وعلايتي، نقيّة مما يشينها تجاه الله ورسله والمؤمنين.

والله على ما أقول شهيد

Slide 7

Session 1

علاقة الأطباء بمرضاهم

- * حق المريض في الموافقة على العلاج الذي يقترحه الطبيب .
- * لا يفرض على المريض طبيب لا يختاره إلا في حالات الطوارئ و أمراض الحجز الصحي .
- * في حالات الطوارئ يكون من واجب الطبيب أن يقوم باللائم دون رضا المريض أو ذويه
- * على الطبيب أن يقوم بالعمل الطبي مستخدماً الوسائل الطبية الـ



Slide 8

Session 1

علاقة الأطباء بمرضاهم

- * لا يكون الطبيب مسؤولاً عن أي نتائج ضارة قد تحدث إذا لم يثبت وجود خطأ فني .
- * يوقع المريض إقرار بقبول أي عملية جراحية أو تخدير يراه الطبيب لازماً لحالته .
- * يجب ان يكون مضموا لدى المريض أن عقد العلاج ليس عقد للشفاء .
- * يلتزم الطبيب بتنصير المريض بالمخاطر العامة والمعتادة فقط.



Slide 9

Session 1

واجبات الأطباء

واجبات الأطباء نحو المرضى

- * على الطبيب أن يبذل كل ما في وسعه نحو مرضاه وأن يسعوى بينهم في الرعاية .
- * يجوز للطبيب أن يعتذر عن معالجة أي مريض آلا في حالات الطوارئ .
- * على الطبيب أن ينجيه المريض و أهله باتخاذ أسباب الوقاية .
- * على الطبيب عند الضرورة أن يهبط في غير .
- * لا يجوز للطبيب إفشاء أسرار مريضه .
- * عند حدوث أخطاء مهنية تؤدي إلى وفاة المريض يقوم الطبيب بنفسه بإبلاغ النيابة المختصة .

Slide 10

Session 1

بناء السر

- * إفشاء السر بطلب المريض .
- * إفشاء السر بطلب أحد الزوجين .
- * إفشاء السر في حالة التأمين على الحياة .
- * شهادة الطبيب أمام القضاء .

Slide 11

Session 1

التسوية

- * التبليغ عن الأمراض السارية والواحدة .
- * التبليغ عن المواليد والوفيات .
- * حق الطبيب في إفشاء السر في حالات أربعة :
 - 1 الحفاظ على مصلحة المجتمع .
 - 2 الحفاظ على مصلحة أحد الأفراد .
 - 3 الحفاظ على مصلحة المريض .
 - 4 الحفاظ على مصلحة الطبيب أو المهنة .

Slide 12

Session 1

واجبات الأطباء

واجبات الأطباء نحو زملائهم

- * على الطبيب تسوية أي خلاف ينشأ بينه وبين أحد زملائه في شؤون المهنة بالطرق الودية أو بجمعية النقابة الفرعية .
- * لا يجوز للطبيب أن يسعوى لمزاحمة زميل له بطريقة غير كريمة ، و لا يجوز له الإقلال من قدرات زملائه .
- * إذا حل طبيب محل زميل له في عيادته فعليه ألا يحاول استغلال هذا الوضع لصالحه الشخصي .

Slide 13

Session 1

واجبات الأطباء

واجبات الأطباء نحو زملائهم

- * لا يجوز للطبيب أن يتقاضى أتعاباً عن علاج زميل له أو علاج زوجته أو أولاده .
- * لا يجوز للطبيب فحص أو علاج مريض يعالجه زميل له في المستشفى إلا إذا استدعاه لذلك الطبيب المعالج أو إدارة المستشفى .
- * لا يجوز للطبيب المعالج أن يرفض طلب المريض أو أهله دعوة طبيب آخر ينضم إليه على سبيل الاستشارة .

Slide 14

Session 1

واجبات الأطباء

واجبات الأطباء نحو مهنتهم



- * على الطبيب أن يراعي الدقة والأمانة في جميع تصرفاته وأن يحافظ على كرامته وكرامة المهنة .
- * لا يجوز لطبيب أن يضم تقريراً أو يعطي شهادة تخاير الحقيقة .
- * لا يجوز للطبيب أن يستغل وظيفته بقصد الاستفادة من أعمال المهنة أو الحصول على كسب مادي من المريض .

Slide 15

Session 1

أخطاء المهنة

أ. الخطأ القائم على الإهمال .

ب. الخطأ الفني .



Slide 16

Session 1

بعض الحالات التي يرتكب فيها الأطباء أخطاءً ضد الإنسانية

- * الطبيب الذي يجري عملية جراحية دون رضا المريض في غير حالات الطوارئ .
- * إذا تدخل تدخل يضر بالجسم دون فائدة للصحة .
- * إذا عرض المريض لخطر عملية لا يتناسب مع الخير المتوقع منها .
- * لم يتخذ احتياطات منع العدوى اللازمة .
- * إذا أعطى للمريض وصقة مكتوبة تحمل ضرراً للمريض .
- * إذا نسي خطأ شيئاً داخل الجسم .

Slide 17

Session 1

مسئولية الأطباء الجزائية عن أخطائهم في ممارسة المهنة

حدد القانون أحوال الخطأ كما يلي

- * الرعونة .
- * التفريط (أي عدم الاحتياط).
- * الإهمال .
- * عدم الانتباه .
- * عدم مراعاة اللوائح .



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Session 1

بعض آداب الممارسة المهنية

- * المسؤولية الطبية عن الإهمال .
- * المسؤولية الطبية عن التلقيح الصناعي .
- * المسؤولية الطبية عن التعقيم .
- * المسؤولية الطبية عن البحوث على الحوامل
- * المسؤولية الطبية عن التقرير الطبي .



Slide 19

Ethics in practice

- ◆ Women seeking treatment for incomplete abortion often are under severe emotional stress
- ◆ Women may be fearful or reluctant to provide the information needed for appropriate emergency treatment.
- ◆ Quickly establishing a good, positive relationship can help ease the anxiety and concern that patients may feel.
- ◆ Moreover, it is important to respect women's rights and needs and to provide care without expressing judgment, either verbally or non-verbally.

Slide 20

Patient rights

- ◆ The right to immediate emergency treatment, regardless of whether they have had a spontaneous abortion or resorted to unsafe abortion.
- ◆ The right to information about their condition.
- ◆ The right to discuss their concerns and condition in an environment in which they feel confident.
- ◆ The right to privacy and confidentiality.

Slide 21

Session 1

Summary

Learning Objectives

By the end of this session, each participant should be able to:

1. Identify and explain the meaning of ethics and the importance of the oath in medical practice.
2. Recognize the importance of ethics in medical practice and in public and private health services.
3. Explain the ethical aspects of a physician's relationship with his/her patients.

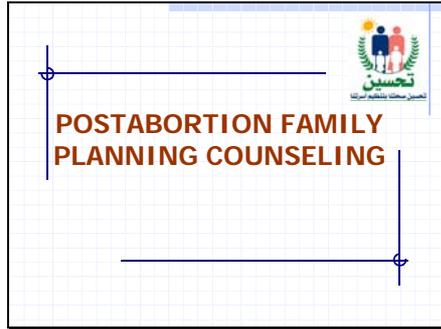
Slide 22

Session 1

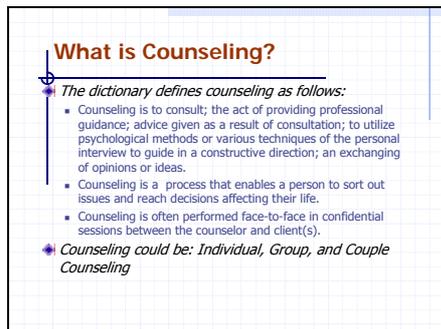
Learning Objectives (Cont.)

