



ARAB REPUBLIC OF EGYPT
MINISTRY OF HEALTH AND POPULATION

PROGRAM GUIDE FOR PAC SERVICES
IN EGYPT

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Strengthening PAC Services in Egypt

Introduction

Beginning in 1992 the Egypt Ministry of Health and Population, in collaboration with USAID-funded partners, undertook a focused effort to improve the quality of maternal health care. These activities have resulted in a dramatic reduction in maternal mortality, from 174 maternal deaths per 100,000 live births in 1992 to 84 maternal deaths per 100,000 live births in 2000.¹ Among the improvements in maternal care contributing to this reduction are increased use of antenatal care, a gradual shift from home to institutional births, and an increase in skilled attendance at birth. In addition, between 1998 and 2003, contraceptive use among married women has increased from 38 percent to 60 percent, and fertility declined from 4.4 births to 3.2 births per woman.²

Despite these gains in maternal health care, the problem of undesired pregnancies remains a significant issue. A 1997 study of 89 public hospitals found that complications related to spontaneous or induced abortion accounted for 19 percent of all admissions (Figure 1).³ The study reports that approximately 340,000 women present for postabortion care (PAC) annually and 85 percent are less than 12 weeks pregnant. Eighty nine percent of PAC admissions were treated by D&C under general anesthesia, while only 3 percent were treated with manual vacuum aspiration (MVA) under local anesthesia. Only 47 percent of the women presenting for PAC have ever used contraception, and only 20 percent were provided a contraceptive method as part of PAC services.

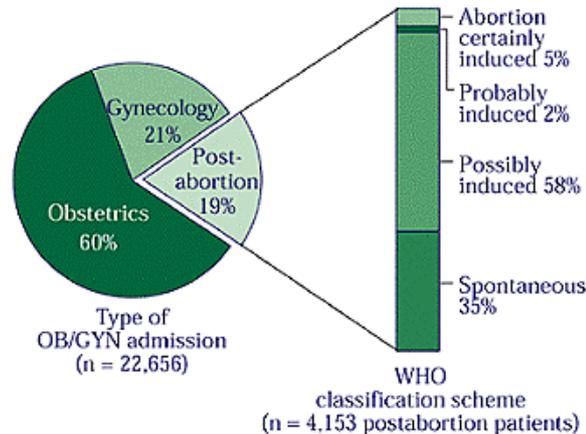


Figure 1. OB/GYN Department Admissions During 30-Day Period in Egyptian Public-Sector Hospitals

The National Population Council/Research Management Unit and Suez Canal University 1993 study found that 26 percent of all women aged 35-60 in Egypt have had one or more abortions.⁴

Health Consequences

The health consequences related to complications of spontaneous or unsafe induced abortion are devastating for women and their families. Death may be a direct result of complications

such as sepsis, hemorrhage, genital and abdominal trauma, and perforated uterus or it may result from secondary complications. Long-term disability may occur, related to reproductive tract infections, chronic pelvic pain, pelvic inflammatory disease, and infertility. The majority of women seeking abortion are married and the number of adolescents seeking abortion is increasing.¹ Thus, infertility is a significant consequence of abortion complications.

The Egypt National Maternal Mortality Study of 2000 reported that abortion was associated with 20 deaths, contributing to four percent of all maternal deaths. Of these, 11 cases (55 percent) were judged to be spontaneous abortion and nine (45 percent) were thought to be induced abortion. The study notes that “identifying deaths due to abortion [...] is extremely difficult” because “deaths in early pregnancy may be missed and because families will be reluctant to report deaths due to induced abortion in settings where induced abortion is illegal” The study concludes that “abortion deaths were probably missed by the NMMS 2000.”¹

Unsafe Induced Abortion

The WHO 2000 report on global and regional estimates of the incidence of unsafe abortion and associated mortality states that “Unsafe abortion is entirely preventable. Yet, it remains a significant cause of maternal morbidity and mortality...” The report concludes “Where contraception is inaccessible or of poor quality, many women will seek to terminate undesired pregnancies...Prevention of unplanned pregnancies by improving access to quality family planning services must therefore be the highest priority, followed by improving the quality of...postabortion care.”⁵

The Cairo Demographic Center 1996 study found that one-third of 1,300 Egyptian women surveyed had tried to terminate a pregnancy.⁶ In a study of obstetric visits to public hospitals in 1998, Huntington estimated the induced abortion rate to be 14.8/100 pregnancies and the case fatality rate to be 0.43 deaths per 100 abortion-related admissions.⁷

PAC Strategy for Egypt

Since the early 1990s, USAID has led the international community in supporting PAC as an important intervention to address complications of abortion by improving treatment and linking women to family planning and other reproductive health services. A global PAC evaluation⁸ conducted in 2001 led USAID to refine its 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.

In addition, the evaluation summarized the following key 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

- Manual Vacuum Aspiration (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.
- MVA can be provided safely by mid-level providers.
- 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. As illustrated in Figure 2, the PAC strategy is inclusive, involving all stakeholders, from the hospital to the community. Key to the successful implementation of the strategy is the Safe Motherhood Committees at the national, provincial, and district levels, as well as District Health Committees.

The TAHSEEN Project PAC strategy for Egypt has three components:

- To increase demand for high-quality PAC services through community awareness and mobilization;
- To train primary health care providers in emergency treatment, referral, and follow up; and
- To increase the supply and quality of PAC services through hospital-based activities focused on instilling a client perspective and improving provider performance.

All activities, whether at the community, primary health care unit, or hospital level, will be supported by the appropriate Safe Motherhood Committee (SMC).

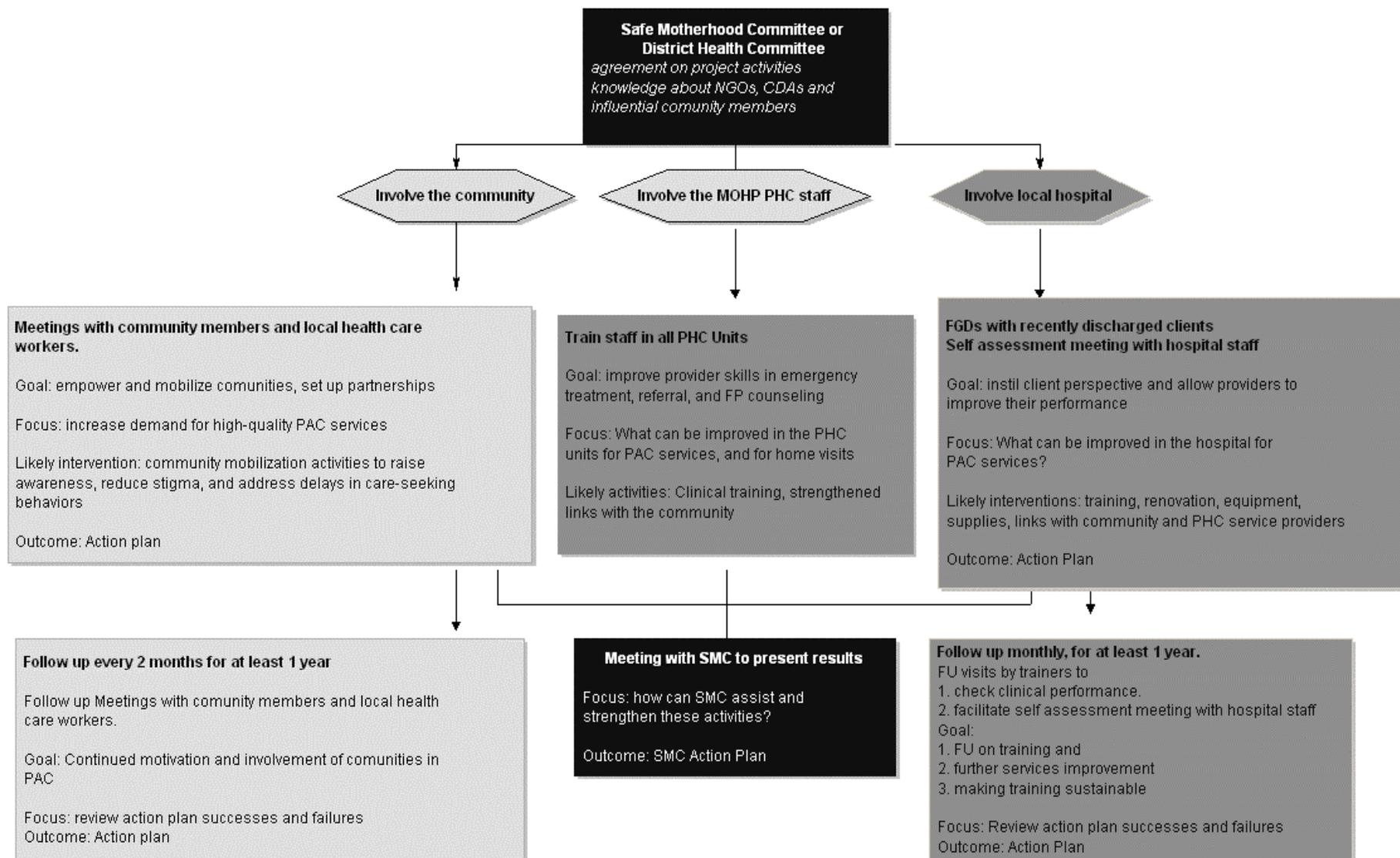


Figure 2. Comprehensive PAC Strategy for Egypt

The primary approach used in the PAC Strategy for Egypt is to demonstrate that complications of spontaneous and unsafe abortion are, in fact, obstetric emergencies and to link PAC to the existing emergency obstetric care (EmOC) system through the Safe Motherhood Committees.

Access to care is often impeded by what are called “the three delays.”⁹ These delays occur at all levels of the health care system, from the community to the provider, and have many causes including unsupportive policies, gaps in services, and inadequate community and family awareness and knowledge:¹⁰

- Delays in deciding to seek care may be caused by failure to recognize signs of complications, failure to perceive the severity of the illness, cost considerations, previous negative experiences with the health care system, and transportation difficulties.
- Delays in reaching care may be created by the distance from a woman’s home to a facility or provider, the condition of roads, and a lack of emergency transportation.
- Delays in receiving care may result from unprofessional attitudes of providers, shortages of supplies and basic equipment, a lack of health care personnel, and poor skills of health care providers.

TAHSEEN has worked with Egyptian communities to develop a local conceptual framework based on these three delays (Figure 3). The framework identifies two families, one in which a desired pregnancy aborts spontaneously and one in which an undesired pregnancy is terminated by unsafe induced abortion. The framework follows these women through their subsequent care and identifies issues in both the community and the health care system that can be addressed to help solve the problems they face.

