Medical Abortion Training Guide

Using medicines for first-trimester pregnancy termination

Ipas
Protecting women's health
Advancing women's reproductive rights

ISBN: 1-933095-56-3

Produced in the United States of America.

Suggested citation: Ipas. 2010. *Medical Abortion Training Guide.* Chapel Hill, N.C.: Ipas

Ipas works globally to increase women's ability to exercise their sexual and reproductive rights and to reduce abortion-related deaths and injuries. We seek to expand the availability, quality and sustainability of abortion and related reproductive health services, as well as to improve the enabling environment. Ipas believes that no woman should have to risk her life or her health because she lacks safe reproductive health choices.

Ipas is a registered 501(c)(3) nonprofit organization. All contributions to Ipas are tax deductible to the full extent allowed by law.

Cover photo credits, clockwise from top: G.M.B. Akasht/Panos Pictures, Ipas, R. Lord

The illustrations and photographs used in this publication are for illustrative purposes only. No similarity to any actual person, living or dead, is intended.

For more information or to donate to Ipas:

Ipas

P.O. Box 5027

Chapel Hill, NC 27514 USA

1-919-967-7052

ipas@ipas.org

www.ipas.org

Graphic designer: Valerie Holbert

Managing Editor: Alyson Hyman

Printed on recycled paper.

Ipas
Protecting women's health
Advancing women's reproductive rights

Medical Abortion

Training Guide

Using medicines for first-trimester pregnancy termination

Acknowledgments

*We would like to thank the following people for giving their time and expertise to the development of Ipas's Medical Abortion Training Program:**

Ali Samba, Ghana
Alison Edelman, USA
Anne Burke, USA
Beth Kruse, USA
Beverly Winikoff, USA
Blami Dao, Burkina Faso
Caitlin Shannon, USA
Chanda Karki, Nepal
Christina Wegs, USA
Danielle Hassoun, France
Dalia Brahmi, USA
Fabian Rodriguez, Uruguay
George Huggins, USA
Hela Chelli, Tunisia
Helena Von Hertzen, Switzerland
Joe Taylor, Ghana
Kusum Thapa, Nepal
Lisa Memmel, USA
Lisa Moreau, USA
Meera Ojha, Nepal
Meera Upadhyay, Nepal
Melanie Peña, USA
Mitchell Creinin, USA
Nitin Joglekar, India
Nguyen Thi Nhu Ngoc,Vietnam
Paige Layno-Winn, USA
Paul Blumenthal, USA
Phillip Stubblefield, USA
Pramila Pradha, Nepal
Rodica Comendant, Moldova
Selma Hajri, Tunisia
Shilu Aryal, Nepal
Suchitra Dalvie, India
Swaraj Rajbhandari, Cambodia

* The protocols and content in this publication do not necessarily reflect the views and opinions of each individual contributor.

Thanks to Ipas staff who contributed to the development of this material:

Alfonso Carrera, Mexico
Alyson Hyman, USA
Bill Powell, USA
Cansas Mulligan, USA
Ganesh Shrestha, Nepal
Indira Basnett, Nepal
Jennie Orcutt, USA
Joachim Osur, Kenya
Joan Healy, USA
Joseph Mills, Ghana
Josephine Addy, Ghana
Karen Trueman, South Africa
Kari Koita, Kenya
Katherine Turner, USA
Karen Padilla, Nicaragua
Laura Castleman, USA
Makgoale Magwentshu, South Africa
Mary Fjerstad, USA
Mary-Jane Zondo, South Africa
Marian Abernathy, USA
Nadia Shamsuddin, Thailand
Phan Bich Thuy, Vietnam
Robyn Sneeringer, USA
Rodolfo Gómez Ponce de León, Argentina
Sangeeta Batra, India
Sarah Packer, USA
Sikiratu Kailani, Nigeria
Takele Geressu, Ethiopia
Tiemoko Ouattara, Burkina Faso
Traci Baird, USA

Especially, a big thanks to the many participants of the field testing of this material:

Nepal Training on Medical Abortion for Lead Trainers and the Family Health Division, Government of Nepal

Africa Regional Training of Trainers on Medication Abortion and the Centre de Formation Internationale et de Recherche (CéFIR), Tunisia

Cambodia Technical Working Group on Medical Abortion and the National Reproductive Health Program, Government of Cambodia

South African Medical Abortion Curriculum Review Committee

We thank the Swedish International Development Agency for contributing funding to this training package through a grant to Ipas.

Overview

The Ipas Medical Abortion (MA) Training Program is intended to help train clinicians on the use of first trimester MA, particularly in limited-resource settings. It has three major components:

- Self-directed study
- In-person workshop
- Clinical practicum

This blended learning approach combines learning essential information through self-guided study with skills development in a workshop setting to then apply to work situations through the practicum.

As a participant in this training program, individuals are required to complete the Medical Abortion Study Guide prior to attending the workshop and practicum. There will be a pre-test prior to or on the first day of the workshop covering the information included in the *MA Study Guide*. Learners must score 75 percent on this test in order to participate in the workshop and practicum. This requirement will provide all trainees a base of knowledge to then focus classroom time on interactive discussion for deeper learning during the workshop.

Training Package

- *MA Study Guide* – to be used for self-directed study prior to attending an in-person workshop and clinical practicum, as well as a resource document for future reference.
- *MA Training Guide* – to be used by clinical trainers to lead participants through an in-person workshop followed by a clinical practicum.

Intended Participants

This training program is designed for health-care workers, including midwives, nurses or other mid-level providers, general practice physicians, and obstetrician/gynecologists who will provide first trimester medical abortion. The content is aimed toward basic information necessary for provision of care, but includes resources for further study or expansion of training, depending on the participants' needs.

Prerequisites

Participants in the MA training program should *minimally* already be able to:

- Demonstrate knowledge of the anatomy and physiology of the female reproductive system
- Demonstrate thorough skills in taking a medical history and conducting a physical exam
- Assess accurately the gestational age of an early pregnancy
- Recognize and manage or refer women for treatment of complications of abortion

Participants *ideally* should already be able to:

- Describe the key concepts of woman-centered abortion care, in which providers prioritize each woman's individual needs
- Describe circumstances in which abortion is permitted, and those in which it is restricted by law or policy
- Perform or refer women for vacuum aspiration services
- Recognize clinical symptoms of ectopic pregnancy

Duration of Training Program

The following are estimates; actual times will vary:

- *Self-directed Study:* 2-4 hours to read and complete the exercises in the Study Guide.
- *Workshop:* 2-4 days depending on use of the modules and expansion or reduction of content.
- *Clinical Practicum:* 4-6 hours to complete the practicum, but this may be adapted as needed.

Medical Abortion Training Guide

The MA Training Guide is for the second and third components of the Ipas MA training program (i.e. in-person workshop and clinical practicum).

Purpose

The MA Training Guide includes activities designed for trainers to use in helping health-care workers acquire the knowledge and practical skills they need to provide first-trimester medical abortion.

Goal

To equip health-care workers with the necessary knowledge and skills to provide medical abortion to women who request and are eligible for this abortion method.

Organization of MA Training Guide

The Training Guide is divided into nine units: seven workshop units, a clinical practicum unit, and an assessment, evaluation and closing unit. Each unit strengthens knowledge and skills for a specific component of MA service delivery. Trainers are highly encouraged to adapt the units to fit the local training needs and objectives.

Each training unit includes five elements:

1. **Time:** An estimate of how long it should take to complete the unit.

2. **Unit Objectives:** Specific objectives to be met by the end of each unit.

3. **Advance Preparations** Instructions regarding information or materials to be prepared ahead of time.

4. **Instructions and Materials:** A list of the handouts, presentations, and other resources needed for each activity, followed by step-by-step guidance on how to facilitate interactive learning.

   Notes: The MA Study Guide is considered a basic resource document to be used throughout the training course. If PowerPoint (PPT) presentations are not possible, trainers can copy PPT slides onto transparencies or use photocopies as handouts.

5. **Unit Materials:** Copies of all learner materials for distribution and answer keys for trainers.

Accompanying CD-ROMs

1. A companion training CD-ROM includes several resources that are to be used in the workshop activities in this Training Guide. They are:
   - *Medical Abortion Study Guide: Using Medicines for First-trimester Pregnancy Termination*
   - Medical abortion gestational dating wheel
   - *Best Practices in Medication Abortion: Starting Contraception after First-trimester Medication Abortion*
   - Sample certificates of completion and competency in Microsoft Word®
   - Sample workshop agenda template in Microsoft Word®
   - PowerPoint® presentations:
     - — Medical Abortion Overview
     - — Medical Abortion Eligibility and Regimens
     - — Medical Abortion Quiz Show
   - Video clip of Medical Abortion Quiz Show instructions
   - Color visual images of side effects continuum
   - *Medical Abortion Training Guide: Using Medicines for First-trimester Pregnancy Termination*
   - Trainer and participants materials

2. An additional CD-ROM, *Ipas IEC materials and job aids for medical abortion,* can be used in the workshop as well as for broader programmatic purposes. These information/education/communication (IEC) materials are useful in providing simple key points along with visual cues to help remember MA information. The materials can be adapted for use with health-care providers, women and intermediaries (people who assist women such as pharmacists or community health volunteers) from

the clinic to the community level. It is recommended that the materials be adapted appropriately to the local setting where they will be used. Art files of illustrations are included to assist in the process of adaptation. Guidance for adapting these templates for local use is also included.

The job aids for providers are:

- Counseling flipbook
- Counseling reference sheet handout
- Counseling wall chart
- Medical abortion and MVA comparison cards
- Medical abortion dosage card
- Medical abortion gestational dating wheels

The educational materials for women are:

- Text-based and picture-based medical abortion booklets for women for use in clinic or community settings
  - — Mifepristone and misoprostol regimen: sublingual, buccal and vaginal routes
  - — Misoprostol-only regimen: sublingual and vaginal routes

Blending Learning Pre-test Requirement

To facilitate a blended learning approach in which trainees are given a base of knowledge and classroom and clinical practicum time is focused on interactive discussion for deeper learning, the following steps should be completed:

1. Program organizers or trainers should send to all potential participants the *MA Study Guide* and pre-test at least a month (preferably two) in advance of the workshop and practicum with an explanation that individuals are required to complete the *MA Study Guide* and the pre-test prior to acceptance to the workshop and practicum.
2. Organizers should inform and obtain the support of supervisors of potential participants about the blended learning process, encouraging them to allow time for the learner to complete the Study Guide and pre-test.
3. Participants are to complete and return the pre-test for scoring preferably prior to the workshop. Ipas recommends that learners must score 75 percent on this pre-test to participate in the workshop and practicum *(Note: adjust the percentage required based on local norms)*.
   - — If the pre-test is not given until the first day of the workshop, it can be awkward for participants who score less than 75 percent, and difficult to turn them away from the training. However, if everyone does not have a baseline of the same information, it diminishes the classroom time together because more basic information has to be covered to bring these learners up to the same level as those who did score 75 percent or above. For this reason, the pre-test is designed to be given and scored in advance.