4. Explain the physician's duties toward his/her patients.
5. Explain the need to treat PAC clients with high regard and respect.

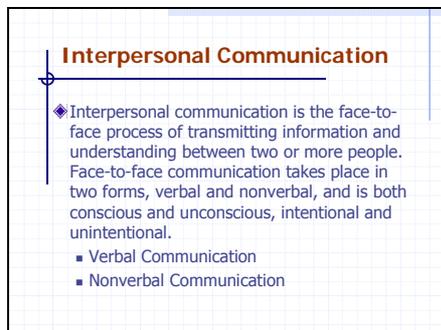
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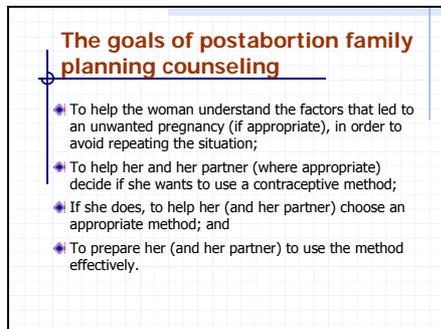
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Slide 4



Slide 5

Free and informed choice

- ◆ Free and informed choice means that the client chooses a method voluntarily without coercion or pressure.
- ◆ It is based on a clear understanding of the benefits and limitations of the methods that are available.
- ◆ The client should understand that almost all methods can be used safely and effectively immediately after treatment of an incomplete abortion and that she can choose another method later if she wishes to change.

Slide 6

General Approach to Counseling

- ◆ Counseling is a two-way communication process
- ◆ Counseling is an ongoing process and must be part of every client-provider interaction in health care delivery.
- ◆ Counseling should take place in a private, quiet place.
- ◆ Confidentiality must be ensured, both in the process of counseling and the handling of client records.
- ◆ It is essential that counseling take place in a non-judgmental, accepting and caring atmosphere.

Slide 7

General Approach to Counseling (Cont.)

- ◆ The client should be able to understand the language the provider uses.
- ◆ Clinic staff must use good interpersonal communication skills, including the ability to question effectively, listen actively, summarize and paraphrase clients' comments or problems and adopt a non-judgmental, helpful manner.
- ◆ The client should not be overwhelmed with information.
- ◆ Use audiovisual aids and contraceptive samples
- ◆ Always verify that the client has understood what has been discussed.

Slide 8

Specific Approach for Counteracting Rumors and Misinformation

- ◆ Always listen politely. Don't laugh.
- ◆ Define what a rumor or misconception is.
- ◆ Find out where the rumor came from and talk with the people who started it or repeated it.
- ◆ Explain the facts.
- ◆ Use strong scientific facts to counteract misinformation.
- ◆ Always tell the truth.
- ◆ Clarify information with the use of demonstrations and visual aids.
- ◆ Reassure the client by examining her and telling her your findings.

Slide 9

The GATHER Technique

- ◆ Greet the client
- ◆ Ask the woman how she is feeling and express concern
- ◆ Tell the client about family planning methods without losing sight of her concerns and preferences
- ◆ Help client consider her needs, and what method best meets them
- ◆ Explain how the chosen method works and how it should be used
- ◆ Return visits OR Refer client to another facility

Slide 10

Objectives of Postabortion Contraception

- ◆ To avoid the risk of subsequent pregnancy
 - A woman's fertility generally returns within 2 weeks after an incomplete abortion in the first trimester.
 - Unfortunately, many women are not aware of this because it differs from the postpartum period
 - Postabortion family planning should be initiated as soon as possible.

Slide 11

Contraception after postabortion complications

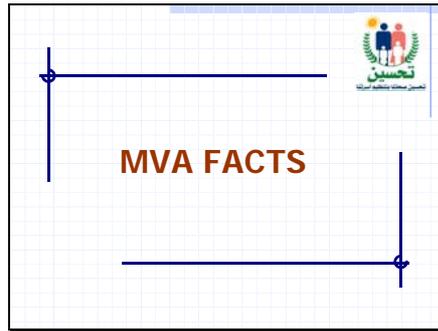
- ◆ Women who have been treated for postabortion complications may have medical conditions that could affect the selection of a contraceptive method.
- ◆ Women with postabortion complications need careful assessment prior to using FP methods.

Slide 12

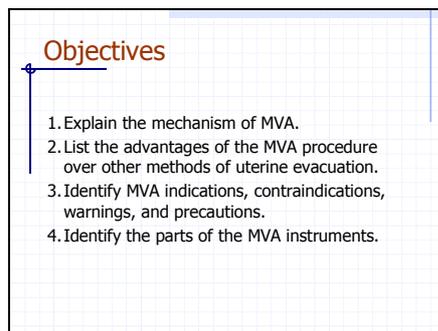
خطوات المشورة لحالات ما بعد الاجهاض

بعد العملية	أثناء العملية	قبل العملية
<ul style="list-style-type: none"> ◆ الخطوات يجب التوجيه بطريقة واضحة وجيدة ◆ وطبقا لتحتا على صحتها مع توضيح الفرق ◆ المناجزة الى الزمسة ◆ التقديرية السليمة ◆ عمدة المشورة في خلال السبعين ◆ الفعية استخدام وسيلة تنظيم الأسرة ◆ علامات الخطر ◆ مؤاميد والعمية المتابعة 	<ul style="list-style-type: none"> ◆ التحدث الى العمريسة بطريقة واضحة ◆ واجباتها ◆ شرح السليمة لها بحيث تشارك العمريسة ◆ مساعدة العمريسة على الاستعداد ◆ والتخفيف من الامها 	<ul style="list-style-type: none"> ◆ طباعة العمريسة والتشجيعها ◆ شرح مزايا الماخدر العمريسة على اجراء العمريسة ◆ المساعدة الكافية العمريسة على الاستعداد ◆ ارفق على الماخدرات العمريسة ◆ ارفق على الماخدرات العمريسة ◆ وجاهدتها

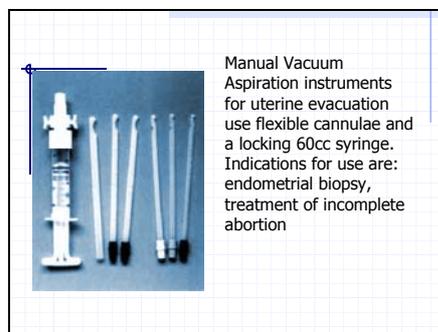
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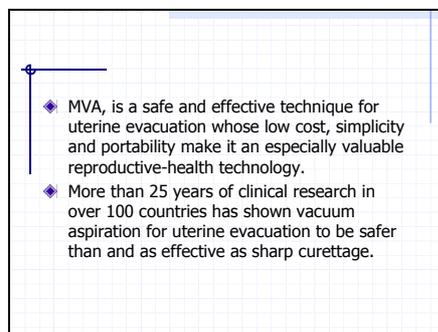
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Slide 5

- ◆ IPAS has manufactured MVA instruments since 1973
- ◆ It is a double-valve aspirator. It is composed of the following parts:
 - A valve with a pair of buttons that control the vacuum,
 - A plunger with a plunger handle,
 - A 60cc cylinder for holding evacuated uterine contents,
 - A removable collar stop &
 - Two O-rings – one inside the valve and the other on the end of the plunger

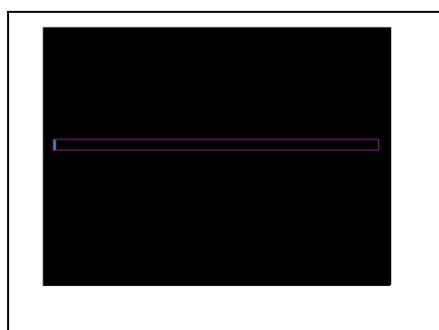
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- ◆ The IPAS cannulae are available in sizes 6, 7, 8, 9, 10 and 12mm. The smaller cannulae (6mm - 8mm), have two opposing apertures.
- ◆ The larger cannulae (9,10 and 12mm), have a larger single scoop aperture to allow for the removal of thicker tissue.
- ◆ Dots imprinted on each cannula indicate the location of the main aperture.
- ◆ The first dot is 6cm from the cannula tip and dots thereafter are spaced at 1cm intervals.