This framework is used in all SMC, community, and health care system meetings to develop appropriate and clear plans for interventions.

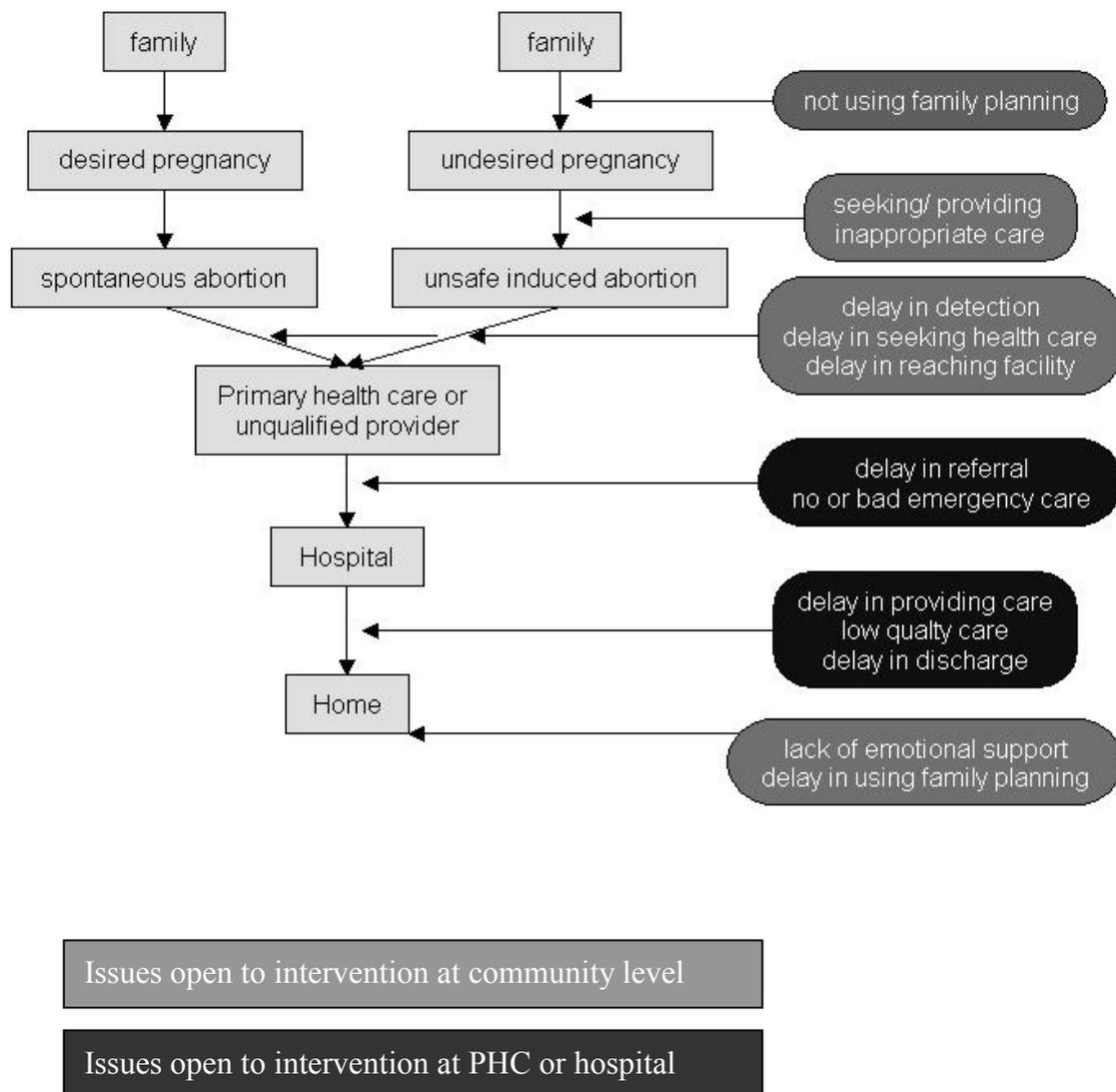


Figure 3. PAC Conceptual Framework for Egypt

Implementation Activities

As with all reproductive health services, the attitudes of community members, religious leaders, and health care providers are central to the creation of sustainable, high-quality PAC services.¹¹ Implementation activities, therefore, will 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. Finally, clinical training will focus on emergency management and referral and use of MVA as the procedure of choice in the treatment of incomplete abortion at less than 20 weeks' gestation, as specified in the Ministry of Health and Population essential obstetric care protocols.¹²

One of the main challenges to postabortion contraceptive use in Egypt is the woman's belief that fertility will not return immediately. In addition, women are often more concerned with the need to return immediately to daily routines, without a chance to rest and recuperate.¹³ 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.¹⁴

A new study confirms the need for postabortion contraception, demonstrating that in Latin America, 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.¹⁵

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.¹³

Involve Safe Motherhood Committees

Goal: To introduce postabortion care activities in the target governorate.

The initial meeting, conducted by TAHSEEN staff, involves the entire SMC. The meeting will discuss the issue of complications of unsafe and spontaneous abortion, the impact of such complications on maternal mortality and morbidity in Egypt, how high-quality PAC services can save women's lives, and the need for community involvement in PAC services. The conceptual framework (Figure 3) is explained. The SMC is asked to provide support to hospital and community-based activities. The SMC will identify additional community members, non-governmental organizations (NGOs), and Community Development Associations (CDAs) who might be influential and/or interested in participating in PAC activities. (See attachments for a sample agenda for the first SMC meeting).

The SMC will review hospital and community action plans and identify areas where the committee can provide support. The SMC will develop an action plan detailing the activities it will undertake to support the community, primary health care provider, and hospital. (See attachments for how to do action planning and an action plan form). Involvement of SMCs throughout the process will help to ensure sustainability of both services and community involvement.

Involve the Community

Goal: To empower and mobilize communities and set up partnerships.

In Egypt, as in other countries, women and adolescents who experience complications of spontaneous or induced abortions experience social stigma. They may not seek care because of fear of punitive attitudes of community members and service providers at the health care facility. Thus, stigma has an impact on both prevention and access to PAC services. In addition, women and adolescents may have little voice in their communities. Therefore, raising awareness of the problem and community mobilization around the issue of complications of abortion are essential aspects of a comprehensive PAC package of activities.

Communities will be mobilized around the focus of "what can they do to prevent undesired pregnancies and reduce maternal death and disability from complications of spontaneous and unsafe induced abortions."

For communities to mobilize around prevention, they must first understand that unsafe abortion and its complications are an outcome of an undesired pregnancy. Therefore, prevention can be achieved by improving the quality of information provided to the

community about available contraceptive methods, ensuring access to these contraceptive methods, and allowing community members to make informed choices.

Community actions to reduce maternal death and disability from complications of spontaneous and induced abortions include raising awareness of the problem in order to reduce delay in seeking care and emergency preparedness plans that reduce delay in reaching care. As previously discussed, reducing stigma associated with postabortion care is best done by demonstrating that complications of spontaneous and unsafe abortion are an obstetric emergency and linking PAC to the existing emergency obstetric care system. An additional advantage of this approach is the fact that communities can organize around both issues as one and leverage limited financial and human resources.

The community mobilization process will be led by representatives of grassroots and other community organizations and will begin with a workshop in which the issue of complications of spontaneous and unsafe induced abortion is introduced and community members are asked to present their analysis of the problem. Community members include NGO and CDA representatives, religious leaders, traditional birth attendants, teachers, youth center leaders, members of the local press, local physicians etc for a maximum of about 40 people. (See attachments for a sample agenda for the community needs assessment workshop).

The workshop facilitator will discuss the conceptual framework (Figure 3) and inform participants about the link between undesired pregnancy and unsafe induced abortion, the fact that all complications from spontaneous and unsafe induced abortions threaten women's lives, that such complications are an obstetric emergency, and appropriate care-seeking behavior. The workshop will also serve as an opportunity for participatory data collection, with community members voicing their thoughts on why undesired pregnancy and unsafe abortion occur, and offering insights to what community members do when faced with each of these situations. After participants have identified and described the problem for themselves, they will brainstorm on what they themselves can do to address the problem.

At the end of the workshop, the community groups will develop action plans that will likely include activities aimed at preventing undesired pregnancies and increasing access to PAC services. Elements of prevention could include education about available contraceptive methods and where to obtain them. Elements of access could include education about danger signs of postabortion complications and development of emergency preparedness systems to transport women with postabortion complications and other obstetric complications to health facilities. (See attachments for a guide to conducting an action plan meeting and an action plan form).

The action plan should include activities that link the community to the primary health care units and hospitals, either through community feedback to the facilities about quality of care or by having service providers participate in community IEC efforts. (See attachments for a sample community action plan).

To further assist community IEC efforts, a second workshop will be held to train interested community members on the use of banners and facilitator guides developed by the TAHSEEN Project. These materials were developed at the request of the first community groups involved in PAC activities and reflect their input. (See attachments for the facilitator guide and client brochure).

Bi-monthly workshops will be held throughout the project to provide ongoing monitoring, assessment, and evaluation of the process in order to ensure that the community is empowered and that as many stakeholders as possible are involved. Although the workshops will be

facilitated by TAHSEEN staff, their focus will be on the community groups and their activities—through presentations of successes and failures, sharing mutual advice, and development of new action plans.

Involve the Primary Health Care Providers

Goal: To improve provider skills in emergency treatment, referral, and follow up.

TAHSEEN will train all primary health care physicians in the public sector as well as two nurses per primary health care unit. The one-day training session will include emergency treatment, referral, and FP counseling. (See attachments for the training session agenda). Trainer and trainee guides are included as separate documents. Following training, it is expected that primary health care providers will become involved in the community activities.

Involve the Hospital

Goal: To instill client perspective and allow providers to improve performance in providing postabortion care services.

TAHSEEN staff will meet with the hospital Ob/Gyn staff to discuss the issue of complications of spontaneous and unsafe induced abortion, the impact of such complications on maternal mortality and morbidity in Egypt, how high-quality PAC services can save women's lives, and the need for community involvement in PAC services. During these discussions, which are assisted by the director of the Ob/Gyn department (who is also a member of the SMC), special attention is given to the concepts of quality of care and the value of the clients' perspective.

Following this initial meeting, the TAHSEEN staff will collect information on the quality of PAC services through client focus group discussions (FGD) and a baseline assessment of PAC services at the hospital.