Finally, potential participants may use their *MA Study Guide* to help them answer the pre-test correctly (like an 'open book' test). By using the *Study Guide* to help answer the pre-test questions, participants are presumably gaining basic knowledge needed for the course.

Documentation, Certification and Legal Requirements

Trainers are responsible for ensuring that someone documents relevant information about participants (such as attendance and pre- and post-test results). The CD-ROM that accompanies this Training Guide includes sample certificates of completion and competence (trainers can use the Microsoft Word® versions to personalize the certificates). Trainers should determine whether the process for participant certification meets local regulations and consider legal requirements for conducting the onsite clinical practicum.

Evaluation

The pre and post-tests will serve as knowledge assessments of each individual learner while the MA Clinical Skills Checklist is to be used for skill assessment during simulated practice and the clinical practicum. Knowledge assessment and skill acquisition should be used together to determine competency of each learner.

Ipas recommends that an informal process evaluation be conducted at the end of each workshop day to assess participant satisfaction with the day's topics and activities. Participants should also complete the final evaluation after the practicum to provide feedback for future training events.

Values Clarification and Attitude Transformation (VCAT) for Medical Abortion Training

Health-care providers and trainers may hold beliefs and attitudes about preferred abortion methods and care options for women. Providers may have a preference for one method over another that may not be directly related to women's clinical or life circumstances. They may direct women toward a particular method or regimen that doesn't respect women's needs and informed choice. Many providers are also accustomed to directly performing the abortion procedure. They may feel uncomfortable about women controlling the process themselves. Providers may question women's ability to monitor the medical abortion process and assess whether the medications worked. Beliefs and attitudes such as these can have an impact on whether and how abortion services are provided. These and related issues can be useful to bring out and explore through a values clarification and attitude transformation (VCAT) process. Two VCAT activities focused on MA are included in this Training Guide. Other activities from Ipas's VCAT toolkit can be tailored to specifically address beliefs and attitudes about MA compared with other methods and care options. For more information, training activities and tools on abortion VCAT, please see Ipas' *Abortion attitude transformation: A values clarification toolkit for global audiences* at http://www.ipas.org/Publications/Abortion_attitude_transformation_A_values_clarification_toolkit_for_global_audiences.aspx?ht=

Additional Resources

Medical Abortion Matters: Sharing Global Perspectives is a semiannual e-mail newsletter featuring summary of the latest medical abortion research, stories of innovative and inspiring efforts to improve women's access to medical abortion, interviews, questions and answers, and highlighted resources and organizations. To subscribe to *Medical Abortion Matters* and other newsletters from Ipas, please visit http://www.ipas.org/Sign_Up.aspx.

Ipas's Medical Abortion Initiative website (www.ipas.org/medicalabortion) contains resources about Ipas's work on MA, access to Ipas publications, including training guides and other online resources, links to Ipas University for free online courses on MA, and more.

For more information about woman-centered abortion care training, effective training methods and other topics, see other Ipas training materials and publications:

- *Woman-Centered Abortion Care* and *Woman-Centered Postabortion Care Reference Manual* and *Trainer's Manual*
- *Effective Training in Reproductive Health: Course Design and Delivery, Reference Manual* and *Trainer's Manual*

These and other publications can be downloaded at http://www.ipas.org/Publications/Index.aspx or by contacting training@ipas.org.

Table of Contents

Unit One: Medical Abortion Overview

Time

Two hours

Unit Objectives

By the end of this unit, participants will be able to:

- Discuss key content from the *MA Study Guide*
- Explain the role of MA in comprehensive reproductive health services for women
- Discuss the current context of abortion services in their country, including the legal status of abortion care and barriers to access

Advance Preparations

- ☐ Prepare the Workshop Agenda handout to fit with local customs (see template on CD-ROM)
- ☐ Prepare flipcharts for Expectations, Parking Lot, Ground Rules and Unit One Objectives
- ☐ Practice using the MA Quiz Show (MAQ show) PPT slide show or game board
- ☐ Write the MAQ Show instructions on a flipchart (optional)
- ☐ Ensure pre-tests completed in advance are scored and recorded
- ☐ Photocopy pre-test key (or pre-tests if they were not issued in advance)
- ☐ Learn about the legal indications for abortion in the country and insert the key points into slide #12 of the MA Overview PPT presentation

Instructions and Materials

A. Introduction and Training Overview (25 minutes)

Materials:

- Blank flipchart paper and stand, markers, tape, note cards
- Pre-prepared flipcharts:
  - *Expectations* (blank)
  - *Parking Lot* (blank)
  - *Ground Rules* (blank)
  - *Unit One Objectives* (list)
- Handout: *Workshop Agenda*

1. Welcome participants to the training workshop
   - Introduce the trainers.
   - Facilitate a brief, interactive activity for participants to introduce themselves.

2. Post flipchart: *Expectations*
   - Ask participants what they hope to learn in the workshop and write down their expectations on the flipchart.
   - Review participants' expectations and identify those likely to be met.
   - Point out any expectations that may be beyond the workshop's scope.
   - Keep the list to review with participants at the end of the workshop to ensure that realistic expectations were met.

3. Distribute and review Handout: *Workshop Agenda*

4. Post flipchart: *Parking Lot*
   - Explain that when topics come up during any unit that the group does not have time to address, or which would be better addressed at a later time, trainers will write them down on the "parking lot" flipchart.

5. Post flipchart: *Ground Rules*
   - Explain that ground rules are mutually agreed-upon guidelines to help the group work together, create a safe and respectful learning environment, and accomplish tasks efficiently.
   - Ask participants to suggest ground rules; write their suggestions on the flipchart.
   - Possible ground rules may include participating, listening respectfully, speaking one at a time, turning off cell phones, maintaining confidentiality, etc.

6. Post and review flipchart: *Unit One Objectives*

B. MA Study Guide Review: MA Quiz (MAQ) Show (45 minutes)

Materials:

- Blank flipchart paper and stand, markers, tape
- LCD projector and screen with laptop computer
- MAQ Show materials:
  - ► PPT slides or prepared game board (on CD-ROM)
  - ► Clock or stop-watch
  - ► Bell or chime
  - ► Instructions
  - ► Question-and-Answer Key
  - ► Prizes for winning group (optional)

1. Explain that participants will review key MA content through a "quiz show" activity with the trainers as the game show host and judge.
   - Creatively divide participants into two to three teams.
   - Ask each team to choose a name.
   - Write the team names on flipchart paper, with space underneath for scorekeeping.
   - Use the detailed MAQ Show Instructions to explain how to play the game (or refer to optional instructions written out in advance on flipchart).
   - Refer to the MAQ Question-and-Answer Key as teams respond to the questions on each slide.

2. Announce the winning team after the game is complete. Give prizes to the winning team (optional).

C. MA Study Guide Review: Pre-test (*20 minutes)

**presuming pre-tests were completed in advance as the blending learning approach describes; more time will be needed if pre-tests will be completed now*

Materials:

- Scored pre-tests of each participant
- Copies of pre-test answer key
- Copies of pre-tests if they were not given in advance of the workshop

1. If pre-tests were taken in advance and submitted to training organizers, return scored pre-tests and an answer key to participants. If pre-tests were not completed in advance, issue them at this time (***Note:*** *time will need to be adjusted for learners to take the pre-test, for trainers to score them, and then return them at a later point*).

2. Go over pre-test answers *briefly*, and inform participants that all the topics will be covered more thoroughly over the course of the workshop.

3. Answer any outstanding questions or put them in the parking lot to be covered later.

D. Overview of Medical Abortion (30 minutes)

Materials:

- LCD projector and screen with laptop computer, or overhead projector with pre-printed transparencies
- PPT Presentation: "Medical Abortion Overview" (on CD-ROM)

1. Review the role of MA in comprehensive, woman-centered reproductive health-care services.

2. Facilitate an interactive presentation about the role of MA in increasing access to safe abortion care, and the acceptability of MA to women *(**Note:** show slides #1-11 of the "Medical Abortion Overview" PPT presentation).*

3. Review the legal status of abortion.

   - Ask participants what they know about the legal indications for abortion services in their country.
     - ► *Does the law restrict the provision of abortion care?*
     - ► *Are there any special restrictions on the provision of MA specifically?*

- After hearing from a few participants, show and discuss the last slide *(**Note:** slide #12 of the "Medical Abortion Overview" PPT presentation)*.

4. Inform participants that the workshop focuses on building the skills and knowledge they need to provide high-quality MA services.

5. Answer any outstanding questions.

Unit One: Materials

1. MA Quiz Show Instructions *(for trainers)*

2. MA Quiz Show Question-and-Answer Key *(for trainers)*

3. MA Pre/Post-test *(for participants)*

4. MA Pre/Post-test Answer Key *(for trainers and participants)*

For Trainers

MA Quiz Show (MAQ Show) Instructions

Instructions for PowerPoint® Version of MAQ Show

*(**Note:** these instructions are also demonstrated through a video clip that can be found on the CD-ROM)*

1. Open the PowerPoint presentation and start the slide show. The first slide (#1) is "Medical Abortion Quiz Show." Advance to the next slide (#2), which shows different numbers *(**Note:** You can refer to the numbers as local currency, or use them as points).*

2. After the second slide has finished loading, advance through the next slides, reading aloud the following **response categories** teams can choose from:
   - MA Issues & Information
   - Regimens
   - Eligibility
   - Side Effects & Complications
   - MA or MVA
   - Potpourri (surprise!)

3. Tell the teams that they will take turns answering the questions. Decide which team will go first (toss a coin if available).