Slide 7

- ◆ The flexible Karman cannulae are used with adapters that are color-coded by size, using the same color system used for the cannula dots (6mm=blue, 7mm=tan, 8mm=ivory, 9mm=brown, 10mm=green, 12mm no adaptor needed).
- ◆ To attach an adapter to a flexible Karman cannula, locate the correct adapter for the cannula being used and push it securely onto the end of the cannula.

Slide 8



Slide 9



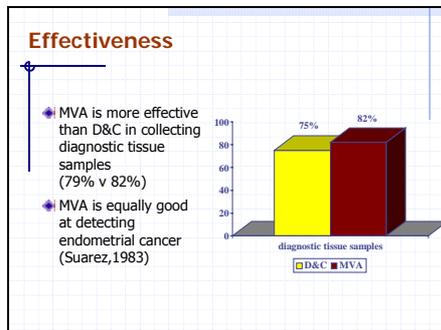
Slide 10

Effectiveness

Treatment of Incomplete Abortion	
Studies	19
Procedures	>5.000
Evacuation Rate	Majority ±98%

Adapted from Greenaldo et al, 1993.

Slide 11



Slide 12

Safety

Complications per 100 Abortion Procedures

Type of Procedure	Total	Major
Vacuum Aspiration	5.0	0.4
Sharp Curettage	10.6	0.9

Slide 13

Safety: Selected Studies Comparing Complications of MVA & Sharp Curettage

Author (Year) Country	Excess Blood Loss		Pelvic Infection		Cervical Injury		Uterine Perforation	
	MVA	SC	MVA	SC	MVA	SC	MVA	SC
Verkuyl & Crowther (93) Zimbabwe	2.8	10.0	1.5	5.3	NA	NA	0.0	0.8
Mohamed et al. (92) Zimbabwe	0.2	0.7	NA	NA	0.1	0.3	0.0	0.2
Kizza & Rogo (90) Kenya	3.3	5.8	5.4	6.0	NA	NA	0.0	0.4

Slide 14

Studies Comparing Complications of Vacuum Aspiration (VA) and Sharp Curettage (SC)

Finding: Complication rate for VA lower than or equal to SC

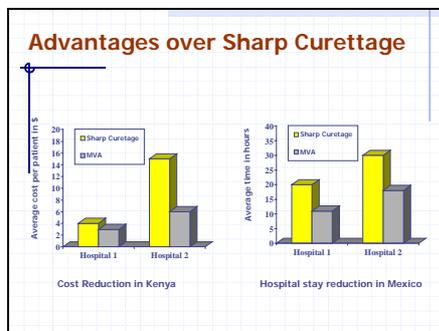
- ◆ Excess Blood Loss ◆ 10 out of 13 studies
- ◆ Pelvic Infection ◆ 7 out of 9 studies
- ◆ Cervical Injury ◆ 6 out of 7 studies
- ◆ Uterine Perforation ◆ 10 out of 12 studies

Slide 15

MVA Advantages

- ◆ Outpatient procedure
- ◆ Pain Control: only by oral analgesia – Paracervical Block and heavy sedation is not necessary. (could be done in absence of anesthesiologist as is the case in some Egyptian hospitals in district areas)
- ◆ Patients recover more quickly and return home sooner! (356 min. vs 2,577 min.)

Slide 16



Slide 17

MVA Advantages

- ◆ Syringe and cannula made of durable plastic
- ◆ Flexible cannula has rounded tip, narrow, uniform width:
 - Little dilation is required (the size of cannula chosen depends on: size of intrauterine remnants and cervical dilatation)
 - Gentle to uterine lining
- ◆ Aspiration time is 3 – 5 minutes.

Slide 18

Indications

- ◆ Uncomplicated incomplete abortion < 12 weeks
- ◆ Infected abortion after managing the infection
- ◆ Inevitable abortion < 12 weeks
- ◆ Uncomplicated missed abortion < 12 weeks
- ◆ Hydatiform mole < 12 weeks

Slide 19

Use with precautions

- ◆ Excessive anxiety
- ◆ Antecedents of coagulation disorders
- ◆ Recent uterine surgery
- ◆ Suspicion of uterine perforation
- ◆ Severe anemia
- ◆ Uterine myomas
- ◆ Uterine abnormalities
- ◆ Hemodynamic instability:
 - Cardiopathy
 - Hypovolemic shock
 - Septic shock
- ◆ Acute purulent cervicitis.

Slide 20

Contraindications

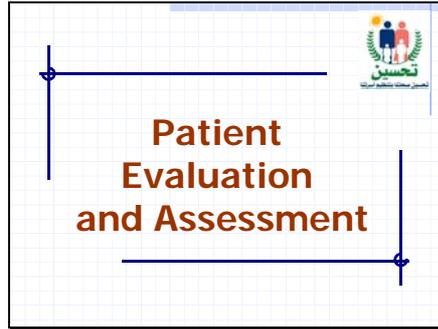
- ◆ Biopsy: Suspicion or confirmation of pregnancy
- ◆ Uterine size greater than 12 weeks since last menstrual period (LMP)
- ◆ Dilation greater than 12 mm

Slide 21

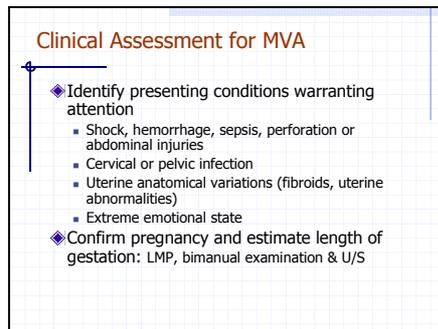
Possible Complications (rare)

- ◆ Incomplete evacuation
- ◆ Uterine or cervical perforation
- ◆ Hypotension
- ◆ Vaginal reaction
- ◆ Pelvic infection
- ◆ Hemorrhage
- ◆ Acute hematometra
- ◆ Air embolism

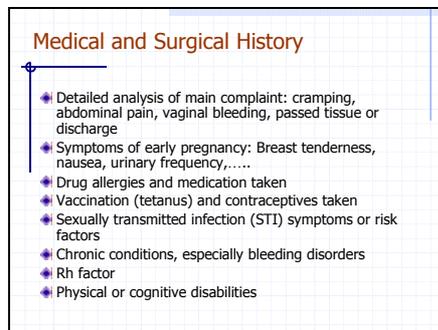
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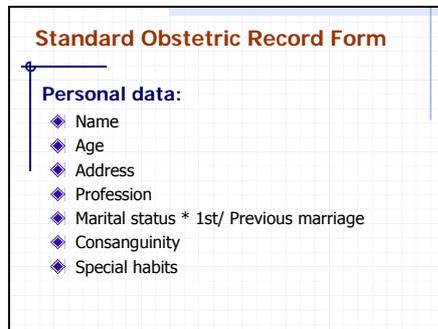
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Slide 4



Slide 5

- L.M.P. EDD.