- FGDs will be held with women receiving PAC services who have been recently discharged from the hospital, and invited to return for the purpose of these FGDs. (See attachments for the focus group discussion guide). Questions will focus on:
 - ▶ What is their opinion of the services they received?
 - ▶ How can services be improved?
- TAHSEEN staff will conduct the baseline assessment of the Ob/Gyn department, focusing on PAC services. (See attachments for the initial hospital assessment form).

The TAHSEEN staff will prepare a report of information collected from the FGDs and baseline assessment. Within 2 weeks, TAHSEEN staff will meet with the ob-gyn staff to present the findings. All staff, from the housekeeping staff to the director of the department, will be asked to perform a self-assessment by brainstorming ways to improve PAC services.

With the entire staff it is then decided what action will be taken. Potential actions are:

- Training on clinical PAC services, including MVA and counseling
- Integrating FP clinic services with hospital ward care by ensuring that FP commodities and counseling are available night and day on the ward
- Ensuring privacy and confidentiality
- Improving infection prevention practices

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- Implementing a policy of assigning one nurse to each client
- Informing the community about FP options
- Informing the community about PAC services, referral etc.
- Informing Primary Health Care Unit providers about PAC services, emergency treatment, and referral

The staff will draft an action plan with advice from TAHSEEN staff as needed. (See attachments for how to conduct an action plan meeting, how to do cause finding, and an action plan form).

It is anticipated that training will be a component of most action plans. (See attachments for the training schedule and tools to record and monitor training). The clinical training package for hospital-based training is included as a separate document.

For the first year, the clinical trainer will conduct follow-up visits on a monthly basis to monitor progress of the action plan and provide technical coaching and mentoring. At each visit, the clinical trainer will assess clinical services and discuss the findings with the assembled Ob/Gyn staff. (See attachments for follow-up visit tools).

From month 8, responsibility for the clinical services assessments and training will devolve to the Ob/Gyn staff.

Attachments

Attachment A	Sample agenda for first SMC meeting
Attachment B	Sample agenda for community needs assessment workshop
Attachment C	Sample agenda for community follow up workshop
Attachment D	Sample agenda for community follow up workshop for BCC materials training
Attachment E	How to conduct an action plan meeting
Attachment F	Sample community action plan
Attachment G	How to do clinical coaching
Attachment H	How to do cause finding
Attachment I	How to provide constructive feedback
Attachment J	Focus group discussion guide
Attachment K	Facilitators guide: Scenario of losing a pregnancy
Attachment L	Training schedule for hospital-based providers
Attachment M	Training report
Attachment N	Individual trainee follow up report
Attachment O	Monthly follow up visit report (including clinical indicators)
Attachment P	Medical record form
Attachment Q	Initial hospital assessment form
Attachment R	Client brochure

Attachment A

Sample Agenda – Initial Meeting with the Safe Motherhood Committee

Date:

Venue:

Goal: To introduce postabortion care activities in the target governorate

Objectives:

1. Discuss the issue of complications of spontaneous and induced abortions and available health services in the target governorate.
2. Discuss working with one or more hospitals to improve PAC services.
3. Discuss the need for community involvement in PAC activities and identify additional community members, non-governmental organizations (NGOs), and Community Development Associations (CDAs) who might be influential and/or interested in participating in PAC activities.
4. Discuss SMC support for community and hospital action plans.

Sample Schedule for Initial SMC Meeting

10:00 - 10:15	Introduce participants
10:15 - 10:45	Situation of postabortion care services in the target governorate <ul style="list-style-type: none">• Opinion of committee members
10:45 - 11:30	Discussion of TAHSEEN curative sector potential activities <ul style="list-style-type: none">• What does TAHSEEN propose to do (general outline)?
11:30 - 12:00	Clinical activities <ul style="list-style-type: none">• Explain vision for intervention (train all staff, train off site, long term follow up)• Explain tools (training, commodities in wards, brochure etc.)• Choose hospital/s – schedule• Free discussion
12:00 - 13:00	Community activities <ul style="list-style-type: none">• Needs of the community to contribute to health services• Obstacles that could be met• Explain tools (workshops, BCC tools)• Important community members, NGOs, CDAs, religious leaders, teachers etc. to invite• Free discussion
13:00 - 13:30	Discussion of Safe Motherhood Committee role <ul style="list-style-type: none">• Assure commitment
13:30	Closing

Attachment B

Sample Agenda – Community Needs Assessment Workshop

Date:

Venue:

Goal: Empower and mobilize communities and establish partnerships

Objectives:

1. Discuss the issue of complications of spontaneous and induced abortion and explore community members' experience and awareness of the problem. Develop a conceptual framework for PAC at the community level.
2. Describe the PAC activities to be introduced in the target governorate and the role and support of the SMC.
3. Gain commitment from community leaders to inform and educate the community about preventing unintended pregnancies, postabortion complications, and need for prompt treatment and care.
4. Assess activities the community could undertake to support the introduction of PAC services and overcome obstacles to care.
5. Develop an action plan detailing activities to support PAC services.

Sample Schedule for Community Needs Assessment Workshop

10:00 – 10:30	Opening/participant introductions
10:30 – 10:50	Presentation/discussion: Losing a Pregnancy as a Risk to Safe Motherhood. Develop a conceptual framework for PAC. Resources: “Scenario of Losing a Pregnancy” and “Conceptual Framework for PAC Services”
10:50 – 11:30	Discussion: Introducing PAC services in the target governorate: How can the community help?
11:30 – 12:00	Working groups Group 1: Needs of the community to contribute to health services Group 2: Obstacles to PAC services
12:00 – 12:30	Coffee break
12:30 – 13:00	Presentations of working groups
13:00 – 14:00	Working groups Divide into natural groups: What can we do during the next 2 months? Each group develops an action plan detailing support for the introduction of PAC services.
14:00 – 15:00	Presentations of action plans
15:00	Closing remarks

Attachment C

Sample Agenda – Community Follow up Workshop

Date:

Venue:

Goal: To follow up on community leaders' activities

Objectives:

1. For the program managers and the community leaders to learn from successes and mistakes in implementing community activities on PAC
2. To review old action plans
3. To make new action plans for the coming period

Sample Schedule for Community Follow Up Workshop

10:00 – 10:30	Opening/participant introductions
10:30 – 11:30	Presentations: Community leaders explain to the group what activities they have undertaken. They will focus on what worked well, what did not work well and share experiences. They will also report on number of people in awareness-raising sessions etc.
11:30 – 12:00	Coffee break
12:00 – 13:00	Group work: Community leaders work in groups to make plans for the upcoming period.
13:00	Closing remarks

Attachment D

Sample Agenda - Community Follow Up Workshop for BCC Materials Training

Date:

Venue:

Goal: To enable community leaders to implement community awareness-raising sessions

Objectives:

1. Explain the banners and facilitator guides. Explain the key messages and their importance.
2. Practice leading sessions with feedback

Sample Schedule for Community Follow Up Workshop for BCC Materials Training

10:00 – 10:30	Opening/participant introductions
10:30 – 10:50	Presentation/discussion: In response to the community leaders plans to conduct awareness-raising sessions, TAHSEEN developed some banners to use in those sessions. With each banner comes a facilitator guide, to help the facilitator guide the discussion. Show/explain the banners and guides.
10:50 – 11:30	Preparation: Community leaders decide who will facilitate which part and prepare individually for the sessions.
11:30 – 12:00	Coffee break
12:00 – 14:00	Practice: Community leaders practice leading awareness-raising sessions. They receive feedback from facilitator
14:00	Closing remarks

Attachment E

How to Conduct an Action Plan Meeting¹⁶

Before the Action Plan Meeting

If this is the first action plan meeting, prepare a blank action plan form (see attachments) on a flipchart page or white board.

If this is a meeting to review progress on an action plan, prepare an action plan form with the first column (problem) filled in with the result of the first meeting (e.g., self assessment, review of indicators, old action plan). See example below.

Sample Action Plan to Review Progress						
	Problem	Cause	Decision or Solution	Employee Responsible	Date	Expected Results
From old action plan, not yet solved	Still no commodities on the ward					
From indicators	% FP use still low at 20%					
From self assessment	No clear posting of working hours No IEC materials for PAC counseling					

During the Action Plan Meeting

Praise the quality of activities or services

Describe specific examples of appropriate activities or high-quality service provision, including examples of positive results. If applicable, show again the graphs of indicators that have good results.

Prioritize

If you have many problems you have to decide how to deal with them all. The first preference is to spend more time and do them all. The second preference is to prioritize. To do this you first have to work with the staff on what criteria you will use to prioritize on. Some sample criteria are:

- It is solvable with our resources
- It affects many community members/clients
- It affects the safety of community members/clients
- It affects how community members/clients see the clinic
- It is important for the community/facility staff
- Community members/facility staff recognize the need to change it
- It is important to the community or religious leaders/facility directors

- It is in compliance with policies/strategies

The following technique, called nominal group process, can be used to prioritize. It builds commitment to the group's choice by equal participation in the process, allows every group member to rank issues without pressure from others, and puts quiet group members in the same position as more vocal members.

1. Give each problem a letter. (A, B, C etc). Numbering might cause confusion with the ranking later on.
2. Each team member records the letters on paper and scores what he thinks is the importance for the Quality of Care according to the criteria. For example, if there are five problems, the most important solvable (!) problem gets a "5", the next important a "4" etc. (This method minimizes the effects of some team members leaving some statements blank. Therefore a blank [=0] value would not increase its importance.)
3. Combine the scores of all group members. The problem with the highest number of points has the highest priority.

Sometimes all problems can be dealt with but this is unlikely in the beginning. Do not tackle too many problems and do not tackle the very hard problems. Especially in the beginning it is important that the team manages to successfully resolve some problems on their own. This is very motivating! If none of the problems on the first action plan are solved, no one will be interested in doing a second action plan.

Find causes

For simple problems, brainstorm causes. For complex problems use a fish bone diagram. (See attachments).

Find solutions

For each cause, discuss a solution or action that is feasible in terms of time, money, authority etc. (e.g. do not send someone to the Ministry of Health to argue for more salary for the staff).

Find a person responsible

Often when you discuss actions that need to be taken, it is clear who is going to be responsible. Usually this is someone in the team. If there is an action that needs to be taken by someone outside the clinic team (e.g., NGO representative, clinical supervisor/manager/trainer) make sure that there is someone in the team who will follow up/keep contact etc. For every action one person within the clinic needs to be responsible. That person is to be written by name, not function, in the action plan. Make sure that not all responsibility falls on the shoulders of only one or two persons.