4. The next slide is the main screen/category play board (slide #9). Ask the first team to choose a **category and numerical amount**, then click on the corresponding square and read the question. The team must answer the question within 15 seconds *(**Note:** Use a clock or stopwatch for timekeeping and a bell or chime for when time is up).*

5. Use the Question-and-Answer Key to determine whether the team's answer is correct. (**Note:** *Some questions have several possible correct answers. The answers on pages 9-15 follow the MA Study Guide and provide suggestions but this is not an exhaustive answer key. Use your judgment to decide whether a team's answer is correct or not.)*

6. If the answer is correct, click on the **green** button at the bottom of the screen (there will be a sound effect and you will be taken back to the main screen/category board). Record team points or money amount on flipchart paper.

7. If the answer is incorrect, click on the **red** button (there will be a sound effect and the question screen will remain).

8. If the team answers incorrectly or cannot answer the question, allow another team to answer if they can *(**Note:** If the next team answered the question that the previous team couldn't answer, then that team still gets to take their normal turn – in other words, they get to go again).*

9. If no team can answer, click the **blue** button (no sound effect) to be taken back to the main screen/ category play board.

10. Allow the next team to choose a **category and numerical amount** from the remaining squares on the board.

11. For each answer, continue to click on the **green**, **red**, or **blue** buttons, and return to the main game board when the question is answered correctly. Be sure to record scores on the flipchart.

12. Play until all squares on the board have been answered or as long as time allows.

13. Add up scores. The team with the highest amount wins.

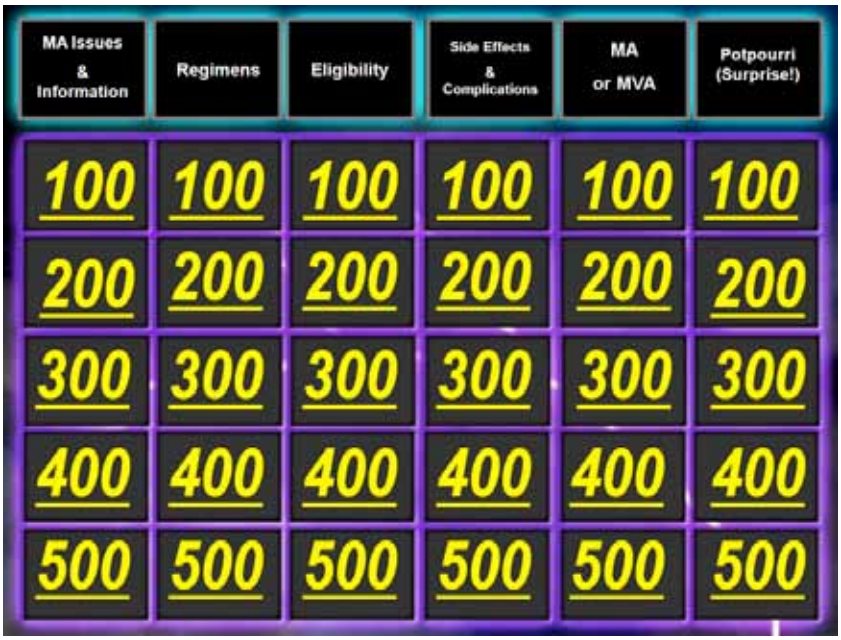
14. Give prize to the highest scoring team (optional).

Instructions for Paper Version of MAQ Show

If PowerPoint presentation equipment is not available, the MAQ Show game can be played using a paper version. Print out the PowerPoint slides and use them to assemble the game board.

1. Prepare the game board:

- Using the MAQ Show Question-and-Answer Key and illustration below as a guide, create a game board on paper, poster board, or a white board. Create a grid with six columns and six rows. Post the categories across the top row and the questions onto the remaining rows, following the order of their monetary or point value (lowest to highest). Be sure to put the questions on the correct category (column) and number amount (row). Use the Question-and-Answer Key as a guide.
- Then take the print-outs of the numbers and cover each question, but leave the categories in the top row visible. It should then look like this:



2. Conduct the game as instructed above. Manually reveal the numbered questions as teams choose categories and numerical amounts.

For Trainers MAQ Show Question-and-Answer Key

MA Issues & Information		
100	**Q:** What is one reason MA is important to offer to women seeking abortion services?	**Possible Answers:** • It's beneficial in low-resource settings and where access to other safe methods is limited • MA has the potential to reduce maternal morbidity and mortality • MA is simple and easy to use • The necessary medications do not require refrigeration • The method can be safely given by mid-level providers, potentially reaching women closer to their communities
200	**Q:** Why is it important for health-care providers to show empathy to women undergoing MA?	**Possible Answer:** Empathetic counseling contributes to a positive experience from the woman's perspective, which increases her adherence to medical care instructions and makes her more inclined to trust health-care workers and seek appropriate medical care in the future. Empathetic counseling should be provided to all women undergoing MA, regardless of age, marital status or HIV/AIDS status.
300	**Q:** What are two potential barriers to women seeking MA services?	**Possible Answers:** • Narrow interpretations of legal indications for abortion • Clinic restrictions that affect access, such as physician approval and attitudes about MA as an acceptable abortion method • Provider shortages (not enough trained providers) • High charges for the medications • Provider personal objections or refusal to give care
400	**Q:** What are three myths or misconceptions about MA?	**Possible Answers:** • Only doctors can provide MA • Ultrasound exams are necessary for MA services • MA is not appropriate for women without immediate back-up services at the facility at which they received the MA • MA is not safe or effective for adolescents • MA is less effective for women who have never had children • Obese women need an increased dose of misoprostol • Women with multiple pregnancies need an increased dose of the MA drugs • Women who have had prior C-sections should not use MA • Women must have access to a telephone to use MA
500	**Q:** What are three things a provider should inform a woman about MA before she begins the regimen?	**Possible Answers:** • What she will experience—vaginal bleeding and cramping • How long the MA might take • What kind of pain management she can use • What side effects, risks and complications are associated with the method • What kind of follow-up care is needed • The counselor should be certain that the woman understands the information and has provided informed consent

For Trainers MAQ Show Question-and-Answer Key

Regimens		
100	**Q:** What are the current abortion methods/regimens available in your country?	**(answers will vary)**
200	**Q:** True or False? The combination of mifepristone + misoprostol is more effective in achieving complete abortion than either drug used alone.	**Answer:** True When used together, mifepristone and misoprostol are up to 98 percent effective up to nine weeks LMP and up to 97 percent effective from nine-13 weeks LMP. Misoprostol used alone is effective up to 90 percent for pregnancies up to nine weeks LMP and up to 87percent effective from nine-13 weeks LMP.
300	**Q:** How does misoprostol work in MA?	**Answer:** It softens the cervix and causes strong uterine contractions which lead to expulsion of the pregnancy.
400	**Q:** Which misoprostol route does Ipas recommend for up to nine weeks LMP regardless of whether using misoprostol with mifepristone or by itself?	**Answer:** Sublingual When using mifepristone with misoprostol, buccal is also a recommended route and when using misoprostol only, vaginal is also an option; but sublingual is an option with either regimen. Ipas does not express a preference for one route over the other.
500	**Q:** What if the woman inserts the misoprostol vaginally, bucally or sublingually and the pills don't dissolve – what should she do?	**Answer:** Women need to be reassured that the active medicine within misoprostol will absorb within 30 minutes through the mucus membranes into the blood stream; the outer pill casing may not dissolve but the medicine is absorbed

For Trainers MAQ Show Question-and-Answer Key

Eligibility		
100	**Q:** True or False? MA can be given to women in the following categories: HIV/AIDS, STIs, breastfeeding, asthma, obesity, multiple gestation	**Answer:** True Women using asthma inhalers alone may have MA since the medications in inhalers are not systemically absorbed. Although some prostaglandins are vasoconstrictors, misoprostol is a type of prostaglandin that promotes bronchodilation. Women with HIV/AIDS may be at risk for anemia but as with any woman, if severe bleeding occurs, provide prompt treatment with MVA. There is no evidence to suggest that MA drugs are harmful to infants (in a six hour period, no drug is detectable in the breast milk). STI treatment can be started on the same day as MA drugs, although if the woman has an upper reproductive tract infection, it should be treated first and she should be asymptomatic before taking the MA drugs. There is no dose adjustment needed for obese women or women with multiple pregnancies.
200	**Q:** What are three questions you could ask a woman to help her remember the date of her last menstrual cycle?	**Possible Answers:** • What were you doing the day you started your period or one of the days that you remember having your period? • Where were you when your period started? • Who were you with when your period started? • What day of the week was it when your period began? • Was the first day of your period close to a holiday, special event, market day or weekend day? • What was the weather like when your period started? • What were you wearing on the day your period began?
300	**Q:** What are three commonly used approaches for pregnancy dating?	**Answers:** • Determining the date of the last menstrual period (LMP) • Performing a pelvic exam to assess uterine size • Using ultrasound
400	**Q:** If a bimanual exam indicates the uterus is larger than expected, what are three possible causes?	**Possible Answers:** • Inaccurate menstrual dating (pregnancy more advanced than expected) • Multiple pregnancies • Uterine anomalies such as fibroids or bicornuate uterus • Gestational trophoblastic neoplasm (molar pregnancy) • Normal variation between women at a given length of pregnancy

(continued on page 12)

For Trainers MAQ Show Question-and-Answer Key

(continued from page 11)

Eligibility

500	**Q:** What are two precautions and two contraindications to MA?	**Possible Answers:** ***Precautions*** • IUD in place (must be removed before beginning regimen) • Severe anemia, unstable health problems – no evidence exists on the use of MA in women with these conditions, thus providing MA to these women will depend on available options for safe abortion care, referrals, and clinical judgment • Steroid-dependent women when using the mifepristone + misoprostol regimen – no evidence exists on MA use in these women; providers must use clinical judgment; increase steroid dose for three to four days and monitor the woman very closely; conditions such as chronic adrenal failure and poorly controlled asthma may still worsen ***Contraindications:*** • Allergy to mifepristone (with mifepristone + misoprostol regimen), misoprostol or other prostaglandins • Confirmed or suspected ectopic pregnancy • Hemorrhagic disorder or concurrent anticoagulant therapy • Inherited porphyria (with mifepristone + misoprostol regimen)