- * Pattern
- * Amount
- * Date of 1st day

Slide 6

Obstetric data:
GP

- * Parity number (pregnancy outcome, route of delivery)
- * Live births (sex and age)
- * Still births (sex and number)
- * How many children are presently living?
- * If they died, from what causes?
- * Mode of delivery (cesarean, forceps, ventous, normal)
- * Abortions (gestational age, number and types)
- * Date of last labor
- * Date of last abortion
- * Congenital anomalies of previous

Slide 7

Vaginal bleeding

- ✓ Color
 - * Brownish
 - * Rosy
 - * Red
- ✓ Amount
 - * Light
 - * Moderate
 - * Severe
- ✓ Duration
- ✓ Presence or absence of clots
- ✓ Passed tissue or not

Slide 8

Pain

- ◆ Back pain
- ◆ Lower abdominal pain



Slide 9

Symptoms of Hypotension / Hypovolemia

- ◆ Dizziness (drowsiness)
- ◆ Nausea / Vomiting
- ◆ Headache
- ◆ Pallor
- ◆ Visual disturbances
- ◆ Thirst
- ◆ Diaphoresis
- ◆ Fainting
- ◆ Oliguria



Slide 10

Associated urinary tract symptoms

- ◆ Dysuria
- ◆ Frequency
- ◆ Retention
- ◆ Urinary flow interruption
- ◆ Oliguria

Slide 11

Psychosocial Assessment

- ◆ Open communication can aid in developing the best treatment plan
- ◆ Encourage but do not force, patient to discuss the circumstances of her abortion
- ◆ The patient's pain may result from patient's physical and emotional status

Slide 12

Examination of a Client at Risk of Abortion

When gestational age < 12 weeks, associated with mild bleeding and colic, management should include the following:

- ◆ No examination
- ◆ No intercourse
- ◆ Bed rest
- ◆ Ultrasound
- ◆ Follow-up

Slide 13

When gestational age < 12 weeks, associated with moderate/severe bleeding and colic, management should include the following:

- ◆ Pelvic/vaginal examination
- ◆ First aid measures
- ◆ Termination

Slide 14

Physical Examination

- ◆ General health
- ◆ Vital signs
- ◆ Assess heart, lungs and abdomen
- ◆ Perform pelvic exam
 - Speculum exam
 - Bimanual exam

Slide 15

Pelvic Examination

- ◆ Briefly explain the purpose of exam to patient
- ◆ Support her while she assumes lithotomy position
- ◆ Assure privacy:
 - Cover patient
 - Close door
 - No unnecessary equipment in room
 - Files are confidential

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Speculum Exam

- ◆ Inspect perineum for bleeding, trauma, discharge and lesions
- ◆ Check vagina and os for bleeding, lesions and friability
- ◆ Note any pus from os, suggesting infection and need for antibiotic coverage before procedure
- ◆ Manually remove tissue and any foreign bodies protruding from os

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Bimanual Exam

- ◆ Assess size, consistency, shape and position of uterus and adnexa
- ◆ Check for any uterine, adnexal, or abdominal tenderness or abnormalities
- ◆ Sometimes the uterine size is not certain

Slide 18

Difficulty in Assessing Uterine Size

- ◆ Retroversion
- ◆ Obesity or full bladder
- ◆ Abdominal guarding
- ◆ Fibroids or anatomic abnormalities
- ◆ Ectopic pregnancy
- ◆ Incomplete abortion

In these cases, assume the pregnancy may be further advanced than initially suspected

Slide 19

Uterus Larger than Expected

- ◆ Pregnancy may be more advanced than LMP suggests
- ◆ Multiple pregnancies
- ◆ Uterus filled with clots (hematometra)
- ◆ Molar pregnancy
- ◆ Fibroids or other abnormalities

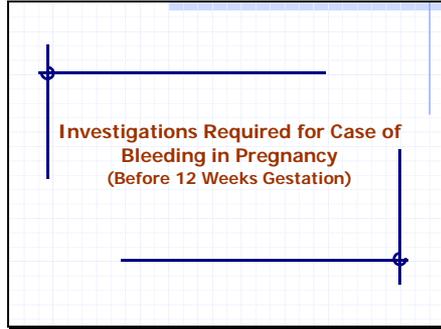
MVA is indicated for uterine sizes up to 12 weeks LMP

Slide 20

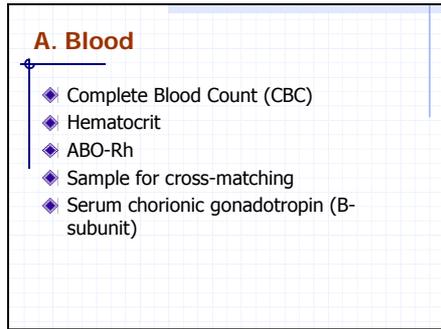
Uterus Smaller than Expected

- ◆ Consider partial expulsion of products of conception (incomplete abortion)
- ◆ Consider complete expulsion of products of conception (complete abortion)
- ◆ Consider ectopic pregnancy

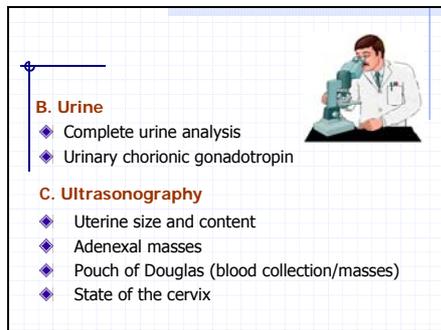
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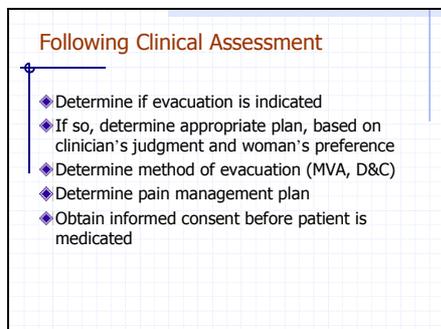
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Slide 23



Slide 24



Slide 25

If the Cervix is Open

Before 12 weeks:
Consider incomplete, inevitable abortion, or molar pregnancy. In these cases empty the uterus by MVA or curettage.



Slide 26

If the Cervix is Closed

Consider ectopic pregnancy, threatened or missed abortion, and molar pregnancy.

1. Perform an ultrasound examination. A gestational sac should be visible in a normal pregnancy six weeks after the last menstrual period and when serum chorionic gonadotropin is equal to or greater than 3,000 mIU/ml.

Slide 27

2. Check blood chorionic gonadotropin levels, which double every two days in 66% of normal pregnancies. If the level is decreasing or has plateaued, consider an ectopic pregnancy or a blighted ovum. A molar pregnancy may exist if the levels of chorionic gonadotropins are very high (more than 100,000 mIU/ml serum or 1,000,000 IU/liter urine).

Slide 28

3. If a diagnosis of threatened abortion is made, recommend bed rest and no sexual relations. Follow-up weekly in the outpatient clinic. Repeat quantitative hematocrit and chorionic gonadotropin.
4. For threatened abortion, admit the patient and follow the management flow chart; if the situation changes into an inevitable abortion, evacuate the uterus.

Slide 29

5. If there is a high suspicion of an ectopic pregnancy, or if the diagnosis is in doubt, conduct laparoscopy if available or a laparotomy with further management according to findings.

6. In the case of a missed abortion, an evacuation procedure should follow after coagulation profile testing (bleeding time, coagulation time).