Find a due date

Ask the person responsible for each action what a reasonable timeframe is for the action to be taken. Stick to that timeframe. Do not impose a shorter time. If the timeframe he indicates is very far away (e.g. more than 2 months) consider if the action is not too complex or too large. Can it be broken up in smaller pieces and can the responsibility be divided?

Determine how you will know if you were successful

Determine how you are going to know that the action was successful. What indicator will we use to measure success? This is easiest for problems related to the client interview and observation of services – you simply decide what value you would like the indicator to have next time.

Set a date for the next meeting or visit.

Agree on what you will do to follow up in the meantime (accountability).

Attachment F

Sample Action Plan from Community Needs Assessment Workshop

Governorate: Minia

Problem	Cause	Decision or solution	Person responsible	Date required	Result and how to measure
<p>1. Lack of awareness of problem of losing a pregnancy</p> <p>2. Lack of knowledge about services available to PAC patients.</p>		<p>Conduct orientation sessions to discuss:</p> <ul style="list-style-type: none"> • High-risk pregnancy • Health problems of losing a pregnancy • Family planning services and methods. 	<p>Dr. Moussa Adel Fam with the health care team (physician, nurse, raeda) of El Amoudein village will be responsible for conducting these sessions in coordination with NGOs working with CEDPA.</p>	<p>On a monthly basis:</p> <ul style="list-style-type: none"> • During the months of April and May. 	

Attachment G

How to Do Clinical Coaching¹⁶

What is the purpose of coaching?

By coaching you try to improve a provider's performance through motivation, modeling, practice, constructive feedback, and gradual transfer of skills.

Coaching can be used in many different situations. This handout shows how coaching is used as part of clinical training or supervision. Coaching is usually used for new service providers or for staff not performing correctly.

Important issues for clinical coaching

Coaching is about learning. Trainees will learn best if:

- They are at ease when they are with the coach.
- They want to learn something new
- They understand what is expected of them
- They are not afraid they will be embarrassed or lose face in front of the patient

Demonstrate respect for the client's safety, comfort, dignity and privacy at all times.

Steps in holding a clinical coaching session

- **Briefing.** To help providers learn most effectively, determine with the provider what she/he needs to learn (learning objectives). If needed go over checklist/5 step demonstration method or just the main points, depending on skill level. The goal is agreement about the nature of a performance problem or full understanding of the need for skill development.

Create a good atmosphere for learning.

Determine your own role as supervisor/coach (will you be the assistant or the observer?) Sometimes the trainee/provider can determine which role they would feel most comfortable having you do.

If needed, agree on some hand signals to let the provider know that you agree or disagree with what is being done.

Agree on who does what. Decide who will inform patient about what is happening.

- **Work with the provider in the clinical situation.** Working closely with a provider puts special demands on your tact and care. Avoid saying or doing anything that would make the provider feel inadequate or stupid or ashamed in front of a client. People who are feeling unhappy with themselves or with their trainer do not learn anything! Be careful not to criticize or correct the provider when the patient is present. Save your feedback for when you are debriefing the provider.

Likewise, be careful with the patient's feelings. Your patient is in a very vulnerable position. Respect her privacy. Try to have as few people as possible in the room. Do not make her afraid or uncertain by giving obvious feedback in her presence or during the procedure.

During clinical procedures, also emphasize other important aspects of care such as respect for the patient and a friendly and caring attitude. These things are best taught by giving a good example!

The coach's role will depend on the current level of skill of the trainee. In some situations you will demonstrate the procedure while in others you will serve as the assistant, or perhaps further in the background. Focus on the bigger picture (such as support from nursing staff, organization of the supplies and equipment, attention to infection prevention, etc). You might want to stand nearby and wear gloves in case you need to step in. Verbal communication and explanations are generally kept to a minimum. Teamwork is important! Key points are to:

- ▶ Perform the procedure smoothly and efficiently.
 - ▶ Enable the trainee to do as much of the case independently as possible.
 - ▶ Encourage increasing competence and independence.
- **Feedback and planning for the future.** This is where a large part of the learning takes place.

It is very important that you are motivating. Express your confidence in the provider and your willingness to provide continued support.

Feedback should be provided as soon as possible after a skill is practiced. This is where a large part of the learning takes place.

Ask the provider how he thought the case went. Ask him what he did well and what he would do differently next time.

Explain clearly what was done well and what the provider needs to work on. Start with the positive things done well. To avoid overloading the provider with things to work on, focus on three to five things of primary importance. However, sometimes you can group several things in a larger category.

Make sure you discuss the things that you mentioned in the briefing, were the provider's learning objectives.

Reinforce correct procedure using models or otherwise demonstrate the parts needing additional practice and attention.

Make a plan for further learning (theory/model/next practice) Make sure the plan is realistic and can be done by the provider.

Attachment H

How to Do Cause Finding¹⁶

For Simple Problems

Brainstorming is used for creating a high volume of ideas, free of criticism and judgment. It encourages “open” thinking when a group is stuck in “same old way” thinking. It gets everybody involved and enthusiastic so that a few people do not dominate the group.

There are two major methods for brainstorming.

- **Structured.** In this process each person gives an idea in turn
- **Unstructured.** In this process people give ideas as they come to mind.

Structured Brainstorming

- The central question is written down and agreed on
- Each person gives an idea in turn. No ideas are criticized or discussed. Ideas are written down on a flipchart or white board.
- Ideas are generated until everybody passes, indicating all ideas are exhausted
- Discard duplicates.

Unstructured Brainstorming

The process is the same except there is no “turn” and everyone can give ideas when they want.

Brainwriting is the same as brainstorming except that people write down the ideas themselves as they come up. The advantage is that it may feel safer for some people to do it this way, especially if you collect ideas anonymously. This may result in better ideas.

Variation

The 6-3-5 method (proposed by H. Schlicksupp in “Creativity Workshop”). There are a maximum of 6 persons in a group. Each person writes down 3 ideas on a sheet of paper within 5 minutes. Each person then passes the sheet to the next person who has 5 more minutes to add 3 more ideas that build on the first 3 ideas on the paper. This rotation is repeated until everybody has seen and added to all sheets. This method is very hard to do anonymously.

Other Methods for Simple Problems

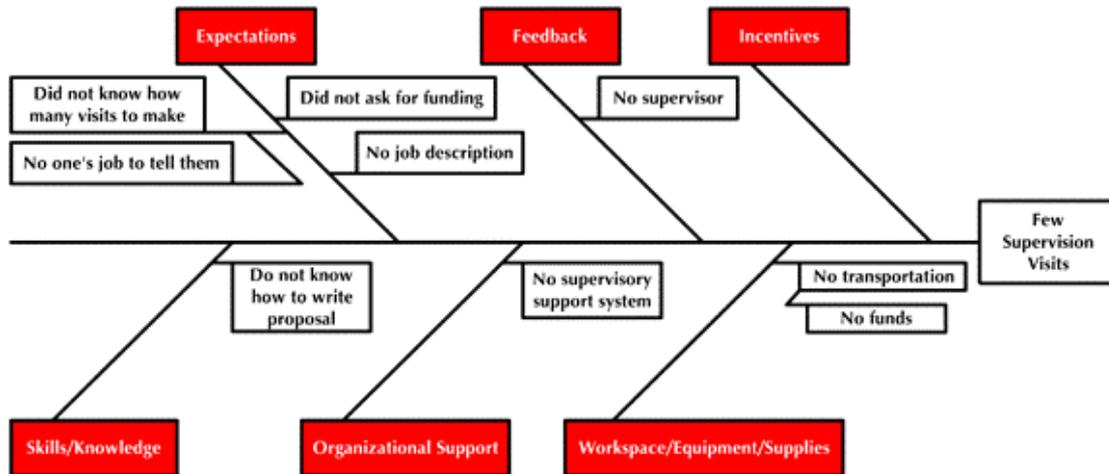
Card collection. Because some people may be uncomfortable expressing their ideas in front of a group, this alternative allows them to remain anonymous. Each person gets a stack of 3 x 5 cards on which to record one idea per card within a specified time period. Afterwards, the cards are collected and read out loud, and can then be sorted into similar themes.

Idea gallery. Several problem statements are written on separate pieces of flipchart paper, which are posted around the room. The group moves around and writes down their solutions to the problems on the flipcharts. This technique generates creativity and piggybacking on peoples’ ideas.

For Complex Problems

For this we use the Ishikawa or fishbone technique. It was developed by Mr. Ishikawa, who found that most often the causes of problems are in one of four categories. He then designed a figure to write these causes in, in the form of a fishbone.

Cause and Effect, or Fishbone, Diagram of Supervision Performance Gap in Ghana



Source: Adapted from Performance Improvement Consultative Group, 2001(124)

Population Reports

For every category, ask why does this contribute to the problem. The answers are written, each on its own line, as smaller bones of the big bone. For each of these you again ask “why” and you add smaller and smaller bones to the diagram. Clearly you would quickly run out of space to write.

The main use of this technique is to allow a team to explore in detail all the possible causes related to a problem. It enables people to focus on the content of the problem, rather than on its history or on different personal interests. It also makes people realize they collectively have much knowledge and it enables them to reach a consensus. Lastly it focuses them on causes, not symptoms.

Steps In Cause Finding

Typically it is best to formulate the problem in the clients’ perspective. Describe how the problem has an impact on clients. This way you leave all possible causes open and you focus on the final important outcome of your work: improving quality of care to clients.

Make sure everyone agrees on the problem statement. Include as much information on the “what” “where”, “how much” “when” of the problem. Use concrete data if you have it. Write down the problem on a large flipchart. For example:

The percentage of women using FP after a spontaneous or unsafe induced abortion is only 20%.

Select broad categories of possible causes. A good start would be

- Staff
- Policies/rules/standards
- Materials/equipment/facility

- Clients
- Organization of the work

There is no perfect set of categories. Try to make them fit the problem. (But these five will do for most problems). Please note that these categories are not mutually exclusive. Some causes belong in more than one category.

Instead of making a fishbone, give each category a flipchart with that title.

Brainstorm (or brain write or use post-it notes) all possible causes in one category and then place them on the left side of the category flipchart. Some causes fit in more than one category. In that case, place them in both. If the ideas are slow in coming, use the major categories as catalysts. For example, ask “What policies/rules might contribute to the problem that...” You might ask small groups to work on one category each. To increase participation you might switch groups after a while so more people have a chance to work on the same category.

For each cause you find ask “why...”. Write the answer to “why” next to it, on the right of the flipchart. This way you will find underlying or root causes. Stick to those causes that are controlled by you at your level or at most at the level that your supervisor works at. When a cause is controlled by people at much higher levels, you generally cannot do anything about it (for example, salary levels). Trying to analyze the root causes at these high levels make this an exercise in frustration.