For Trainers MAQ Show Question-and-Answer Key

Side Effects & Complications		
100	**Q:** What pain medications can be taken to relieve MA cramping?	**Possible Answers:** Ibuprofen or paracetamol (acetaminophen.) Ibuprofen was found to be significantly more effective for pain relief after medical abortion compared with paracetamol.
200	**Q:** What are two rare, but possible, complications that could occur during or after MA?	**Possible Answers:** • hemorrhage • infection • allergic reactions
300	**Q:** What are four potential side effects associated with misoprostol?	**Possible Answers:** • Nausea • Diarrhea • Vomiting • Fever, warmth or chills • Headache • Dizziness
400	**Q:** What is one possible diagnosis of intense, persistent pain (longer than four-six hours that is unrelieved by pain medication) with no bleeding after misoprostol?	**Possible Answers:** • Pregnancy tissue trapped in the os • Ectopic pregnancy • Upper reproductive tract infection • Poor pain tolerance
500	**Q:** What are three indications that bleeding requires immediate medical attention?	**Possible Answers:** • Excessive bleeding: soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, lightheadedness, and increasing fatigue • Abundant gushing bleeding • Bleeding like a heavy period that persists for weeks leading to significant anemia and hypovolemia • Pale appearance accompanied by weakness, agitation or disorientation • Blood pressure drop or woman feels faint when she stands up • Rapid pulse especially when associated with low blood pressure

For Trainers MAQ Show Question-and-Answer Key

MA or MVA		
100	**Q:** True or False? Both MVA and MA less than nine weeks should be done onsite for safety reasons.	**Answer:** False MA of pregnancies less than nine weeks can be safely and effectively done outside the clinic, by the woman taking the pills and aborting at home or in a safe space once she has received screening, counseling and instruction from trained providers.
200	**Q:** What is a benefit that MA offers women that MVA does not?	**Possible Answers:** • MA is simple and easy to use by women themselves • Surgical skills are not needed • MA can be done at home or in a safe space rather than the clinic • MA is managed more by the woman herself rather than a clinician, allowing some women a better sense of control and confidence • MA is often seen as a more natural and non-invasive process by women, including adolescents and young women
300	**Q:** What is a benefit that MVA offers women that MA does not	**Possible Answers:** • Procedure is done in a clinic by a health care provider which can leave some women feeling more satisfied and confident • Procedure is completed usually in less than 10 minutes • Abortion is confirmed as complete by the provider the day of the procedure • Women perceive less bleeding with MVA because much of the blood is taken in through the aspiration so the woman doesn't see it
400	**Q:** What are two benefits of offering both MA and MVA at service-delivery sites?	**Possible Answers:** • Services are strengthened when these complementary technologies are offered together because women can choose the method that best meets their needs and have an enhanced degree of control over the timing and setting of its use • Training for these two technologies can be combined, maximizing efficiency and use of personnel • MVA can be used to complete a failed medical abortion
500	**Q:** What is the follow-up procedure in the case of ongoing pregnancy for MA and incomplete abortion for MVA?	**Answer**: Vacuum aspiration (or sharp curettage when vacuum aspiration is not available)

For Trainers MAQ Show Question-and-Answer Key

Potpourri (surprise!)		
100	**Q:** What does this image depict? [pills in the cheek of the mouth]	**Answer: Buccal route of taking misoprostol**
200	**Q:** How does MA differ from emergency contraception (EC)?	**Answer:** MA stops an implanted pregnancy from growing and causes expulsion of the pregnancy (abortion) but EC prevents a pregnancy from occurring in the first place (it cannot abort an already established pregnancy.)
300	**Q:** What are three important things to tell a woman before she leaves the clinic after choosing MA?	**Possible Answers:** • When to return for a routine but important follow-up visit • Warning signs about possible complications • Instructions about when and where to seek medical help in case of an emergency (plan for emergencies) • Pain medication available • To plan for personal support during the process
400	**Q:** What are two options that can be offered if a woman has not aborted by her follow-up visit	**Answers:** • *A repeat dose of vaginal misoprostol.* An additional dose of misoprostol can be given to women who have persistent gestational sacs. If a pregnancy is ongoing at the follow-up visit after taking mifepristone with misoprostol, about one-third of women will have a successful abortion by taking a repeat dose of misoprostol. (Giving a repeat dose of misoprostol has been studied following MA with mifepristone and misoprostol if there's an ongoing pregnancy at the follow-up visit. Giving a repeat dose of misoprostol following misoprostol-only abortion has not been studied). • Vacuum aspiration. If the woman prefers not to make return visits or if she will be beyond the limit for legal abortion if she takes a repeat dose of misoprostol and returns in one week, vacuum aspiration is recommended to end the pregnancy.
500	**Q:** What are four different warning signs indicating that a woman should contact her health-care provider immediately?	**Possible Answers:** • Excessive bleeding: soaking more than two sanitary pads per hour for two consecutive hours, especially if accompanied by prolonged dizziness, lightheadedness, and increasing fatigue • Fever that occurs any day after the day misoprostol is taken • Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain • Severe abdominal pain that occurs any day after the day misoprostol is taken • Feeling very sick with or without fever, and persistent severe nausea or vomiting after the day misoprostol is used

For Participants
Medical Abortion Pre/Post-Test

Circle **all** correct answers (*there may be more than one correct answer*).

1. What are the preferred methods for uterine evacuation in the first trimester according to the World Health Organization (WHO)?
   a) Medical abortion
   b) Sharp curettage
   c) Vacuum aspiration
   d) Uterotonic instillation

2. Why does MA have the potential to improve access to safe abortion, particularly in settings where only limited or no uterine evacuation services are currently available?
   a) It is simple and easy to use
   b) Mid-level providers can be trained to give information and the medicines
   c) The drugs do not need refrigeration
   d) MA can only be provided in the clinic

3. Why do many women feel that medical abortion is highly acceptable?
   a) The medicines can be taken at home or in a safe place outside the clinic
   b) It is over in less than an hour
   c) It can feel private and natural
   d) The bleeding duration is very short

4. Excluding medical conditions, what criteria below would make a woman a potential candidate for medical abortion?
   a) She comprehends the process and can follow the steps
   b) She has received information on all methods and opts for medical abortion
   c) She is unwilling to sign the legally required consent form
   d) She agrees to undergo vacuum aspiration if medical abortion fails

5. Which of the following are contraindications to MA?
   a) Hemorrhagic disorder or concurrent anticoagulant therapy
   b) HIV/AIDS
   c) Allergy to the medicines
   d) Breastfeeding

For Participants
Medical Abortion Pre/Post-Test

6. What is the sublingual route of taking misoprostol?
   a) Swallowing the pills
   b) Putting the pills inside the uterus
   c) Putting the pills under the tongue
   d) Putting the pills between the cheek and gum

7. How does misoprostol work to cause abortion?
   a) Prevents sperm from fertilizing the egg
   b) Prevents ovulation
   c) Causes cervical softening and uterine contractions
   d) Causes an increase in pregnancy hormones

8. During a bimanual exam, if the uterus is smaller than expected, what might this indicate?
   a) Ectopic pregnancy
   b) Multiple pregnancies
   c) Inaccurate menstrual dating
   d) The woman is not pregnant

9. Which is the most effective regimen for MA?
   a) Misoprostol
   b) Methotrexate and misoprostol
   c) Mifepristone and misoprostol
   d) Mifepristone only

10. Which statement below is true?
   a) Nausea and vomiting are very rare after using misoprostol
   b) All women experience gastrointestinal side effects after using misoprostol
   c) Bleeding is not a side effect, it is an expected effect after using misoprostol
   d) Experience of cramping or pain after using misoprostol is quite similar for all women

11. What are the warning signs of complications?
   a) Excessive bleeding, soaking more than two sanitary pads per hour for two consecutive hours
   b) Fever any day after the day misoprostol is used
   c) Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain
   d) Mild nausea and vomiting

For Participants
Medical Abortion Pre/Post-Test

12. Which contraceptive methods can be started on the day of taking misoprostol?
    a) Oral pills
    b) Injectables
    c) IUDs
    d) Implants

13. What are side effects that women may experience after taking misoprostol?
    a) Nausea, diarrhea, fever, chills
    b) Nausea, diarrhea, itching
    c) Nausea, fever, chills, nose bleeds
    d) Fever, chills, blurred vision, diarrhea

14. Rare risks of MA include:
    a) Allergic reactions
    b) Excessive bleeding requiring emergency treatment
    c) Uterine perforation
    d) Pelvic infection

15. MA information for women should include:
    a) The range of normal bleeding expected
    b) Possible side effects after taking misoprostol
    c) Warning signs for which the woman should contact her provider
    d) To take a pregnancy test before her follow-up visit

16. Which of the following are useful approaches to pain management for MA?
    a) Non-narcotic and narcotic analgesics
    b) Ibuprofen with or without codeine
    c) General anesthesia
    d) Hot water bottle or cloths on the lower abdomen or lower back

17. What is the routine time for a woman to return for the recommended follow-up visit after taking misoprostol?
    a) About two weeks
    b) Three weeks
    c) One month
    d) Follow-up visit is not necessary

For Participants
Medical Abortion Pre/Post-Test

18. What types of problematic bleeding might be seen at the follow-up visit?
    a) Erratic bleeding
    b) Delayed heavy bleeding
    c) History of no bleeding
    d) Hemorrhage

19. What guidance at a two-week follow-up visit can help confirm there is not an ongoing pregnancy?
    a) Evaluation whether pregnancy symptoms are gone
    b) Pregnancy test
    c) Pelvic examination
    d) Clinical history

20. What are potential complications of MA?
    a) Infection
    b) Uterine perforation
    c) Hemorrhage
    d) Spotting or light bleeding lasting for three weeks

21. What is a symptom of ectopic pregnancy?
    a) Feeling cold all over
    b) Persistent fever
    c) Lower abdominal pain (usually one-sided)
    d) Bad-smelling discharge

22. What should be done if pelvic infection is suspected after MA?
    a) Give reassurance
    b) Treat according to the severity of the infection
    c) Provide a vaginal anti-fungal
    d) Only treat if she has a fever too

23. What factors should be in place to promote woman-centered MA?
    a) Client information that is simple and clear
    b) Medications and supplies for MA provision
    c) Monitoring and evaluation system
    d) Allowing women a choice between MA and MVA where available

For Participants
Medical Abortion Pre/Post-Test

24. What does allowing women to take misoprostol at home or in a safe place mean?
   a) The MA will not be as safe
   b) They can have family or friends present for support if they wish
   c) They can have their own personal belongings with them
   d) The MA may not be as effective as in the clinic