Slide 30

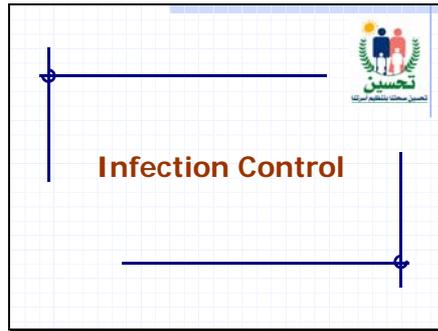
Important Considerations

- ◆ Remember that a patient can lose a lot of blood little by little. Monitor for signs of hypovolemia and tell patients to consult the hospital if they become dizzy or suffer from nausea, vomiting, or faintness.
- ◆ The key to good treatment is an early diagnosis.

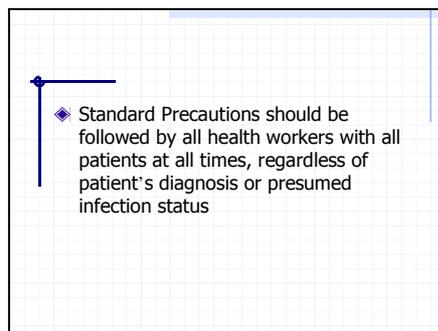
Slide 31

- ◆ The key to an early diagnosis is a highly clinical suspicion.
- ◆ Think of an ectopic or molar pregnancy when a patient presents with bleeding prior to 12 weeks gestation.
- ◆ Consider if a woman was anemic before she became pregnant.

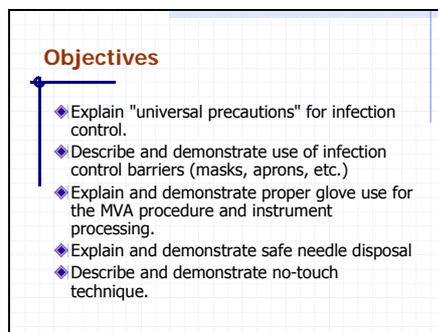
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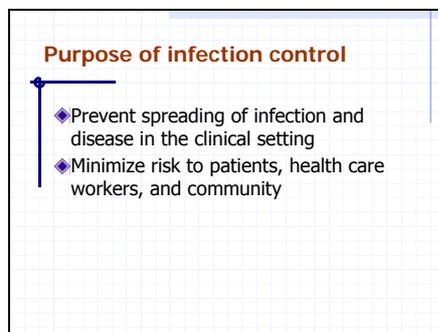
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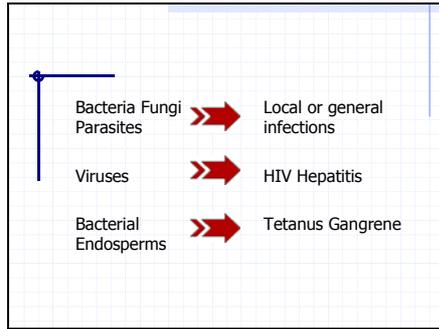
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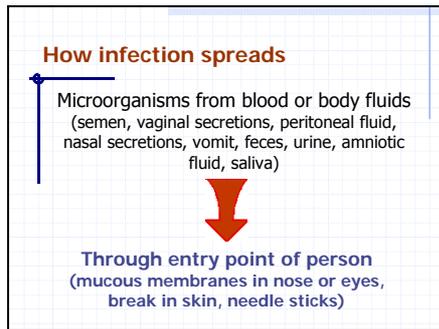
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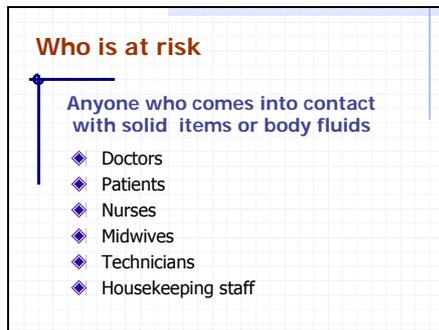
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Slide 6



Slide 7



Slide 8



Slide 9

Universal Precautions Include:

1. Hand-washing
2. Use of barriers
3. Use aseptic techniques
4. Protection from sharp instruments and fluid splash
5. Safe waste disposal
6. Cleaning of operative rooms and tables
7. Decontamination and processing instruments

Slide 10

**Universal precautions:
1- Hand Washing**

The single most important step in preventing infection



Slide 11



Which hands are yours?

Slide 12

When you wash your hands

- ◆ Wash before putting on gloves
- ◆ Wash immediately after removing gloves
- ◆ Wash after any possible contamination (pelvic exam)

Slide 13

How to wash your hands

- ◆ Use soap and running water
- ◆ Rub hands together 15-30 seconds
- ◆ Wash all parts of hands
- ◆ Use clean towel or air dry (do not share towels)



Slide 14

**Universal precautions:
2- Use of barriers**

Wear gowns, aprons, goggles, gloves

- ◆ Whenever doing patient care involving blood or body fluids
- ◆ Whenever handling body items including instruments or sheets



Slide 15

Gloves

- ◆ Use high-level disinfected exam gloves for patient exams and MVA procedure (make sure gloves have no cracks or holes)

Wash hands and change gloves between patient contacts



Slide 16

Gloves

- ◆ Use clean, heavy utility gloves when cleaning
 - Instruments
 - Equipment
 - Tables
 - Rooms
- ◆ Make sure gloves have no cracks or holes



Slide 17

Putting on sterile gloves:
A) Open method

- ◆ When the right glove is put on first, the cuff is grasped on the inside by the left hand



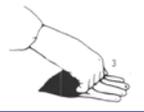
Slide 18

- ◆ The right hand is inserted into the glove, which is then pulled into place with the left hand (the cuff is left in a turned-down position). The grasp is then released.



Slide 19

- ◆ Now the right gloved hand can pick up the left glove by inserting the fingers under its cuff. (the outside is the sterile side.)



Slide 20

- ◆ The left hand is inserted into the left glove and the glove is pulled into place. The cuff is left in a turned-down position



Slide 21

◆ After folding the gown cuff snugly to the wrist, and while holding this fold in place with the sterile right gloved thumb, the fingers can safely pull the sterile glove cuff over the gown cuff



Slide 22

Another method:

◆ The scrub nurse holds the glove open for the person donning the gloves. The glove is held with the thumb facing the recipient. The top of the glove is spread wide so that the hand can be thrust into the glove without touching the person holding the glove. The glove is pulled up over the gown cuff



Slide 23

Universal precautions:
3- Use aseptic Technique

◆ No-touch technique: Instruments entering the uterus must not contact contaminated surfaces, including vaginal walls, before insertion

◆ Antiseptic preparation of cervix

◆ Properly processed instruments

Slide 24

Universal precautions:
4- Protection from sharp instruments & fluid splash

◆ Injuries from sharp instruments are the most common way HBV and HIV are transmitted in health care situations



Slide 25

To protect from needle sticks and other injuries

- ◆ Keep handling of sharp instruments to minimum

Pass sharp instruments on a tray



Slide 26

To protect from needle sticks and other injuries

- ◆ Always have puncture-proof container for sharp within reach



Slide 27

To protect from needle sticks and other injuries

- ◆ Use "no hand" method to recap needles



Slide 28

- ◆ **If you do get a needle stick**
 1. Remove gloves and wash wound immediately with soap and water
 2. If possible, get immune globulin injection

Slide 29

◆ If blood or body fluids splash in your eyes

1. Wash eyes thoroughly with clean water or saline solution
2. If possible, get immune globulin injection

Slide 30

Universal precautions:
5- Safe waste disposal

◆ Two methods to dispose of medical waste

1. Careful incineration
2. Burial in sealed containers

Slide 31

WHAT IS WRONG WITH THIS PICTURE?