Keep asking why until one of three things happens:

- A solution to the problem becomes apparent
- You are discussing causes that are controlled outside your influence
- You are in a different category of causes

After you have collected everybody’s ideas about the causes and the causes behind the causes, now you start to organize them. Try to find root causes in the right hand column by looking for causes that appear more than once within or across categories. You can also select the root causes (the most important ones) by voting. Now for those root causes, try to find a solution. Only select root causes to include in the action plan if the group can actually influence/solve them.

Attachment I

How to Provide Constructive Feedback¹⁶

The following is a format you can use when you want a provider to change her/his behavior or improve their performance.

Before giving feedback consider the following:

- Choose an appropriate time. Try to provide feedback as soon as possible, but make sure the timing is good to give the feedback. Is the provider in the middle of seeing a client or concentrating on something else? If so, wait until you have his/her full attention.
- Choose an appropriate place. The provider will appreciate having privacy when receiving feedback. Take special care not to alarm or worry the client by giving feedback in her presence.

When giving feedback follow these rules:

- Listen. Let the provider teach himself/herself as much as possible, instead of telling him or her what to do. After all, people learn best when they are active learners! A common technique is to start by asking the provider “What did you think went well” and then asking “What do you think you can still improve”. Use paraphrasing, open-ended questions, and other active listening techniques as well.
- Prioritize. Most people find it difficult to absorb more than 3-5 things they need to improve. Try to give feedback about only a few things to improve (sometimes it is possible to group several things you noticed into one larger category).
- State facts, not interpretations. For example, do not say “You are not comforting this client because you are scared/shy/uncaring.” If you do this, you run the risk of being wrong, which does not help the training, coaching, or supervision. Only state what you observe (for example “When you inserted the IV you did not tell her what to expect. I saw her make a face and tense up”) and then ask the provider for the interpretation, if needed.
- Make the feedback practical. Let the provider come up with the solutions to problems. Ask “What can you do to make sure that you comfort the client appropriately.” Do not be content with vague assurances like: “I am sure that with your help I can do better next time.” If they say this, ask “How will you do this?”
- Discuss consequences. An example of a positive consequence is “If you do include the dates, it will help everyone to better serve the client.” An example of a negative consequence is “If you continue to leave out the dates, I will have to write this up on your performance chart.” For the most part, use negative consequences only after you have used a positive consequence at least once. If the person is just learning a skill, only use positive consequences. Also, use negative consequences that fit the seriousness of the incident.

A useful sequence for giving feedback is as follows:

- Praise the provider with a few general words (“good job, that went really well” etc).
- Ask the provider how he/she thought the case went. Ask what he/she did well, what he/she was happy with, what he/she would do exactly the same way next time.

Program Guide for PAC Services in Egypt

- Ask the provider what he/she would do differently next time. This is a more positive way of asking the question than asking what did you do “wrong.”
- Discuss the points he/she brings up and if needed add you own. Prioritize. Ask how he/she can do that better next time. Make the feedback practical.
- Summarize the feedback.

Attachment J

Focus Group Discussion Guide for Women Who Have Received PAC Services

Introduction

Good morning, I am.....working with the project to improve health care services provided to women who have been treated for an incomplete abortion or complications of abortion. We would like to know your opinions about the care you received and your suggestions for improvement, which will help us improve postabortion care services.

Discussion Guidelines

We are all here to listen to each other. No one's opinion is preferred or correct as compared to others. Everyone's opinion is useful.

If you don't mind, we are going to tape record the session to be sure that we include everyone's opinions.

Discussion Points

1. What do you know about abortion? Do you know when and why this could happen? How does your community perceive abortion (acceptability, denial, blame, God's will)?
2. Will each of you tell us about your case (what/when abortion started, symptoms, were you alone, who supported you).
3. Why did you choose this facility for care (reputation, husband's choice, financial restrictions, etc.)? Did you face any obstacles to reach the health facility (e.g., transportation)? How did you overcome the problem – in your communities, what resources are available to help you, what do you usually do?
4. These next questions are about the health care services at the hospital. Who met you at hospital admission (physician, nurse, clerk)? How did they treat you – any blame? Did they explain to you the procedures you are passing through? Did you receive any counseling? If yes, what were you told? Was privacy respected? If you were in pain, what did you receive for it?
5. Did anybody talk to you about the procedure you were going to receive (e.g., what would be done to treat the abortion or complications, any side effects, pain, etc)? Did a nurse or a physician talk to you? Was what they told you appropriate? How did they treat you? Were they respectful? Were they careful to maintain your privacy before/during/after the procedure? Was the room where the procedure was performed clean?
6. After the procedure, were you given any analgesics for pain? Did you ask for analgesics? Did you get them?
7. Were you counseled after the procedure? Who counseled you? What was told to you (anything about rest, nutrition, warning signs, return of fertility, family support, family planning, or time of follow up visit)? Was there anything that you wanted to know about that was not addressed? Was there anything that you wanted to know more about? Where were you counseled (was it private)? Were you treated with respect? Did the person explain things clearly?

8. Were there any further examinations before you were discharged? If so, were they done in a private room? Were you treated with respect?
9. Are you satisfied with postabortion health care service provision? What do you think is missing in this type of care? What do you suggest to improve this type of care?
10. Has anyone experienced any problems after the procedure at the hospital? What did you do? Who gave you advice about what to do (provider, mother, mother-in-law, sister, other relative, neighbors)?
11. After going home, did any one from the hospital or clinic visit you? When was the first time you visited the clinic after returning home? Why did you go? Who met you and what was told to you?
12. Have any of you started to use a family planning method? What method are you using? For those who did not use a method until now, why didn't you use any method? When do you plan to use? Are there any talking/negotiations between you and your husbands about family planning method use? Do you think providers should talk to your husbands about it?

Thank you for your time, valuable ideas, and comments.

Attachment K

Facilitator's Guide – Scenario of Losing a Pregnancy

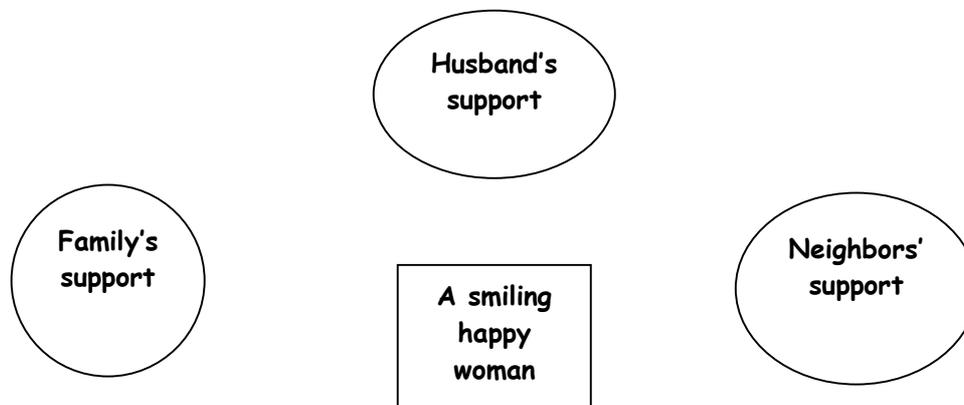
Directions: Prepare a flip chart of two pages, as follows:

PAGE 1

A 35-year old woman was 2 months pregnant. One morning she saw two spots of vaginal blood and she was frightened. In the afternoon, she started to bleed heavily and felt severe lower abdominal and back pain. All her family members gathered around her, giving her advice.

PAGE 2

At home, what are the expectations after a woman has lost a pregnancy?



Discussion guide for page 1

- What do you think is the woman's problem? What are the possibilities? (Losing her pregnancy, other causes)
- What are the possible causes of losing her pregnancy? (Doing too much work, carrying heavy weights, God's will, fetal anomalies, unwanted pregnancy)
- What possible reactions may she have? (Fear, anger, depression, worry)
- What should this woman do? (GO TO THE HOSPITAL, private clinic, primary health center, ask neighbors and relatives, daya, wait and see)

The woman should seek health care as quickly as possible if she has any danger signs of pregnancy complications.

- If she doesn't go to the hospital immediately, what symptoms other than bleeding could occur? (Discomfort, severe pain, shock, and even death)
- In your communities, what are the obstacles that would delay/prevent her from seeking proper health care? (Ignorance, bad advice, fear, no method of transportation, mistrust in doctors at health units)

- How can these obstacles be overcome?
 - ▶ Ignorance (educate community members and raise their awareness) ***Could you help in this?***
 - ▶ Bad advice (all community members should know that the woman should go directly to the hospital if she has any danger sign) ***Could you disseminate this information in your communities?***
 - ▶ Fear (educate community members and raise their awareness)
 - ▶ Lack of transportation (call an ambulance, rent a car, use available cell phones) ***Could you help in this?***
 - ▶ Poor or inappropriate care at health center e.g., untrained provider, male provider (educate the people, MOHP assigns a female doctor) ***Could you help in this?***

Discussion guide for page 2

What does a woman who lost her pregnancy need after she returns from the hospital?

1. If she doesn't want to be pregnant again right away, should she choose an appropriate method of family planning?
2. Does she need rest and proper nutrition?
 - ▶ Women who lose a pregnancy need to rest but do not have to stay in bed. (They should be advised to eat foods such as beans, spinach, tomatoes, and fresh green vegetables to prevent anemia.)
3. What else does she need to know?
 - ▶ Return to work and exercise gradually. Most women can return to normal activities after losing their pregnancy. Women who had heavy bleeding or an infection should not return to hard work and exercise for at least 1 week.
 - ▶ Ensure personal cleanliness.
 - ▶ She needs to know that she could be pregnant again after 2 weeks. (A woman quickly regains her fertility after a spontaneous or unsafe abortion).
4. What else does the woman need at this time?
 - ▶ Emotional support from husband, rest of family, and neighbors.

Attachment L

Postabortion Care Training Schedule 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 Postabortion 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

Attachment M

Training Report

Instructions. The clinical trainer should complete this report following the initial training course.

Name of Hospital _____ Dates of Training _____ Training Site _____

Names of Clinical Trainers _____

Name of Trainee	Male/Female	Hospital	Job Title	Scores				
				Pre-test	Post-test	IP	Counseling	Clinical care

Attachment N

Individual Trainee Follow Up Report

Name of Trainee _____ Hospital _____

Event	Date	Clinical Trainer	Comments/Observations
Initial Training			
Follow up visit #1			
Follow up visit #2			
Follow up visit #3			
Follow up visit #4			
Follow up visit #5			
Follow up visit #6			

Sample Individual Trainee Follow Up Report

Instructions: This form is used to record the progress of each trainee in learning and applying PAC skills. The clinical trainer who conducts the initial training and subsequent follow up visits to the hospital will use this form to record comments and observations on the clinical performance of the trainee.