25. What should be provided for all women undergoing MA?
   a) Contact information in case of questions or emergencies
   b) Information on warning signs
   c) Sterilization procedure
   d) Follow-up visit appointment

For Trainers

Medical Abortion Pre/Post-Test Answer Key

(Answers are in bold)

*Circle **all** correct answers (there may be more than one correct answer).*

1. What are the preferred methods for uterine evacuation in the first trimester according to the World Health Organization (WHO)?

   a) Medical abortion

   b) Sharp curettage

   c) Vacuum aspiration

   d) Uterotonic instillation

2. Why does MA have the potential to improve access to safe abortion, particularly in settings where only limited or no uterine evacuation services are currently available?

   a) It is simple and easy to use

   b) Mid-level providers can be trained to give information and the medicines

   c) The drugs do not need refrigeration

   d) MA can only be provided in the clinic

3. Why do many women feel that medical abortion is highly acceptable?

   a) The medicines can be taken at home or in a safe place outside the clinic

   b) It is over in less than an hour

   c) It can feel private and natural

   d) The bleeding duration is very short

4. Excluding medical conditions, what criteria below would make a woman a potential candidate for medical abortion?

   a) She comprehends the process and can follow the steps

   b) She has received information on all methods and opts for medical abortion

   c) She is unwilling to sign the legally required consent form

   d) She agrees to undergo vacuum aspiration if medical abortion fails

5. Which of the following are contraindications to MA?

   a) Hemorrhagic disorder or concurrent anticoagulant therapy

   b) HIV/AIDS

   c) Allergy to the medicines

   d) Breastfeeding

For Trainers

Medical Abortion Pre/Post-Test Answer Key

6. What is the sublingual route of taking misoprostol?
   a) Swallowing the pills
   b) Putting the pills inside the uterus
   c) Putting the pills under the tongue
   d) Putting the pills between the cheek and gum

7. How does misoprostol work to cause abortion?
   a) Prevents sperm from fertilizing the egg
   b) Prevents ovulation
   c) Causes cervical softening and uterine contractions
   d) Causes an increase in pregnancy hormones

8. During a bimanual exam, if the uterus is smaller than expected, what might this indicate?
   a) Ectopic pregnancy
   b) Multiple pregnancies
   c) Inaccurate menstrual dating
   d) The woman is not pregnant

9. Which is the most effective regimen for MA?
   a) Misoprostol
   b) Methotrexate and misoprostol
   c) Mifepristone and misoprostol
   d) Mifepristone only

10. Which statement below is true?
   a) Nausea and vomiting are very rare after using misoprostol
   b) All women experience gastrointestinal side effects after using misoprostol
   c) Bleeding is not a side effect, it is an expected effect after using misoprostol
   d) Experience of cramping or pain after using misoprostol is quite similar for all women

For Trainers

Medical Abortion Pre/Post-Test Answer Key

11. What are the warning signs of complications?

a) Excessive bleeding, soaking more than two sanitary pads per hour for two consecutive hours

b) Fever any day after the day misoprostol is used

c) Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain

d) Mild nausea and vomiting

12. Which contraceptive methods can be started on the day of taking misoprostol?

a) Oral pills

b) Injectables

c) IUDs

d) Implants

13. What are side effects that women may experience after taking misoprostol?

a) Nausea, diarrhea, fever, chills

b) Nausea, diarrhea, itching

c) Nausea, fever, chills, nose bleeds

d) Fever, chills, blurred vision, diarrhea

14. Rare risks of MA include:

a) Allergic reactions

b) Excessive bleeding requiring emergency treatment

c) Uterine perforation

d) Pelvic infection

15. MA information for women should include:

a) The range of normal bleeding expected

b) Possible side effects after taking misoprostol

c) Warning signs for which the woman should contact her provider

d) To take a pregnancy test before her follow-up visit

For Trainers

Medical Abortion Pre/Post-Test Answer Key

16. Which of the following are useful approaches to pain management for MA?

a) Non-narcotic and narcotic analgesics

b) Ibuprofen with or without codeine

c) General anesthesia

d) Hot water bottle or cloths on the lower abdomen or lower back

17. What is the routine time for a woman to return for the recommended follow-up visit after taking misoprostol?

a) About two weeks

b) Three weeks

c) One month

d) Follow-up visit is not necessary

18. What types of problematic bleeding might be seen at the follow-up visit?

a) Erratic bleeding

b) Delayed heavy bleeding

c) History of no bleeding

d) Hemorrhage

19. What guidance at a two-week follow-up visit can help confirm there is not an ongoing pregnancy?

a) Evaluation whether pregnancy symptoms are gone

b) Pregnancy test

c) Pelvic examination

d) Clinical history

20. What are potential complications of MA?

a) Infection

b) Uterine perforation

c) Hemorrhage

d) Spotting or light bleeding lasting for three weeks

For Trainers

Medical Abortion Pre/Post-Test Answer Key

21. What is a symptom of ectopic pregnancy?

a) Feeling cold all over

b) Persistent fever

c) Lower abdominal pain (usually one-sided)

d) Bad-smelling discharge

22. What should be done if pelvic infection is suspected after MA?

a) Give reassurance

b) Treat according to the severity of the infection

c) Provide a vaginal anti-fungal

d) Only treat if she has a fever too

23. What factors should be in place to promote woman-centered MA?

a) Client information that is simple and clear

b) Medications and supplies for MA provision

c) Monitoring and evaluation system

d) Allowing women a choice between MA and MVA where available

24. What does allowing women to take misoprostol at home or in a safe place mean?

a) The MA will not be as safe

b) They can have family or friends present for support if they wish

c) They can have their own personal belongings with them

d) The MA may not be as effective as in the clinic

25. What should be provided for all women undergoing MA?

a) Contact information in case of questions or emergencies

b) Information on warning signs

c) Sterilization procedure

d) Follow-up visit appointment

Unit Two: Medical Abortion Regimens

Time

One hour, 15 minutes

Unit Objectives

By the end of this unit, participants will be able to:

- Discuss eligibility, contraindications, precautions for use and special considerations for MA
- Describe the efficacy, mechanisms of action, regimens, routes and timing of the medications used for MA

Advance Preparations

- ☐ Prepare flipchart with Unit Two Objectives.
- ☐ Tailor the PPT slides to the MA regimen(s) you will be focusing on:
  - — mifepristone and misoprostol
  - — misoprostol only
  - — both regimens (mifepristone/misoprostol and misoprostol only)
- ☐ ***Optional:*** If discussing both MA regimens, it may be helpful to make copies of the Contraindications and Precautions handout to clarify some small differences between the two regimens.

Instructions and Materials

A. MA Eligibility: Contraindications, Precautions and Special Considerations (30 minutes)

Materials:

- Blank flipchart paper and stand, markers
- Pre-prepared flipchart: *Unit Two Objectives* (list)
- Handout: *Contraindications and Precautions Chart* (optional)

1. Post and review flipchart: *Unit Two Objectives*.
2. Discuss MA eligibility.
   - Make it clear that MA is a medical procedure with clinical considerations.
   - Explain that although most women are probably eligible for MA, it is essential to confirm that a woman has no medical contraindications before undergoing MA (as with any medical procedure).

- Define the terms "contraindications" and "precautions" if participants are confused about the distinction.

3. Post a piece of blank flipchart paper.
   - Draw a straight line down the page to divide it into two halves.
   - Write "contraindications" at the top of one column, and "precautions" at the top of the other column.
   - Ask participants to state the precautions and contraindications for MA, focusing on the course regimens (mifepristone with misoprostol, misoprostol only or both); write them on the flipchart.
   - Add any missing information until the flipchart includes all the correct information.
   - If needed, explain the rationale for the contraindications:
     - *Porphyria:* An extremely rare metabolic blood disorder which causes problems in the production of heme (a protein in hemoglobin). This is a very rare disorder. No studies of humans with porphyria using mifepristone have been performed. Studies of animals with porphyria show that mifepristone may cause a worsening of the disorder (Cable 1994).
     - *Allergy to one of the medicines:* Could lead to mild or severe allergic (anaphylaxis) reactions (Kobrynski 2007). Allergies to either of the MA medications are extremely rare and would only be known if a woman had received them before.
     - *Confirmed or suspected ectopic pregnancy:* MA does not treat ectopic pregnancy. Mifepristone works by blocking progesterone receptors and there are no progesterone receptors in the fallopian tubes where 95-97 percent of ectopic pregnancies are located (Land 1992). Mifepristone and misoprostol do not make an ectopic pregnancy worse (i.e. cause tubal rupture) but using MA when there is concern of an ectopic pregnancy could delay or disguise the diagnosis.
     - *Bleeding disorder:* MA studies have not been conducted on women taking anti-coagulants but the risk of excessive bleeding is likely higher in this group of women. Because blood loss is less monitored with MA, vacuum aspiration is preferred for these women.
   - Point out that generally it is quite uncommon to identify a true contraindication to MA (for example, most clinicians have never seen porphyria and many do not even know what it is).
   - Discuss precautions, clarifying that women can still receive MA in these circumstances but sometimes special care needs to be given.
     - If a woman has controlled asthma with or without the use of asthma inhalers and does not use systemic steroids, there are no contraindications or precautions for her. The steroids in asthma inhalers are not systemically absorbed so it is alright to use this type of inhaled steroids and receive an MA. Mifepristone does not affect the respiratory system and misoprostol has some bronchodilation effects (Creinin 2009).
     - If a woman has poorly controlled/severe asthma and is on systemic steroids, the provider should be aware of the risks of giving mifepristone to her. Mifepristone can block the activity of steroids and thus may make the underlying condition worse (Sitruk-Ware 2003). Temporarily increasing the dose of steroids may overcome the effects of mifepristone, however, there is no guarantee that this will work. In the case of severe or poorly controlled asthma ***for the woman on systemic steroids***, the risk may be greater than the benefits of mifepristone abortion (for example, a severe asthma attack can lead to death). The clinician should carefully weigh the woman's clinical condition, current and recent history of asthma severity, and available options for abortion.

- ▸ If an IUD is in place, it should be removed before MA is begun. There are no studies of MA with IUDs in place, but there is a theoretical risk that the contractions of MA could cause the IUD to perforate the uterus.
- ▸ No evidence exists on the use of MA in women with severe anemia or severe/unstable health problems. Whether to provide MA to women with these conditions will depend on the condition itself, its severity, the available options for safe abortion care, referrals and clinical judgment.