Slide 32

Universal precautions:
6- Cleaning of operative rooms & tables

◆ Use utility gloves and chlorine solution when mopping up spills to decontaminate surfaces

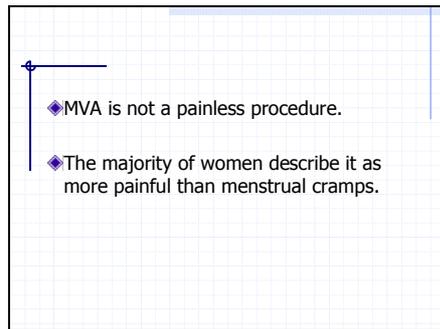
◆ Wash with detergent and water



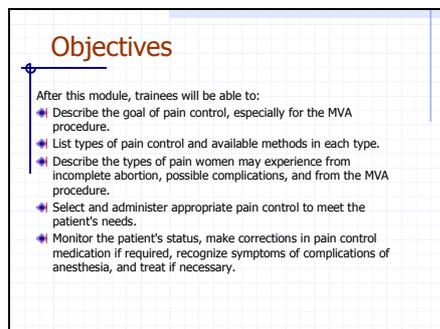
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Slide 2



Slide 3



Slide 4



Slide 5

Factors to Consider When Developing Plan

- ◆ Patient's physical status and medical history
- ◆ Degree of cervical dilatation necessary
- ◆ Psychological concerns, such as anxiety
- ◆ Skill of staff and nature of procedure
- ◆ Availability of pain medications

Slide 6

Elements of Effective Pain Management

- ◆ Quiet, comfortable procedure room with well-trained, gentle providers giving reassurance and clear information
- ◆ Involving patient in decision making
- ◆ Appropriate medications

Slide 7

Source of Pain during Uterine Evacuation

- ◆ Patient's emotional state and level of anxiety
- ◆ Cervical dilatation
- ◆ Cramping from uterine manipulation and evacuation

Slide 8

Types and Origins of Pain

Cervical dilation and/or stimulation	➡➡	Deep intense pain
Scraping of uterine wall, movement of uterus, or muscle spasms	➡➡	Diffuse lower abdominal pain with cramping

Slide 9

Origins of Pain in an Incomplete Abortion and MVA

MVA patients generally experience two types of pain:

- ◆ Deep intense pain that accompanies cervical dilation and stimulation of the internal cervical os and is transmitted by the dense network of nerves surrounding the cervix.

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- ◆ Diffuse lower abdominal pain with cramping, which occurs with the movement of the uterus, scraping of the uterine wall and the muscle spasm related to emptying the uterine cavity. Nerves that follow the utero-sacral and utero-ovarian ligaments transmit this type of pain.

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Verbal Reassurance

- ◆ Talking to patients in a soothing, attentive way, with respect and support
- ◆ Keeping patients informed about what is happening and what they can expect to feel

Every woman perceives and copes with pain differently

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Types of Pain Control Medication

- ◆ **Analgesia:** eases sensation of pain
- ◆ **Anxiolytic:** depresses central nervous system functions (reduces anxiety, relaxes muscles)
- ◆ **Anesthesia:** deadens all physical sensation

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Effective Pain Control for MVA

A combination of drug types
With
Gentle handling, reassurance, and clear communication

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Suggested Drug Combinations

Analgesia +	Anxiolytic +	Paracervical Block
Meperidine + (oral)	Diazepam + (oral)	Paracervical Block
Fentanyl + (IV)	Midazolam + (IV)	Paracervical Block

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Suggested Combinations of Pain-Control Drugs

- ◆ Local anesthesia in the form of paracervical block provides excellent relief from the pain of cervical dilation, but will not relieve abdominal pain.
- ◆ Analgesics heighten the effect of paracervical block and ease abdominal pain.

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- ◆ Anxiolytics given in conjunction with analgesics are sometimes useful to relieve anxiety. For example:
 - Diazepam plus meperidine (oral) or
 - Midazolam plus fentanyl (IV).
 - Paracervical block may be added to either of these regimens.

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Pain Control Medications for MVA Procedures

Cause of pain	Type of Medication Recommended	Example of Medication
Anxiety	Anxiolytic	Diazepam
Cervical dilatation	Local anesthetic	Lidocaine
Evacuation	Analgesic	Ibuprofen Paracetamol

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Use of Analgesia in MVA

Drug Name (Generic)	Mode	Duration of Effect	Common Side Effects
Demerol Pethidine (meperidine)	IV, IM, or oral	2 hrs.	Drowsiness, light-headedness, weakness, euphoria, dry mouth
Sublimaze (fentanyl)	IV or IM	30-60 min	
Paracetamol (acetaminophen with Codeine)	Oral	3-6 hrs.	

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Use of Analgesia in MVA

Drug Name (Generic)	Mode	Duration of Effect	Common Side Effects
(Ibuprofen)	Oral	Up to 5 hrs.	Possible gastro-intestinal upset
Paracetamol (acetaminophen)	Oral	Up to 4 hrs.	
Ketamine (ketalar)	IV	10-15 min.	

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Use of Anxiolytics in MVA

Drug Name (Generic)	Mode	Duration of Effect
Valium (diazepam)	IV, oral	2 hrs.
Versed (midazolam)	IV	30-60 min.

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Back up required for narcotics and anxiolytics:

- ◆ Clinicians trained in resuscitation
- ◆ Appropriate antagonist drug
- ◆ Resuscitative equipment:
 - Ambo bag
 - Oxygen
 - Oral Airway

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Characteristics of Anesthesia

- ◆ **General:** Affects pain receptors in brain, produces complete unconsciousness
- ◆ **Regional:** Blocks sensation from a specific point on the spine, patient awake
- ◆ **Local:** Interrupts transmissions of sensations in local tissue only

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General Anesthesia is Not Recommended

- ◆ Can increase risk to the woman
- ◆ Lengthens recovery time
- ◆ Increases cost

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Characteristics of Anesthesia

	Risk of Complication	Recovery Time	Possible Complications
Local	Lower	Shorter	Drug allergy or seizure (rare), vaso-vagal reaction
Regional	Higher	Longer	Hypertension, cardiac arrest, central nervous system infection, spinal cord injury, drug allergy, seizure
General	Higher	Longer	Hypoxia, cardiac arrest, drug allergy, aspiration of gastric contents

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Paracervical Block

- ◆ Interrupts the transmission of pain only at the level of local tissues during cervical dilatation
- ◆ In the majority of cases treated by MVA, paracervical anesthesia is the safest
- ◆ Inject 2 ml of local anesthetic into the anterior lip of the cervix, which has been exposed by speculum.

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Paracervical Block

- ◆ Apply 5ml of lidocaine 1% or (Zylocaine 1%) to each side of the cervix (at the 3 and 9 o'clock positions) .
- ◆ Or apply 2 ml into each site of the following:
Main sites: at the 3 and 9 o'clock positions and optional sites:at the 2 and 10 o'clock position
- ◆ At the transition of smooth cervical epithelium to vaginal epithelium with spinal needle no. 21 or 22 or ordinary needle with or without needle extender and to a depth 1-1.5 cm.

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Paracervical Block

- ◆ If you have lidocaine 2%, dilute it with an equal amount of saline solution or distilled water to obtain a 1% concentration
- ◆ It is very important to apply the injection slowly with aspiration to avoid applying directly in a blood vessel
- ◆ After completing the administration of anesthesia, wait 3 to 5 minutes for it to take effect

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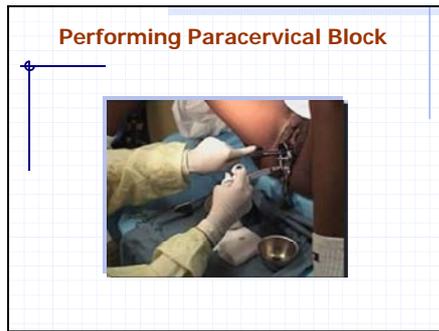
Some practitioners have suggested the following step to divert the patient's attention from the insertion of the needle:
place the tip of the needle just over the site selected for insertion and ask the patient to cough. This will "pop" the needle just under the surface of the tissue.