Example 1

Name of Trainee _____ Hospital _____

Event	Date	Clinical Trainer	Comments/Observations
Initial Training	Jan 5-11, 2005	Dr. XXXX	In the initial clinical training Dr. XXX performed well. His strengths are....His weaknesses are...This was discussed with him and he will.... His score on the clinical care was...
Follow up visit #1	Feb 14, 2005	Dr. XXXX	During this follow up visit I observed Dr. XXXX perform MVA. His clinical care score was... He is now considered competent and I don't plan to observe him again....

Example 2

Name of Trainee _____ Hospital _____

Event	Date	Clinical Trainer	Comments/Observations
Initial Training	Jan 5-11, 2005	Dr. XXXX	<p>In the initial clinical training Dr. YYYY performed poorly. He has particular problems using proper infection prevention practices. His strengths are...His weaknesses are... This was discussed with him and he will...</p> <p>His score on the clinical care was...</p>
Follow up visit #1	Feb 14, 2005	Dr. XXXX	<p>During this follow up visit I observed Dr. YYYY perform MVA. His clinical care score was... He is still not sure about what he can touch and the metal and plastic phases confuse him. I explained the procedure again. The head of the department will give him some extra training in the next 2 weeks. I plan to observe him again on my next visit, which will be on March 23, 2005.</p>
Follow up visit #2	March 23, 2005	Dr. XXXX	<p>During this follow up visit I observed Dr. YYYY perform MVA. His clinical care score was... He is now using proper infection practices and is considered competent and I don't plan to observe him again until...</p>

Attachment O

Monthly Follow Up Report For PAC Program

Instructions: The clinical trainer who conducts the follow up visit to the hospital should complete this report and submit a copy to the head of the Ob/Gyn Department and the Project office. The Project office will also send a copy of the report to the person responsible for the curative sector at the Governorate level.

Name of Hospital _____ Month _____

Name of Clinical Trainer Conducting Visit _____

Date(s) of Visit _____

Component 1. PAC Training					
Staff Category	Not Trained	Program Course	Other Course	Inservice Course	TOTAL
Doctors					
Nurses					
Other (Specify)					
Total					
Comments					
Training Needs					
Designated trainers present			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Training materials present			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Comments					

Component 2. Clinical Indicators		
This information is obtained from the Medical Record Form. This section may be completed by the hospital staff.		
Clinical Indicator	Data for Month of _____	
Total number of PAC clients admitted		
% of clients presenting with complications		
% of clients treated by MVA		
% of clients treated by D&C		
% of clients treated under local anesthesia or no anesthesia		
% of clients with complications during MVA		
% of clients with complications during D&C		
% of clients receiving pre-procedure counseling		
% of clients receiving counseling during procedure		
% of clients receiving counseling after procedure		
% of clients who received counseling from same nurse		
% of all clients referred for FP method		
% of all clients who received FP method		
Comments		
FP Method Provided	Total	%
IUD		
Condom		
Combination OCPs		
Progestin-only OCPs		
Injectables		
Implanon (subdermal implant)		
Tubal ligation		
TOTAL		
Comments		

Component 3. Organization of Services	
Does the PAC program have the support of the hospital director?	
Does the PAC program have the support of the chairman of the Ob/Gyn department?	
Are there providers (nurses/doctors) who are opposed to the PAC program?	
How is the collaboration with the FP clinic?	
Resources	Check if present
Program Resources	
Procedure manual for PAC, including MVA and FP counseling	
For FP Counseling	
Private space for counseling	
Furniture	
Three-page brochures	
FP leaflets	
Wall charts	
FP methods as examples	
FP counseling flipchart	
Instruments and Equipment	
Pan and pan cover (1 each)	
Bivalve speculum (small, medium or large)	
Uterine tenaculum (Braun, straight, 9 1/2" (1) or vulsellum forceps (1)	
Pan emesis (1)	
Kidney dish (1)	
Sponge (Foerster, straight 9 1/2") forceps (2)	
10-20 ml syringe and 22-gauge needle for paracervical block (6 each)	
MVA instruments	
<ul style="list-style-type: none"> • MVA vacuum syringes, double valve (1) 	
<ul style="list-style-type: none"> • Plastic cannulae of different sizes (6 mm to 12 mm) 	
<ul style="list-style-type: none"> • Adapters 	
<ul style="list-style-type: none"> • Silicone for lubricating MVA syringe O-ring (1 tube) 	
Light source (to see cervix and inspect tissue)	

Strainer (for tissue inspection)	
Clear container or basin (for tissue inspection)	
Simple magnifying glass (x 4-6 power) (optional)	
Consumable Supplies	
Swabs/gauze	
Antiseptic solution (preferably an iodophor such as povidone iodine)	
Gloves, sterile or high-level disinfected surgical gloves or new examination gloves	
Gloves, utility	
The essential drugs needed for emergency postabortion care that should be available at the primary and referral levels are listed in Attachment Q.	
Items that should be on hand, but are not required for all MVA procedures:	
Local anesthetic (e.g., 1% lidocaine without epinephrine)	
Curettes, sharp, large	
Tapered mechanical dilators (Pratt [metal] or Denniston [plastic])	
Furniture and Equipment	
Before beginning the MVA procedure, make sure that the following equipment and supplies are in the treatment room and in working order:	
Examination table with stirrups	
Strong light (e.g., gooseneck lamp)	
Seat or stool for clinician (optional)	
Plastic buckets for decontamination solution (0.5% chlorine)	
Puncture-proof container for disposal of sharps (needles)	
Leak-proof container for disposal of infectious waste	
For Environmental Cleaning	
Dry sweeper	
Mop with long handles	
Heavy duty gloves	
Damp cloth	
Mop bucket	
Detergent (e.g., liquid soap)	
Disinfectant (chlorine solution)	
Closed plastic shoes	
For High-Level Disinfection or Sterilization of Instruments	
Nonmetal (plastic) containers	
Detergent	
Clean water	
Chlorine solution (concentrated solution or dry powder)	
High-level disinfectant or sterilization agent (optional)	

Large pot for boiling cannulae (optional)	
Steamer for steaming surgical gloves, cannulae and surgical instruments	
Autoclave (steam) or convection oven (dry heat)	
For Emergency Resuscitation	
These items are seldom required in uterine evacuation cases but are needed for possible emergency use:	
Spirits of ammonia (ampules)	
Atropine	
IV infusion equipment and fluid (OSW or O/S)	
Ambu bag with oxygen (tank with flowmeter)	
Oral airways	

Component 4. Information System	
Resource	Check if present
Dedicated Medical Record Form for PAC clients	
Computerized record system	
Medical Record Form completed for each client	
Daily maintenance of records	
Monthly or bimonthly presentation of information to all staff	
Use of information in evaluation meetings	
Comments	

Component 5. Logistics	
	Check all appropriate
Only donated MVA equipment is used	
MVA equipment purchased with own resources	
MVA equipment received from Department of Health	
List of MVA equipment sources is maintained	
Comments (identify source of MVA equipment if possible)	

Component 6. Action Plan

Using old Action Plan, describe which problems were solved, which were not solved, and what can be done to remedy the situation. Complete a new Action Plan.

Action Plan Form

Problem	Cause	Decision or solution	Person responsible	Date needed	Expected result
Problems remaining from old action plan					
Problems from self-assessment					
Problems from indicators					

Attachment P

Medical Record Form

Instructions: Complete a Medical Record Form for each patient admitted for postabortion care for spontaneous or unsafe induced abortion. The information collected on this form will be compiled and analyzed as part of the monthly follow up visit and report.

Hospital number _____ Date of admission _____

No.	Question	Response
1.	Did the patient have complications (e.g., excessive bleeding, shock, foul discharge, peritonitis)	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify:
2.	What procedure was performed? Choose one.	<input type="checkbox"/> D&C <input type="checkbox"/> MVA <input type="checkbox"/> MVA and D&C
3.	What anesthesia was used? Choose one.	<input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Local and general <input type="checkbox"/> None
4.	When were sedatives and analgesics administered? Choose as many as apply.	<input type="checkbox"/> Pre-operative <input type="checkbox"/> During procedure <input type="checkbox"/> Post-operative
5.	Did complications occur during the procedure? Choose as many as apply.	<input type="checkbox"/> Bleeding <input type="checkbox"/> Shock <input type="checkbox"/> Perforation <input type="checkbox"/> Other Specify:
6.	When was counseling conducted and by whom? Check as many as apply and write name next to each box checked.	Write name of person providing counseling <input type="checkbox"/> Pre-operative _____ <input type="checkbox"/> During procedure _____ <input type="checkbox"/> Postoperative _____
7.	Was family planning counseling conducted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Was family planning method provided?	<input type="checkbox"/> No <input type="checkbox"/> Yes Specify:
9.	If family planning method was not provided, why?	<input type="checkbox"/> Patient referred to FP clinic <input type="checkbox"/> Patient wants to get pregnant and does not want FP now <input type="checkbox"/> Other reason Specify:

Attachment Q

Initial Hospital Assessment for PAC Services

I. GENERAL INFORMATION

Date of visit: Day _____ Month _____ Year _____

Name of Hospital: _____

Location: City _____ Governorate _____

Interviewer (assessment only) _____

Personnel Interviewed (assessment only) 1. _____
 2. _____
 3. _____
 4. _____

Number of Beds Obstetrical Beds _____ Gynecological Beds _____ Total Number of Beds (obst and gyn) _____

Number of OB/GYN staff Head of department name: _____ Telephone number: _____
 No. of Consultants: _____ No. of Specialists: _____ No. of Residents: _____ No. of Nursing staff: _____

Average No. of Days Spent in the Hospital Non-complicated Abortion _____ Complicated Abortion _____

Monthly Number of Normal Deliveries _____ Caesarean Op. _____ Spontaneous or unsafe induced abortions. _____

II. VOLUME OF CLIENTS AND RANGE OF SERVICES							
Care Service Schedule							
SERVICES OFFERED	DAYS/SCHEDULES						
	SAT	SUN	MON	TUES	WED	THURS	FRI
Family Planning Methods available on ward							
Manual Vacuum Aspiration							
Post-Abortion Care Counseling							

II. VOLUME OF CLIENTS AND RANGE OF SERVICES (continued)					
Review the following reproductive health statistics for the past three months and assign an average. Write any additional comment or suggestion in the "Comments" column.					
VOLUME OF POST-ABORTION CARE	MONTH 1	MONTH 2	MONTH 3	AVERAGE	Comments
No. of Spontaneous or Unsafe Induced Abortions Treated					
No. of Post-Abortion Counselings					
CONTRACEPTIVE METHODS OFFERED TO POSTABORTION CLIENTS. Record the number of methods delivered in the past 3 months and assign an average. Write any additional comment or suggestion in the "Comments" column.					
METHOD					
IUD					
Condom					
Combined OCPs					
Progestin-only OCPs					
Injectables					
Implanon (subdermal implants)					
Tubal ligation					

III. Treatment Registry and Protocol			
TYPE OF REGISTRY	IS THERE ONE?		Comments
	YES	NO	
Is there care registration upon admission?			
Is a single medical history available?			
Is there any system to file and retrieve the client's medical history?			
Is a care card or record given to the client?			
Is the following registered in the medical history?			
Clinical Exam. Findings			
Lab Test Request			
Lab Test Results			
Operation Report			
Post-operative Development			
Follow up/Monitoring			
Counseling			
TREATMENT PROTOCOL			
Is there postabortion care protocol?			