- ***Optional:*** If training on both regimens of mifepristone with misoprostol and misoprostol only, it may be helpful to distribute and have participants complete the *Contraindications and Precautions* handout instead of doing the exercise above. Then discuss and correct the answers using the answer key.

4. Discuss "special considerations" for MA

- Explain that women with asthma, HIV/AIDS, STIs, those who are breastfeeding, have multiple gestations, or are obese can all undergo MA.
- Ask participants how common it is for them to care for women in those categories.
- Ask learners whether they think that adolescents and young women can undergo MA; explain that:
  - ▸ MA is safe and effective for adolescents and has been found to be even more effective in women who have never given birth (which is common for many adolescents and young women).
  - ▸ There is no need to change the regimen for adolescents or young women.
  - ▸ Age is not a contraindication or a precaution for MA.
  - ▸ Young women have the same right to information and care as adult women do, and it should be provided respectfully in a way that meets their needs.

- Optional: Break up into six groups and assign each group a "special consideration" to discuss for five minutes, using the *MA Study Guide* for reference. Have each group briefly report back to the larger group.

5. Summarize MA contraindications, precautions, and special considerations

- Women who have **contraindications** should not be given MA and should explore other options with their clinicians.
- Women who have **precautions** may be candidates for MA after consideration and counseling, and with close monitoring.
- Women with conditions known as **"special considerations"** can still undergo MA as described in the *MA Study Guide*.

B. Antibiotics (5 minutes)

1. Discuss the safety of providing MA in the absence of antibiotics.

- Medical abortion is safe, and infection is rare.
- The lack of antibiotics should not be a barrier to the provision of MA.

2. Describe experience in other countries.

- In some countries, such as Sweden and China, women are screened for STIs on a case-by-case basis prior to MA (Fiala 2006). In other countries, there are no routine infection-prevention measures.
- A commonly used MA regimen in the UK is mifepristone followed by vaginal misoprostol; antibiotics are then given routinely as recommended by the Royal College of Obstetricians and Gynaecologists Guidelines (personal communication P. Lohr, bpas, December 2009).
- In the United States, the largest system of clinics providing MA found a 93 percent drop in the rate of serious infection using mifepristone 200mg and misoprostol 800mcg when they switched from vaginal to buccal misoprostol and added routine antibiotics, doxycycline 100mg orally twice a day for seven days, beginning on the day of mifepristone. Because two changes were introduced at once (switch from vaginal to buccal misoprostol and provision of routine antibiotics), it is impossible to know precisely to what extent either intervention alone contributed to the drop in the rate of serious infections. The maximum contribution of the change to the buccal route of misoprostol could be as high as 67 percent, and as low as 0 percent. The maximum contribution of routine use of antibiotics could be as high as 100 percent and no lower than 33 percent (Fjerstad 2009). These are the only data to date about the effect of antibiotics on the rate of serious infection following medical abortion. It should be noted that there have been deaths from Clostridium sepsis in the United States, which do not seem to have occurred elsewhere in the world.

C. MA Regimens (40 minutes)

Materials:

- LCD projector and screen with laptop computer, or overhead projector with pre-printed transparencies
- PPT Presentation: "Medical Abortion Eligibility and Regimens" (on CD-ROM)

1. Give an interactive PPT presentation, focusing on the regimen(s) that will be used in the participants' setting. (Show "Medical Abortion Eligibility and Regimens" PPT slides)

2. Review the following:
   - Eligibility
   - Drug mechanism of action
   - Regimens
   - Efficacy
   - Routes and timing of the medications

3. Answer any outstanding questions.

Unit Two: Materials

For optional activity:

1. Contraindications and Precautions for MA *(for participants)*

2. Contraindications and Precautions for MA Answer Key *(for trainers)*

For Participants
Contraindications and Precautions for MA

Instructions: Put a ✓ mark in the box that applies to the statement and a ✗ mark in the box that does not apply to the statement.

Contraindications	Regimens	
	Mifepristone and Misoprostol	Misoprostol only
Known allergy to mifepristone (if using a combined regimen with mifepristone), misoprostol or to other prostaglandins		
Confirmed or suspected ectopic pregnancy		
Hemorrhagic disorder or concurrent anticoagulant therapy		
Inherited porphyria		
Precautions	**Mifepristone and Misoprostol**	**Misoprostol only**
IUD in place (remove before beginning regimen)		
Steroid-dependent women		
Severe anemia		
Severe/unstable health problems		

For Trainers

Contraindications and Precautions for MA Answer Key

Contraindications	Regimens	
	Mifepristone and Misoprostol	Misoprostol only
Known allergy to mifepristone (if using a combined regimen with mifepristone), misoprostol or to other prostaglandins	✓	✓
Confirmed or suspected ectopic pregnancy	✓	✓
Hemorrhagic disorder or concurrent anticoagulant therapy	✓	✓
Inherited porphyria	✓	✗
Precautions	**Mifepristone and Misoprostol**	**Misoprostol only**
IUD in place (remove before beginning regimen)	✓	✓
Steroid-dependent women	✓	✗
Severe anemia	✓	✓
Severe/unstable health problems	✓	✓

Unit Three: Clinical Care

Time

Three hours

Unit Objectives

By the end of this unit, participants will be able to:

- List the care that should be provided to a woman prior to the MA procedure
- Describe strategies for dating pregnancy using last menstrual period (LMP) and bimanual exam
- List the signs and symptoms of ectopic pregnancy
- Demonstrate the ability to assess clinical eligibility for MA
- Describe the MA process, including expected effects, possible side effects and strategies for managing them
- Describe strategies for prevention and management of pain associated with MA
- Recognize warning signs for seeking care

Advance Preparations

- ☐ Prepare flipchart with Unit Three Objectives.
- ☐ Cut up three sets of pre-procedure care steps strips; distribute a set (mix up the strips) into each of three envelopes and seal them.
- ☐ Prepare flipchart with Scenarios for Gestational Dating Wheel Practice.
- ☐ Prepare three flipcharts with questions about gestational dating by bimanual exam.
- ☐ Review case studies and ensure that they are appropriate for your setting. Modify if necessary.
- ☐ Cut up the six case studies to use for group work.
- ☐ Cut up side effect strips and place in basket or bowl.
- ☐ Prepare three flipcharts with the headings: 1) Expected Effects, 2) Possible Side Effects, and 3) Warning Signs

Instructions and Materials

A. Pre-procedure Care (15 minutes)

Materials:

- Blank flipchart paper and stand, markers, envelopes, tape, bowl or basket
- Pre-prepared flipchart: *Unit Three Objectives* (list)
- Envelopes: *Pre-procedure care steps* (a set of strips in each of three envelopes)
- Prize for winning team (optional)

1. Post and review flipchart: Unit Three Objectives.

2. Tell participants this activity will help to quickly review the care provided to women prior to beginning the MA regimens. This review will be done as a race among teams.

3. Break participants into three teams and give each team a sealed envelope with the pre-procedure care strips set.

4. Explain that in the envelope are strips of paper with the steps a provider should take before giving a woman the MA drugs.
   - Each team should order the steps correctly and tape them on a whiteboard, flipchart or regular paper. Note which team finishes first, second and third in posting their steps.
   - The first group to finish presents the order of their steps. If correct, they win the race. If incorrect, the second team to finish ordering gets to present their steps, and so on.
   - Give a small prize to the winning team (optional).

5. Reiterate the key steps in the correct order:
   - Conduct pregnancy options counseling.
   - Conduct clinical assessment (exam, dating, eligibility).
   - Conduct pre-procedure counseling (including contraceptive counseling).
   - Obtain informed consent.
   - Schedule follow-up appointment.

B. Clinical Assessment: Role of Gestational Dating (5 minutes)

1. Review the importance of gestational dating, while also reminding participants that MA is effective for a range of gestational ages. Cover the following:
   - MA is safe and effective when performed during the first 12 weeks after a woman's last menstrual period (LMP); however, LMP should not be the sole factor used to determine gestational age. MA is also performed in the second trimester; however, the *MA Study Guide* and Training Guide discuss MA in the first trimester. Second-trimester MA is beyond the scope of these materials.

- Gestational age can be accurately estimated by 1) determining the date of a woman's LMP **and** 2) performing a bimanual pelvic exam to assess uterine size.
- Ultrasound (if available) may be used if gestational dating by history and exam is ambiguous.
- If LMP and bimanual exam estimates are consistent with one another, exact dating through ultrasound is unnecessary.
- The next sessions in the unit will focus more in depth on LMP and bimanual exam.

2. Answer any outstanding questions.

C. Gestational Dating by Last Menstrual Period (LMP) (20 minutes)

Materials:

- Assembled MA Gestational Dating Wheels *(these can be obtained from Ipas by contacting medicalabortion@ipas.org or produced locally from the file found on the accompanying CD-ROM)*
- Pre-prepared flipchart: *Scenarios for Gestational Dating Wheel Practice*
  - ▸ *Ava's last period started June 19. Today is September 24. Is Ava eligible for MA?*
  - ▸ *Maria's last period started December 1. Today is January 15. Is Maria eligible for MA?*
  - ▸ *Fatima's last period started February 5. Today is April 30. Is Fatima eligible for MA?*

1. Ask participants to brainstorm questions that might help women remember their LMP; write the questions on a flipchart. Possible questions include:
   - What were you doing the day that your period started?
   - Where were you?
   - What were you wearing?
   - Who were you with?
   - What day of the week was it?
   - Was it close to a holiday, special event, market day or weekend?
   - What was the weather like?

2. Ask participants to recall difficulties women have had in accurately estimating LMP. Some answers might include:
   - Bleeding during early pregnancy (which might be mistaken for a period).
   - Pregnancy during breastfeeding, even in the absence of regular periods.
   - Many indigenous women are not sure of their LMP because they do not use calendars the way that modern calendars are used in medical settings.
   - Women who have irregular periods with spotting in between may have a hard time identifying and remembering their last actual period.

3. Distribute the gestational dating wheels.
   - Explain that the gestational wheel is a tool that providers can use to help determine MA eligibility based on LMP.
   - Demonstrate how to use the wheel.

4. Post flipchart of LMP scenarios for gestational dating wheel practice.
   - Ask a volunteer to read the first scenario aloud.
   - Have participants use the wheels to decide if the woman is eligible for MA.
   - Move around among participants to provide assistance using the wheel.
   - Ask someone to share his or her answer.
   - Continue until you have discussed all three scenarios. Only Maria and Fatima are eligible for first-trimester MA by LMP dating. Ava is beyond 12 weeks, Maria is below nine weeks and Fatima is just at 12 weeks (so her MA should be done in the clinic setting). *(**Note:** You might want to create more or different scenarios with which to practice)*
   - Invite participants to share what they think about the gestational wheel as a job aide.