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Anesthetics for Paracervical Block

	Xylocaine (lidocaine)	Nesacaine (chlorprocaine)
Duration	60-90 min.	30-45 min.
Advantages	Rare allergic reactions	Less toxic due to rapid breakdown
Disadvantages	More toxic due to slow breakdown	More allergic reactions, more costly
Side Effects	Buzzing in ears, numbness of mouth, tongue, metallic taste	

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- Equipment Needed for Paracervical Block**
- ◆ Lidocaine (1.0%)
 - ◆ Antiseptic solution such as Betadine
 - ◆ 10 ml syringe with 22-gauge regular or spinal needle
 - ◆ Tenaculum
 - ◆ Gauze and sponges

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- Performing a Paracervical Block**
- ◆ Prepare syringe of lidocaine
 - ◆ Clean cervix
 - ◆ Aspirate, then inject solution
 - ◆ Place tenaculum and apply traction to cervix
 - ◆ Slowly inject additional lidocaine at several points
-

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Complications of Pain Medications

- ◆ Lidocaine toxicity can occur with
 - Intravascular administration
 - Over doses > 200mg (20cc of 1% solution)
- ◆ Respiratory distress can occur with
 - Over-sedation from narcotics and benzodiazepines

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Complications of Local Anesthetics & Treatment

Allergic reaction (rare):

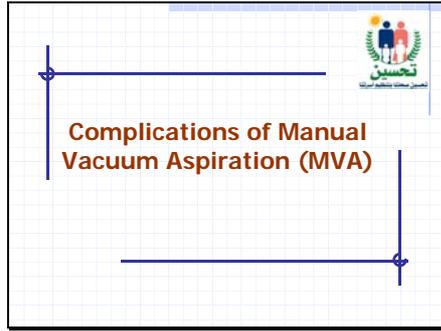
- ◆ If hives, rash give diphenhydramine (Benadryl) 25-50 mg IV
- ◆ If respiratory distress, give epinephrine 0.4 mg subcutaneously, and support respiration

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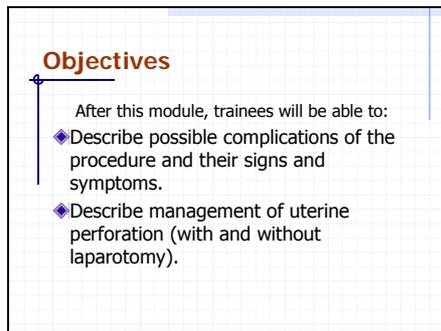
Complications of Local Anesthetics & Treatment

- ◆ **Toxic reaction (rare):** Avoid by using smallest effective dose, aspirating before each injection
 - If mild, give verbal support, monitor closely for a few minutes
 - If severe, give immediate oxygen and slow IV diazepam 5 mg.

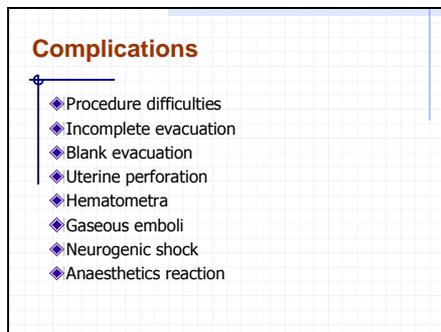
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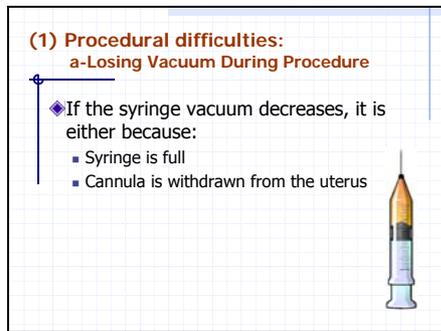
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Slide 3



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(1) Procedural difficulties:
b- Syringe Full:

- ◆ Close the valve(s)
- ◆ Disconnect the syringe leaving the tip of the cannula inside the uterus
- ◆ **Do not push in the plunger when disconnecting the syringe**
- ◆ Open the pinch valve. Empty syringe into a container
- ◆ Re-establish vacuum, reattach the syringe and resume aspiration, OR attach a prepared empty syringe and resume the aspiration

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(1) Procedural difficulties:
c- Cannula withdrawn

- ◆ If cannula is withdrawn from aperture, you must detach, empty, and reestablish vacuum in syringe before resuming the procedure



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- ◆ Do not touch cannula to vaginal walls or other non-sterile surface
- ◆ If contamination occurs, use another sterile cannula



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(2) Incomplete evacuation

- ◆ It is the intrauterine retention of tissue post-MVA that can lead to haemorrhage and infection.
- ◆ The best way to prevent incomplete evacuation is to carefully observe signs of having completed the procedure.
- ◆ Incomplete evacuation is treated by repeating the evacuation and administering antibiotics when necessary

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(3) Blank Evacuation

- ◆ Is the lack of extraction of tissues via MVA.
- ◆ Must conduct a re-evaluation of the pelvis to identify the possibility of complete abortion, uterine perforation, or ectopic pregnancy.
- ◆ This last possibility is suspected when tissue cannot be extracted and a pregnancy test is positive.

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(4) Uterine perforation

- ◆ Very rare with the plastic cannula
- ◆ Incidence less than 1/2 the incidence of the conventional metal curettage

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(5) Hematometra

- ◆ An infrequent condition in which drainage from the uterus is obstructed, creating uterine distension and continuous intrauterine haemorrhage, severe cramps, and vagal symptoms, generally during the first two hours of finishing the procedure.
- ◆ Treatment includes re-evacuation of the uterus and administration of uterotonics or massage to keep it contracted

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(6) Gaseous emboli

- ◆ A rare condition
- ◆ Can take place if the piston of the syringe is pushed forward while the cannula is still in the uterine cavity

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(7) Neurogenic shock

- ◆ Results from intense pain in very anxious patients, causes a vagal reaction, with hypotension and bradycardia, which leads to syncope.
- ◆ Treatment should be fundamentally preventive.
- ◆ Should provide cardio-respiratory support and immediately apply 0.5 mg atropine via IV.

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(8) Anesthetic reaction & toxicity

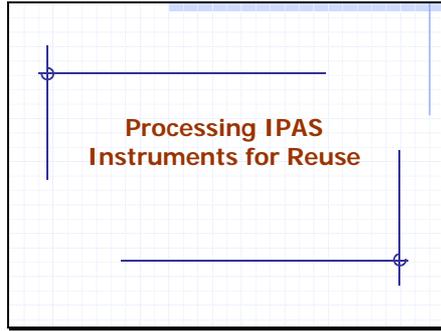
- ◆ Can produce an allergic or toxic reaction to the drug used.
- ◆ Treatment is in accordance with the type of complication.