Program Guide for PAC Services in Egypt

Is the care protocol applied?			
Is there a family planning protocol for postabortion care?			
Is the protocol applied?			
TECHNIQUE FOR INCOMPLETE ABORTION			
Is D&C used?			
Is MVA used?			
Is Electric Aspiration used?			

IV. Rooms and Equipment

Assess the following rooms and their implementation according to the following scale:

STATUS/PHYSICAL STATE: 1 = Inadequate, needs refurbishing 2 = Regular 3 = Good

	IS THERE?		AMOUNT	STATUS		
	YES	NO		1	2	3
TRIAGE						
- Registry Book						
- Client Sheets						
- Phone						
- Desk						
- Chairs						
WAITING ROOM						
Phone						
Chairs						
Lighting (light bulbs, fluorescent lamps)						
Restroom						
Sign posting						
Wastebaskets/Garbage Containers						
IEC MATERIAL FOR FP IN WAITING ROOM						
- TV / VHS						
- Three-page brochure						
- Posters						
- FP leaflets						
COUNSELING ROOM						
Private Room						
Shared Room						
IEC MATERIAL FOR FP IN COUNSELING ROOM						
- Flipcharts						

- Miniature models						
- Three-page brochure						
- FP leaflets						
- Contraceptive methods						

IV. Rooms and Equipment, continued

Assess the following rooms and their implementation according to the following scale:

STATUS/PHYSICAL STATE: 1 = Inadequate, needs refurbishing 2 = Regular 3 = Good

	IS THERE?		AMOUNT	STATUS		
	YES	NO		1	2	3

Gynecological Examination Room

Gynecological Examination Bed						
Stethoscope						
Sphygmomanometer						
Thermometer						
Specula						
Gynecological Instruments						
Sterilized Gauze or Cotton						
Surgical Drums						
Washbasin						
Restroom						
Towels						
Wastebaskets / Garbage Containers						
Materials for Decontamination						
Dressing Room/Lockers						
Surgical Washbasin for Washing Hands						
Surgical Wear						

Procedures Room

Equipment						
Pan and pan cover (1 each)						
Bivalve speculum (small, medium or large)						
Uterine tenaculum (Braun, straight, 91/2" (1) or vulsellum forceps (1)						
Pan emesis (1)						
Kidney dish (1)						

IV. Rooms and Equipment, continued						
Assess the following rooms and their implementation according to the following scale:						
STATUS/PHYSICAL STATE: 1 = Inadequate, needs refurbishing 2 = Regular 3 = Good						
	IS THERE?		AMOUNT	STATUS		
	YES	NO		1	2	3
Sponge (Foerster, straight 91/2") forceps (2)						
10-20 ml syringe and 22-gauge needle for paracervical block (6 each)						
MVA instruments						
• MVA vacuum syringes, double valve (1)						
• Plastic cannulae of different sizes (6 mm to 12 mm)						
• Adapters						
• Silicone for lubricating MVA syringe O-ring (1 tube)						
Light source (to see cervix and inspect tissue)						
Plastic buckets for soaking solution (0.5% chlorine)						
Puncture-proof container for disposal of sharps (needles)						
Leak-proof container for disposal of infectious waste						
Strainer (for tissue inspection)						
Clear container or basin (for tissue inspection)						
Simple magnifying glass (x 4-6 power) (optional)						
Consumable Supplies						
Swabs/gauze						
Antiseptic solution (preferably an iodophor such as povidone iodine)						
Gloves, sterile or high-level disinfected surgical gloves or new examination gloves						
Gloves, utility						
Items that should be on hand, but are not required for all MVA procedures:						
Local anesthetic (e.g., 1% lidocaine without epinephrine)						
Curettes, sharp, large						
Tapered mechanical dilators (Pratt [metal] or Denniston [plastic])						
Furniture						
Examination table with stirrups						
Strong light (e.g., gooseneck lamp)						
Seat or stool for clinician (optional)						

IV. Rooms and Equipment, continued						
Assess the following rooms and their implementation according to the following scale:						
STATUS/PHYSICAL STATE: 1 = Inadequate, needs refurbishing 2 = Regular 3 = Good						
	IS THERE?		AMOUNT	STATUS		
	YES	NO		1	2	3
For Emergency Resuscitation						
These items are seldom required in uterine evacuation cases but are needed for possible emergency use:						
• Spirits of ammonia (ampules)						
• Atropine						
• IV infusion equipment and fluid (OSW or O/S)						
• Ambu bag with oxygen (tank with flowmeter)						
• Oral airways						
Essential drugs						
ANESTHETICS, LOCAL						
Atropine						
Diazepam						
Lignocaine, 1 % without epinephrine						
ANTISEPTICS						
Chlorhexidine, 4% (Hibitane, Hibiscrub)						
Iodine preparations, 1-3% Iodophors (Betadine)						
ANALGESICS						
Acetylsalicylic acid						
Ibuprofen						
Pethidine (or suitable substitute)						
DISINFECTANTS						
Sodium hypochlorite 5-10% (commercial chlorine bleach solution)						
Formaldehyde, 8% (Formalin) Glutaraldehyde, 2% (Cidex)						
ANTIBIOTICS						

IV. Rooms and Equipment, continued						
Assess the following rooms and their implementation according to the following scale:						
STATUS/PHYSICAL STATE: 1 = Inadequate, needs refurbishing 2 = Regular 3 = Good						
	IS THERE?		AMOUNT	STATUS		
	YES	NO		1	2	3
Broad spectrum antibiotics such as: Ampicillin						
Benzylpenicillin						
Crystalline penicillin Chloramphenicol Metronidazole Sulfamethoxazole						
Sulfamethoxazole-trimethoprim Tetracycline						
TETANUS TOXOID						
OXYTOCICS						
Ergometrine injection or Ergometrine tablets or Oxytocin injection						
INTRAVENOUS SOLUTIONS						
BLOOD PRODUCTS St Dried human plasma						
Water for injections Sodium lactate (Ringer's) Glucose 5% and 50%						
Glucose with isotonic saline Potassium chloride Sodium chloride						
Available Contraceptive Methods Equipment						
IUD Insertion kit						
Implanon Insertion/Withdrawal kit						
Decontamination Material						
RECOVERY ROOM						
Private Room						
Gloves						
Available Contraceptive Methods						
- Combined OC						
- Progestine OC only						
- Condoms						
- IUDs						
- Injections						
- implanon						
Procedures room or sterilization department						
For environmental cleaning						
• Dry sweeper						

IV. Rooms and Equipment, continued						
Assess the following rooms and their implementation according to the following scale:						
STATUS/PHYSICAL STATE: 1 = Inadequate, needs refurbishing 2 = Regular 3 = Good						
	IS THERE?		AMOUNT	STATUS		
	YES	NO		1	2	3
• Mop with long handles						
• Heavy duty gloves						
• Damp cloth						
• Mop bucket						
• Detergent (e.g., liquid soap)						
• Disinfectant (chlorine solution)						
• Closed plastic shoes						
For High-Level Disinfection or Sterilization of Instruments						
• Nonmetal (plastic) containers						
• Detergent						
• Clean water						
• Chlorine solution (concentrated solution or dry powder)						
• High-level disinfectant or sterilization agent (optional)						
• Large pot for boiling cannulae (optional)						
• Steamer for steaming surgical gloves, cannulae and surgical instruments						
• Autoclave (steam) or convection oven (dry heat)						

V. Prevention of Infection Practices

Evaluate with a score of 1, 2, or 3 in the column labeled "Score."

(1) DEFICIENT (2) AVERAGE (3) GOOD

Provide any additional comments in the column labeled "Observations."

Personnel Observed:

STEPS IN THE MAINTENANCE OF INSTRUMENTS AND EQUIPMENT	SCORE	OBSERVATIONS
DECONTAMINATION		
Prepare water with chloride at correct concentration (0.5%) and in sufficient quantity (to completely cover instruments and equipment used in the procedure)		
The container that contains the water and chloride is of adequate size and shape		
The container is located within reach of the professional performing the procedure		
The water with chloride is changed after each procedure		
All instruments, gloves, and equipment remain in the water and chloride for the necessary amount of time (at least 10 minutes)		
CLEANING		
The technician uses protective barriers to clean instruments and equipment: apron, cap, mask, gloves, etc.		
Prepare water with detergent in sufficient quantity		
Completely take apart syringes used in the procedure		
Clean instruments and equipment using brushes		
Rinse all instruments and equipment in running water		
Dry all instruments and equipment using clean drying towels		
Apply silicon to security rings of syringes, assemble them, and store them with the adaptors in a clean container		

HIGH-LEVEL DISINFECTION (HLD) OR STERILIZATION		
Prepare HLD substance at adequate concentration and quantity to cover all instruments and equipment		
The container in which the HLD substance is prepared is of adequate size and shape		
Observe that the HLD substance is not cloudy		
In the HLD substance, place the cannulas and dilators as well as instruments that will be needed shortly		
Observe that the instruments and equipment placed in HLD remain at least 20 minutes		
After 20 minutes, rinse instruments and/or equipment with sterile water		
Store instruments and equipment in sterile containers with tops		
Metallic instruments are sent for sterilization with vapor or dry heat		
STORAGE		
Syringes and adaptors are stored in clean containers		
Cannulas and dilators that have been sterilized or have undergone HLD are stored in sterilized containers		
When equipment is not used for seven days, perform the entire maintenance process again		

VI. Counseling

Evaluate with a score of 1, 2, or 3 in the column labeled "Score."