5. Ask participants what other strategies and tools they use to help women remember their LMP and to determine women's eligibility for MA based on LMP.

D. Gestational Dating by Bimanual Examination (25 minutes)

Materials:

- Pre-prepared flipcharts with questions:
  - *What methods do you use for sizing early pregnancies?*
  - *In bimanual exam, if the uterus is smaller than expected, what might this indicate?*
  - *In bimanual exam, if the uterus is larger than expected, what might this indicate?*

1. Emphasize that determining uterine size in an early pregnancy can be challenging and requires practice.

2. Divide participants into pairs to discuss uterine sizing in early pregnancy.
   - Post three pre-prepared flipcharts with questions at the front of the room.
   - Give pairs 10 minutes to discuss the three questions.
   - Invite the pairs to come write their answers on the flipcharts.
   - Review with the large group what has been written and add any missing information until the flipcharts include all the important answers as below:

1) What methods do you use for sizing early pregnancies?

Answers include:
- Bimanual exam
- Review of pregnancy symptoms
- Comparing LMP to bimanual exam
- Ultrasound

2) In bimanual exam, if the uterus is smaller than expected, what might this indicate?

Answers include:

- The woman is not pregnant
- Inaccurate menstrual dating (pregnancy is not as far along as thought)
- Ectopic pregnancy
- Early pregnancy failure, including missed abortion
- Normal variation between women

3) In bimanual exam, if the uterus is larger than expected, what might this indicate?

Answers include:

- Inaccurate menstrual dating (pregnancy is more advanced than thought)
- Multiple pregnancies
- Uterine abnormalities such as fibroids or bicornuate uterus
- Gestational trophoblastic neoplasm/molar pregnancy
- Normal variation between women

3. Explain that often small discrepancies are not clinically significant.
   - For example, if the woman's LMP indicates nine weeks but you feel the uterine size is seven to eight weeks, unless there are other warning signs (of ectopic for instance), there is really no need for additional testing or examination. The MA regimens will be the same at either gestational age.

4. ***Optional:*** Further discuss uterine size:
   - Ask participants to make a circle with their hands to show the approximate size of:
     - ► a non-pregnant uterus
     - ► a six-weeks pregnant uterus
     - ► a seven-eight week pregnant uterus
     - ► a nine-weeks pregnant uterus
     - ► a 10-weeks pregnant uterus
     - ► and a 12-weeks pregnant uterus
   - Assist the learners in the appropriate size (use flipchart to draw on as needed)

5. Tell participants to ask a second clinician to check uterine size using bimanual exam if:
   - The first clinician is uncertain about size
   - There are discrepancies between uterine size and LMP

6. If ultrasound is available, remind participants that it may also be used to determine gestational age if it cannot be determined using LMP and bimanual exam.

7. Remind participants to be mindful of women, particularly adolescents and young women, who have never had a bimanual exam before, or of women who may have experienced of sexual violence. They may fear being touched or may be particularly concerned about pain.

- Ask a few participants to share techniques that can be used to address the needs of women who are concerned about the bimanual exam.

E. Identifying Ectopic Pregnancy (25 minutes)

1. Ask participants why ectopic pregnancy is a key concern when performing MA. Take a few answers.

2. Ask participants when have they seen a woman with ectopic pregnancy and if they can remember the signs and symptoms of it prior to rupture. Have a few learners share and discuss their experiences.

3. Describe the next activity, which focuses on identifying ectopic pregnancy.
   - Divide participants into three groups to discuss:
     - ► risk factors (group one)
     - ► signs and symptoms (group two)
     - ► what to do if ectopic pregnancy is suspected (group three)
   - Instruct each group to pick a note-taker and someone who will report back to the larger group.
   - Remind participants to refer to the *MA Study Guide* as needed.
   - Allow the groups 10 minutes to discuss their topic.
   - After 10 minutes, ask the first group to report back to the full group; invite comments, questions, and feedback from the other groups.
   - Ask the second and third groups to present their results to the full group and continue to discuss.

4. Summarize the key points from the discussion of ectopic pregnancy, including:
   - More than half of identified ectopic pregnancies occur in women without known risk factors. Previous tubal surgery, previous ectopic, history of severe pelvic inflammatory disease and tubal abnormalities are strongly associated with an increased risk of ectopic pregnancy.
   - Becoming pregnant with an IUD device in place is rare, but an estimated 25 to 50 percent of such pregnancies are ectopic (Barnhart 2009).
   - Spotting/ irregular bleeding is the most common symptom, but spotting is also common in early pregnancy.
   - A woman with an early ectopic pregnancy may not have any symptoms at all.
   - If symptoms are present, they may include smaller uterine size than expected, sudden and intense lower abdominal pain that is often one-sided, fainting, dizziness, shoulder pain, and rapid heartbeat.
   - Clinical evidence of a possible ruptured ectopic pregnancy includes: low blood pressure, falling hemoglobin or hematocrit, guarding, rebound tenderness and severe abdominal pain.

- It is rare to assess ectopic pregnancy by bimanual exam. Even if a pregnancy is ectopic, the uterus typically grows somewhat larger than non-pregnant size; it is common for it to be six-week size. Rarely though, an adnexal mass in the fallopian tube can be palpated.
- An ectopic pregnancy can be life-threatening and should be treated or transferred for diagnosis and treatment immediately.

F. Determining MA Eligibility: Clinical Assessment Case Studies (45 minutes)

Materials:

- MA Clinical Assessment Case Studies
- MA Clinical Assessment Case Study Answer Key

1. Inform participants that case studies will help them to practice determining MA eligibility.
   - Divide participants into six groups and handout the case studies.
   - Assign each group a case study to review and discuss.
   - Instruct each group to pick a note-taker and someone who will report back to the larger group.
   - Remind participants that they can refer to the *MA Study Guide* for information.
   - Allow the groups 10 minutes to discuss their case study and five minutes for report-back and questions or comments.
   - After 10 minutes, call participants back together. Ask each group to briefly review their case study and the conclusions they reached.
   - Take questions and comments from the full group after each case.
   - Fill in any missing points, using the answer key.
2. Summarize key points of determining eligibility through clinical assessment.

G. Identifying Symptoms and Signs (15 minutes)

Materials:

- Side effects continuum pictures (posted on wall or drawn on board)
- Side effects strips in basket or bowl
- Flipcharts for notes on *Expected Effects, Possible Side Effects, and Warning Signs* (blank).

1. Introduce the following key points:
   - To manage side effects (or seek emergency care when needed), women must know what side effects are normal and possible, and must be able to recognize the signs of more serious concerns.

- During the MA process, most women will experience a range of normal or "expected effects."
- Some women may experience other "possible side effects" that are bothersome but not serious.
- In a smaller number of cases, women will experience "warning signs" that require immediate follow-up.

2. Explain that the group will do an interactive activity called the "side effects continuum." The exercise lets participants review what they have learned about the MA process from their self-directed study of the *MA Study Guide*.
   - Post the "side effects continuum" at the front of the room.
   - Ask participants to look at the continuum.
   - Ask several volunteers to choose a "side effects" strip from a basket or bowl.
   - Ask each volunteer to read their strip aloud and tape the strip on the continuum under the appropriate sign:
     - ► Band-aid (plaster) symbol: normal side effect
     - ► Phone symbol: woman should call the clinic
     - ► Red cross symbol: woman should go to the emergency room (ER)
   - After each strip is placed on the continuum, ask the other participants if they agree with the strip's placement; correct the placement, if necessary. In a few cases, the answer could fall under more than one category; explain and discuss as needed.
   - As participants discuss the strips, take notes on the appropriate flipchart, distinguishing between Expected Effects, Possible Side Effects, and Warning Signs.
     (***Note:*** *Use these flipcharts again when discussing these topics in Activities H, I, and J)*
3. Discuss symptom combinations that could move a minor side effect along the continuum of severity. For example:
   - Cramping is often a normal effect of MA, but if the cramps are severe and pain pills don't help, the woman should call the clinic.
4. Return to the flipcharts and ask participants to add any missing information, using their *MA Study Guide* for reference.

H. Expected Effects (10 minutes)

Materials:

- Flipcharts from Activity G (Identifying Symptoms and Signs)

1. Review expected effects:
   - Refer to the flipchart from the previous activity (G. Identifying Symptoms and Signs).
   - Explain that women have a range of experiences with bleeding and cramping when undergoing MA. (***Note:*** *You may use the "Bell Curve" described in the MA Study Guide to illustrate this point*)

- The MA process may:
  - ▸ feel like an intense, painful menstrual period
  - ▸ be similar to a spontaneous miscarriage

2. Remind participants that vaginal bleeding is a normal, expected and necessary part of the MA process. Go over the following key points:
   - Bleeding is usually heavier than a menstrual period.
   - Bleeding is often accompanied by passage of clots.
   - Bleeding usually starts within one to three hours after taking misoprostol.
   - Bleeding usually decreases after the pregnancy has been expelled.
   - Women usually bleed, ranging from a light menstrual-type flow to spotting for one to two weeks after MA (but bleeding patterns vary widely).
   - Women experience more bleeding with MA than with vacuum aspiration, during which much of the blood and tissue is removed by the provider during the procedure. A study was done comparing blood loss among women having MA and VA in China, Cuba and India; the percent of women whose hemoglobin dropped by >2gm/dl, a clinically meaningful indicator, was small and differed significantly among the two groups only in Cuba (Winikoff 1997).
   - Women who express discomfort with heavy bleeding may be better candidates for vacuum aspiration.
   - Severe hemorrhage and prolonged heavy bleeding require immediate attention. *(**Note:** This will be discussed in the unit on Problems, Complications and Emergencies)*

3. Point out that cramping is also an expected effect of MA medications. Key points are:
   - Cramping can begin within 30 minutes after taking misoprostol.
   - Pain levels vary greatly among women.
   - Cramping occurs during uterine contractions and when the pregnancy is expelled.
   - Pain diminishes after the pregnancy has expelled.
   - It is important to address pain before it gets too severe.