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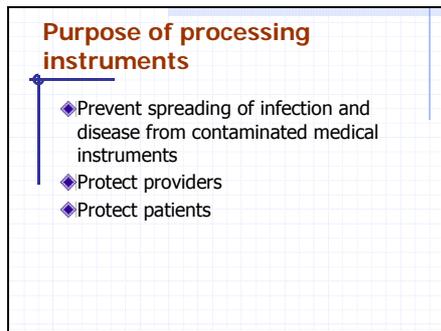
Complications in women undergoing MVA procedures

SIGNS AND SYMPTOMS	DIAGNOSIS
Vaginal bleeding; uterus smaller than expected; less tissue than expected; abdominal pain; signs of infection	Incomplete evacuation Retained tissue
Torn or lacerated cervix; heavy vaginal bleeding; vaginal bleeding after evacuation; sudden excessive pain; rapid heart rate; falling blood pressure; instruments pass further than expected; fat, bowel or omentum in aspirate	Cervical/abdominal injury/ uterine perforation
Vaginal bleeding; large soft uterus	Uterine atony
Fever; chills; foul-smelling discharge; lower abdominal pain; prolonged vaginal bleeding; uterine tenderness	Pelvic infection
Positive pregnancy test, continued signs of pregnancy; no POC on tissue inspection	Failed abortion
Respiratory distress; rash; swollen face; metallic taste; ringing in ears; disorientation; seizures; slurred speech	Medication-related reaction
Hard, enlarged, blood-filled uterus hours or days after procedure; pelvic pain; scant vaginal bleeding	Acute hematometra
Inability of blood to clot, bleeding	DIC
Less tissue than expected, difficult dilatation and cannula insertion	Asherman's syndrome

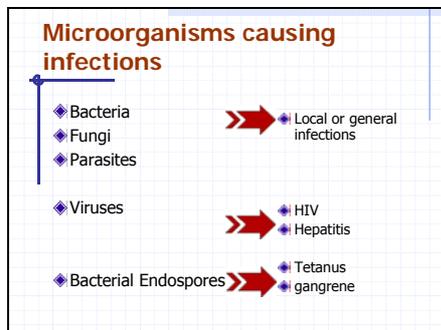
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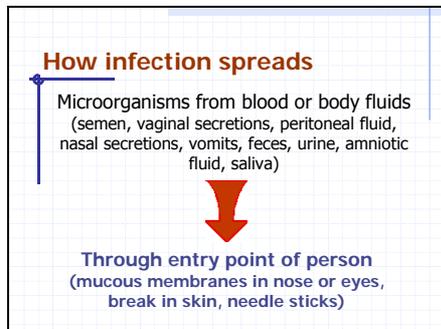
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How to protect against infection

- ◆ Follow the steps to process instruments for reuse:
 - **Step 1:** Decontamination
 - **Step 2:** Cleaning
 - **Step 3:** Sterilization or High-Level Disinfections
 - **Step 4:** Storing instruments safely

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Step 1: Soaking

- ◆ Is the first step in the processing of instruments.
- ◆ Destroys the HIV and Hepatitis B viruses.
- ◆ Instruments should be submerged in a plastic container that contains a 0.5% solution of chloride for 10 minutes.

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Step 1: Soaking (Cont)

- ◆ Soak all instruments and gloves immediately after use in a 0.5% chlorine solution
 1. Draw solution through cannula into syringe



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Step 1: Soaking (Cont)

2. Drop soiled instruments – syringe, cannula, gloves – directly into solution
 - Soak for 10 minutes. (Longer soaking will corrode metal).



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Step 1: Soaking (Cont)

3. When removing items, use gloves or strainer bag to avoid contact with skin.

- Change solution at least once daily



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Step 2: Cleaning

- Consists of removing all visible foreign material and microorganisms.
- Disassemble instruments and submerge in water with detergent.
- Remove the dirt with brushes .
- Rinse and dry.

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Step 2: Cleaning (Cont.)

- Wash the syringe and cannula in lukewarm water with detergent (not soap)
- Hot water will coagulate blood and make it harder to clean



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Step 2: Cleaning (Cont.)

- To disassemble the syringe:
 - Remove the collar stop, pull plunger out of barrel, remove valve set, and open valves.
 - Remove -ring from plunger



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Step 2: Cleaning (Cont.)

- ◆ To clean the syringe:
 - Wash all parts with lukewarm sudsy water
 - While holding syringe under surface of water, scrub with soft brush



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Step 2: Cleaning (Cont.)

- ◆ After washing, rinse syringe and cannula thoroughly with clean water
- ◆ Dry by air or with a clean towel



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Step 3: Sterilization or high level of disinfections

High Level of disinfections:

- ◆ Process that destroys the majority of microorganisms except endospores.
- ◆ HLD by boiling: Place cannulas in container with boiling water for 20 minutes.
- ◆ Chemical HLD: Submerge cannulas in disinfectant solution for 20 minutes:
 - Glutaraldehyde 2% (Cidex)
 - Formaldehyde 8%
 - Sodium hypochlorite 0.5% (bleach)

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Step 3: Sterilization or high level of disinfections (Cont.)

Sterilization:

- ◆ Process that destroys all microorganisms including endospores.
- ◆ Cannulas should not be subjected to wet heat (autoclave) nor dry heat.
- ◆ Chemical sterilization: Submerge cannulas in: Cidex 2% for 10 hours or formaldehyde 8% for 24 hours.

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Step 3: Sterilization or high level of disinfections (Cont.)

- ◆ All clean, dry instruments should be either sterilized or high-level disinfected
- ◆ **Use:**
 - Boiling
 - 2% Glutaldehyde
 - Other chemical high-level disinfections methods
- ◆ **Do not use:**
 - Autoclaving (steam)
 - Dry heat

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Step 3: Sterilization or high level of disinfections (Cont.)

Sterilization vs. HLD

- ◆ **Sterilization:** kills all microorganisms, including bacterial endospores
- ◆ **High-Level Disinfection:** kills all microorganisms, but may not kill bacterial endospores
- ◆ When sterilization of cannula is unavailable, HLD is the only acceptable alternative for protecting against infection

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Step 3: Sterilization or high level of disinfections (Cont.)

- ◆ Be sure items are completely submerged
- ◆ Be sure the solution fills the inside of cannula and syringes



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Step 3: Sterilization or high level of disinfections (Cont.)

- ◆ Low-level disinfectants and antiseptics **will not** kill microbes on cannula
- ◆ Cannula must be sterilized or high-level disinfected



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Step 3: Sterilization or high level of disinfections (Cont.)

- ◆ Sterilizing cannula with 2% Glutaraldehyde (Cidex)
 1. Soak cannula for 10 hours
 2. Remove the sterile forceps
 3. Rinse with sterile water
 4. Air dry



Note: Solution lasts up to 14 days

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Step 3: Sterilization or high level of disinfections (Cont.)

- ◆ High-level Disinfecting Cannula by Boiling
 - Place cannula in boiling water
 - Bring to boil again
 - Boil for 20 minutes
 - Remove with HLD forceps
 - Rinse with boiled water & air dry



Note: Boiling syringes will crack the valves

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Step 3: Sterilization or high level of disinfections (Cont.)

HLD for cannula or syringes with chlorine

- 1. Soak items for 20 minutes in non-metal container
- 2. Remove with HLD forceps
- 3. Rinse with boiled water & air dry



Note: Change solution daily

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Step 3: Sterilization or high level of disinfections (Cont.)

- ◆ Mid-Level Disinfection for syringes with Alcohol/Iodophors
 - Soak for 20 minutes
 - Remove with HLD forceps
 - Rinse with boiled water
 - Air dry



Note: Change solution daily, or when cloudy

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Step 4: Storage

- ◆ Handle sterile cannula only with sterile instruments
- ◆ Rinse in sterile water and air dry



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Step 4: Storage (Cont.)

- ◆ Removing cannula from storage:
 - Keep instruments in small amounts in each container
 - Use sterile/HLD forceps to remove cannula by the non-aperture end
 - Avoid touching the rest of the cannula



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Step 4: Storage (Cont.)

- ◆ Sterile cannula should be wrapped in sterile paper or cloth or stored in sterile covered tray
- ◆ Date instruments and use within one week, or re-clean and re-sterilize