(1) DEFICIENT (2) AVERAGE (3) GOOD

Provide any additional comments in the column labeled "Observations."

Personnel Observed: _____

قائمة التحقق من جودة تقديم المشورة

- اسم مقدم المشورة:
- درجات التقييم: ١ ضعيف ٢ - متوسط ٣ - جيد

i. ملاحظات		لا	نعم	ii. المهمة
b. ملاحظات عامة:				
التأكيد علي خصوصية المكان				
				التأكد من نظافة المكان
				التأكد من ترتيب المكان
				مراجعة تاريخ المريضة قبل المشورة
				استخدام وسائل توضيحية
				شرح هدف المشورة للمريضة
المشوره - قبل اجراء العمليه				
				يقوم مقدم المشوره بتعريف اسمه
				تحية المريضة بطريقه محترمة وحميمة
				السؤال عن انطباع المريضة تجاه العمليه
				وصف العمليه بطريقه سهله ومبسطة شارحا المزايا والأخطار لكسب ثقة المريضة
				تعريف المريضة باحتمال حدوث بعض الألم وتوضيح إمكانية التغلب عليه
				سؤال المريضة عن أهدافها الإيجابية والطرق المفضلة لوسائل منع الحمل

i. ملاحظات	لا	نعم	ii. المهمة
			التأكد من وجود الموافقة الاختيارية للمريضة علي إجراء العملية مذكور فيه التاريخ المرضي للمريضة
			تسجيل الوقت الذي تمت فيه هذه المشورة
			أثناء العملية
			مساعدة المريضة علي الاسترخاء
			التحدث مع المريضة
			توقع احتياجات المريضة
			جذب انتباه المريضة للتعاون التام أثناء خطوات العملية
			التغلب علي الألم عند الشعور به
			متابعة العلامات الحيوية للمريضة
			عند اختيار المريضة للولب كوسيلة منع حمل راقب خطوات تركيبه
			بعد العملية
			السؤال عن حالة المريضة
			إخبار المريضة أن عودة الخصوبة في خلال ٢-٣ أسابيع و يمكن أن تحدث في أقل من ١١ يوم
			إخبار المريضة باحتمال حدوث بعض الأعراض مثل آلام في الحوض - إفرازات
			توضيح علامات الخطر للمريضة والتأكد من معرفتها لها مثل : نزيف اكبر من كمية دم الدورة , زيادة في آلام الحوض , ارتفاع في درجة الحرارة مع رعشه , إفرازات ذات رائحة كريهة
			تعريف المريضة بمكان واسم مقدم الخدمة عند حدوث مضاعفات
			المشورة لاستخدام وسائل تنظيم الأسرة بعد الإجهاض
			التعرف علي الميول الإنجابية للسيدة
			إخبار المريضة بكل وسائل منع الحمل مع شرح الفوائد والأخطار لكل وسيلة
			ترك المريضة لاختيار الوسيلة بحريه
			شرح مفصل للطريقة المختارة مع التأكد من معرفة المريضة بكل نواحيها
			إعطاء المريضة الطريقة المختارة

.i ملاحظات	لا	نعم	.ii المهمة
			اعطاء المريضه كتيب بجميع الوسائل المتاحة الاخرى با لمستشفى *

VII. Provider's Performance

Evaluate with a score of 1, 2, or 3 in the column labeled "Score."

(1) DEFICIENT (2) AVERAGE (3) GOOD

Provide any additional comments in the column labeled "Observations."

Personnel Observed: _____

STEPS DURING THE PROCEDURE	SCORE	OBSERVATIONS
PRE-PROCEDURE		
Conduct a counseling session to determine the emotional state of the patient and her family planning intentions		
Review the clinical history and obtain information on: <ul style="list-style-type: none"> • Reproductive Health History • Anesthetic history • Allergies • Prior surgeries • Blood type 		
Verify existence of written, informed consent of the patient in the clinical history.		
Introduce yourself to the patient in a friendly manner		
Explain procedure to the patient.		
Confirm that all necessary materials, medications, and instruments are available.		
PRE-PROCEDURE PHYSICAL EXAM		
Ensure patient privacy during the exam and procedure. Ask for patient consent to be observed by students, interns, or other personnel.		
Wash hands before examining the patient		
Put on sterile gloves without contaminating them		
Conduct bimanual exam to determine size of uterus		
PROCEDURE: "NO-TOUCH TECHNIQUE"		
Make a note of the start time		
Change gloves (sterile)		

Prepare the table with instruments, "metallic moment"		
• Insert ring fórceps in "rigid zone"		
• Place speculum, tenaculum forceps, ring forceps, and MVA Instruments (Aspirator, Canulae, and Adaptors).		
• Prepare local anesthetic: 10 cc Lidocaine 1% or xylocaine 1%		
STEPS DURING THE PROCEDURE	SCORE	OBSERVATIONS
• Insert speculum smoothly and at an oblique angle		
• Using speculum, identify cervical lacerations and/or trauma and signs of infection and inform patient of findings		
• Clean cervix and vagina with antiseptic solution		
• Place the tenaculum correctly and delicately		
Administer paracervical block:		
• Inject abou2 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.		
• The infiltration is slow with ongoing aspiration		
• Wait 2-4 minutes before continuing procedure		
Prepare the table for the "plastic moment"		
• 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.		
• 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.		
• Request syringes, check that they are functional (they retain vacuum) and place them in semirigid zone		
• Request adaptors and place on respective cannulas		
In case of incomplete abortion, dilate cervix introducing necessary dilators. Begin with number 5 up to a number larger than the number of cannula being used.		
Introduce cannula smoothly and measure uterine cavity		
Connect cannula to the syringe, feel the bottom of the uterine cavity and withdraw 1 cm. Open security valves.		
Begin aspiration of uterine contents with clockwise rotation of syringe and then from inside to outside maintaining clockwise rotation		
When presented with any complication in the use of MVA technique (loss of		

vacuum, vacuum not conserved, obstruction of cannula, contamination of cannula), resolve correctly		
Conduct final exam using cannula number 6 in STRICT clockwise motion		

STEPS DURING THE PROCEDURE	SCORE	OBSERVATIONS
Confirm signs of end of intervention by verifying: remains no longer aspirated in the cannula, presence of pink bubbles, noting roughness of uterine cavity, the uterus puts pressure on the cannula.		
When requested by patient, correctly insert IUD		
Confirm that there is no bleeding before removing tenaculum and speculum		
Conclude the procedure placing all used equipment in a solution of chlorine 0.5% for decontamination		
Examine aspiration remains		
Send aspiration remains to pathological anatomy for examination (review whether the protocol for care of incomplete abortion establishes this)		
Remove gloves and place them in decontaminating solution		
Wash hands with water and soap		
Take note of finish time		
POST-PROCEDURE		
Determine patient condition before transfer to recovery room		
Monitor patient recovery during recovery time and before discharge.		
At discharge, give patient instructions on medications to be used and emergency signs and a brochure <ul style="list-style-type: none"> • Abundant blood, more than a normal menstrual period • Strong pelvic pain or pelvic pain that increases • Fever and/or shivers • Vaginal secretions of foul odor 		

Attachment R

Client PAC Brochure and English Translation of Text



بعد فقدان الحمل، ازاي تهتمى بصحتك





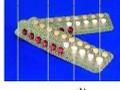



لو مش عايزة تحملى بسرعة لازم تستخدمى وسيلة لتنظيم الأسرة فى خلال أسبوعين

• أى وسيلة من وسائل تنظيم الأسرة ممكن تكون مناسبة .
• الدكتور والممرضة ممكن يساعدوكى تختارى الوسيلة المناسبة .



كيسولة تحت الجلد



الحبوب



المولب



الواقي الذكري (للزوج)



الحقن



• لو عايزة تستخدمى وسيلة لتنظيم الأسرة
ممكن تاخديها من المستشفى هنا أو تروحى لعيادة
قبل يوم



الوكالة الأمريكية للتنمية الدولية
السياسة هذه الإصدارات متاحة من خلال
مساندة وزارة الصحة والسكان والتنمية
الأمريكية للتنمية الدولية تحت بنود العقد
رقم HRN-A-00-00003-00

العلامات دي خطر و لو حصلت بعد العملية لازم تروحي للدكتور



• غممان نفس أو قيء
• حمى
• إهرارات مهبلية ليها
• رائحة كريهة



• نزيب شديد
• دوخة أو إغماء
• مقص جامد قوى مش
• ممكن تستحمله



كلنا هنا لخدمتك ورعاية صحتك

بعد ما تروحي البيت اعملى بالنصايح دي:

- 1- تترتاحى كويس لكن ممكن
تقومى ببعض الأعمال الخفيفة
فى البيت .
- 2- تاكلى الفداء الجيد اللي بيحتوي على
الحديد زى اللحوم - الخضراوات الورقية -
الفصل الأسود- الفواكه الطازجة .
- 3- ممكن ترجعى للعلاقة الزوجية بعد
ما الدم والأفرازات تقف وتكونى
مستعدة نفسياً .
- 4- بس خلى بالك انه ممكن يحصل حمل
تانى فى خلال اسبوعين من عملية
فقدان الحمل .
- 5- اوعى تنسى تاخدى الادوية اللي
كتيها لك الدكتور بانتظام .

Brochure Text

Cover Page

How to care for your health after losing a pregnancy?

Photo of woman coming out of the hospital accompanied by her husband and mother/mother in law

Page 1

After you go home:

1. Be sure to rest; however, you can do some light household activities.
2. Eat food that contains iron, such as meat, green leafy vegetables, black molasses, and fresh fruits.
3. You can resume your sexual relationship after bleeding and discharge stops, and when you are ready psychologically.
4. Take care; you can be pregnant within two weeks postabortion.
5. Don't forget to take your medication.

Page 2

These are the danger signs. If you have any of these danger signs, go to your treating physician immediately! (*Corresponding photos*)

1. Severe bleeding
2. Drowsiness or coma
3. Severe intolerable colic
4. Nausea or vomiting
5. Fever
6. Vaginal discharge with bad odor

Page 3

If you don't want to get pregnant, you should use a family planning method within two weeks postabortion (*Corresponding photos*)

Any FP method is suitable. The physician/nurse can help you choose an appropriate method. Examples are:

1. IUD
2. Pills
3. Subdermal capsule
4. Injections
5. Male condom

You can receive FP method from the hospital or the nearest FP clinic. **We are here to serve you.**

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