4. Ask participants to brainstorm ways to help women know what to expect and how to manage their pain.
   - Verbal support
     - ▸ Counseling about what to expect
     - ▸ Reassurance during the abortion
   - Pain management
     - ▸ Heat to the abdomen or lower back
     - ▸ Hot-water bottle or warm cloths
     - ▸ Hot bath or shower
   - Pain medications (should be taken before cramping begins)
     - ▸ Non-narcotic and narcotic analgesics can be used
     - ▸ Ibuprofen
     - ▸ Paracetamol (acetaminophen) with or without codeine (not as effective as ibuprofen)

– Dose of acetaminophen must not exceed 4 grams in a 24-hour period to avoid liver toxicity (Creinin 2009).

- Codeine

5. Ask participants to name locally available medications that could be used for pain relief during MA.

I. Possible Side Effects (10 minutes)

Materials:

- Flipchart from Activity G (Identifying Symptoms and Signs)

1. Review Side Effects:
   - Refer to the flipchart from Activity G (Identifying Symptoms and Signs).
   - Remind participants that MA can have a range of possible side effects, including:
     - Nausea
     - Vomiting
     - Diarrhea
     - Fever, warmth or chills
     - Headache
     - Dizziness
   - Explain that some of these symptoms may be caused by the pregnancy itself rather than MA.
   - Symptoms caused by the pregnancy may actually decrease after the MA begins.

2. Discuss other key aspects of side effects:
   - Most side effects begin after taking misoprostol.
   - Most side effects are temporary and do not need treatment.
   - With proper counseling, most women are able to manage their side effects without major difficulties.

J. Warning Signs (10 minutes)

Materials:

- Flipchart from Activity G (Identifying Symptoms and Signs)

1. Review Warning Signs:
   - Refer to the flipchart from Activity G (Identifying Symptoms and Signs).
   - Discuss key warning signs, including:
     - Excessive bleeding (i.e. soaking more than two sanitary pads per hour for two consecutive hours), especially if accompanied by prolonged dizziness, lightheadedness and increasing fatigue

- ▸ Fever any day after the day misoprostol is used
  *(**Note:** The MA Study Guide states "fever of 38°C/100.4°F or higher or fever after the day misoprostol is used." However, misoprostol commonly causes fever the day it is taken -- often much higher than 38°C/100.4°F -- and should not be a symptom of concern in that context. Concern should arise only if the fever occurs on days after the day misoprostol is taken)*
- ▸ Unusual or bad-smelling vaginal discharge, especially if accompanied by severe cramps or abdominal pain
  *(**Note**: The Study Guide lists "foul-smelling vaginal odor and/or discharge" but does not mention that this is a warning sign only if accompanied by pelvic/abdominal pain that is not going away. Bad smell alone is not enough to indicate a need for immediate care)*
- ▸ Severe abdominal pain that occurs any day after the day misoprostol is taken
- ▸ Feeling very sick with or without fever, and persistent severe nausea or vomiting after the day of taking misoprostol

2. Remind participants that it is essential for providers to give women the information they need to:
   - manage expected effects
   - manage any side effects
   - distinguish expected effects and possible side effects from true warning signs of complications
3. Answer any remaining questions.

Unit Three: Materials

1. Key Components of Pre-procedure Care Strips *(for trainers)*

2. Clinical Assessment Case Studies *(for participants)*

3. Clinical Assessment Case Studies Answer Key *(for trainers)*

4. Side-effects Continuum Pictures *(for trainers)*

5. Side-effects Continuum Strips *(for participants)*

6. Side-effects Continuum Answer Key *(for trainers)*

For Trainers

Key Components of Pre-procedure Care

Instructions: Make three copies of this sheet, then cut into three sets of strips and put a mixed up set in each of three envelopes, then seal the envelope.

Conduct pregnancy options counseling

Conduct clinical assessment (exam, dating, eligibility)

Conduct pre-procedure counseling (including contraceptive counseling)

Obtain informed consent

Schedule follow-up appointment

For Participants

Medical Abortion Clinical Assessment Case Studies

Case Study 1

A 20-year-old woman comes to the clinic two weeks after her missed period, or six weeks since her last menstrual period (LMP). She was not using any birth control method and usually has regular periods every 28-30 days. She says she's been having mild nausea and breast tenderness. You perform a bimanual exam and find her uterus to be anteverted and consistent with six weeks LMP. You find no adnexal masses or tenderness. She has heard about MA and asks if she can start the process today or if she needs an ultrasound.

Question: *How do you respond?*

Case Study 2

A 17-year-old woman comes to the clinic because she thinks she may be pregnant and was told that she could take a medicine to make her period "come down." When you ask about her last menstrual period she says she cannot remember when it last came. You do a pelvic exam and estimate a seven-week pregnancy.

Question: *What else could you do to confirm your pelvic exam estimate?*

Case Study 3

A 30-year-old woman comes to the clinic wanting to terminate her pregnancy, which she confidently estimates is about eight weeks by LMP. Her pelvic exam concerns you because you feel a large uterus with many fibroids that you estimate to be comparable to a 12-week pregnancy.

Question: *If you are unsure of your exam, what are your options?*

Case Study 4

A 24-year-old woman has three children. She wants to get the "abortion pill." She plans to tell her family that she is having a miscarriage, and does not want to tell her husband or anyone else that she is having an abortion. She had her period about nine weeks ago. You review her menstrual history. Since she stopped breastfeeding, she has had regular periods. The woman has noticed that her breasts became larger and tender about five weeks ago, and she has had occasional nausea since then. She has never used contraception. You perform a bimanual exam and the uterus is retroverted and feels about nine-week size.

Question: *Do you feel confident she is within the eligible range for MA?*

For Participants

Medical Abortion Clinical Assessment Case Studies

Case Study 5

A woman is 28 years old with four children. She does not want another child. Her periods have always been irregular. Sometimes her period lasts a day or two while at other times she bleeds for a week. Sometimes she has a period every month but sometimes her period skips a month. She does not remember when her last period was. You try to help her think back to an event in her life that might help her recall the date of her last period, but this does not help her remember. She had severe bleeding with two of her deliveries but never had a blood transfusion. The woman appears to be somewhat pale and she states she often feels tired. You perform a bimanual exam and her uterus is anteverted, easily palpable and feels eight -week sized.

Question: *Do you think she is eligible for MA?*

Case Study 6

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

Question: *What do you do next?*

For Trainers

MA Clinical Assessment Case Studies Answer Key

Case Study 1

A 20-year-old woman comes to the clinic two weeks after her missed period, or six weeks since her last menstrual period (LMP). She was not using any birth control method, and usually has regular periods every 28-30 days. She says she's been having mild nausea and breast tenderness. You perform a bimanual exam and find her uterus to be anteverted, and consistent with six weeks LMP. You find no adnexal masses or tenderness. She has heard about MA and asks if she can start the process today or if she needs an ultrasound.

Question: *How do you respond?*

Discussion:

This is a straightforward case of early pregnancy diagnosed by a reliable LMP and a consistent pelvic exam done by an experienced clinician. There is no need for an ultrasound and the woman is within the gestational range eligible for medical abortion.

In most cases of MA, women's report of LMP, in combination with review of pregnancy symptoms and bimanual exam, can safely be substituted for routine ultrasound, unless there are clinically significant discrepancies or inconsistencies for gestational dating.

Case Study 2

A 17-year-old woman comes to the clinic because she thinks she may be pregnant and was told that she could take a medicine to make her period "come down." When you ask about her last menstrual period she says she cannot remember when it last came. You do a pelvic exam and estimate a seven-week pregnancy.

Question*: What else could you do to confirm your pelvic exam estimate?*

Discussion:

Clinicians need to be aware of the relevant laws or regulations in their setting related to provision of abortion care to adolescents. Studies show that MA is a safe and effective method for adolescents and young women.

In most cases, in a relatively slim woman, a pelvic exam by an experienced clinician is sufficient to assess gestational age. If further information is needed, it may be useful to review pregnancy symptoms and help the woman to remember her LMP. In cases where women are unable to remember their LMP, they can be helped by a calendar and memory recall cues such as "What day of the week was it?" "What were you doing?" "What part of the month?" "Was there a special event going on?" and "Are your periods regular?" It may also be useful to ask when the woman first noticed pregnancy symptoms such as breast tenderness or nausea. Breast tenderness and nipple sensitivity typically begin around three to four weeks LMP, followed by fatigue, nausea and urinary frequency at four weeks LMP. An exam by another clinician may also help confirm your estimate of a seven-week pregnant uterus.

For Trainers

MA Clinical Assessment Case Studies Answer Key

There is a high correlation between pregnancy dating as determined by a clinician (based on bimanual examination and history) and dating determined by ultrasound. When the two approaches produce differing dates, clinician estimation is generally more conservative — overestimating gestational age. One study found no statistical difference in MA outcomes using ultrasound versus clinician assessment of gestational age. More than half of the clinicians involved in the study were mid-level providers.

Other evidence suggests that small dating errors in gestational age do not expose women to increased risk. Although the combination of mifepristone and misoprostol is known to be most effective within nine weeks, the reduction in effectiveness after this point is gradual, not sudden. Because provision of misoprostol has also been studied past nine weeks (although with repeated doses of misoprostol), it is reasonable to assume that efficacy also reduces gradually after nine weeks with misoprostol-only abortion. In other words, if gestational age is slightly underestimated, exact gestational age is not crucial.

Case Study 3

A 30-year-old woman comes to the clinic wanting to terminate her pregnancy, which she confidently estimates is about eight weeks by LMP. Her pelvic exam concerns you because you feel a large uterus with many fibroids that you estimate to be comparable to a 12-week pregnancy.

Question: *If you are unsure of your exam, what are your options?*

Discussion:

When there is a discrepancy between LMP and exam, ultrasound can be useful if it is available. If ultrasound is available at a referral site, ultrasound may verify that the woman is indeed eight weeks LMP but fibroids are causing uterine enlargement and distortion. Fibroids are not a contraindication to MA. In fact, when fibroids distort the uterus, making access by instrumentation difficult or impossible, MA may be the better abortion method to use.

You may also ask another clinician to confirm your exam. If the exam continues to be inconsistent with the LMP and estimates that the pregnancy is beyond nine weeks, then you may offer the woman a uterine evacuation with vacuum aspiration. Another approach is to offer MA using a regimen and clinical protocols appropriate for her gestational age.

Case Study 4

A 24-year-old woman has three children. She wants to get the "abortion pill." She plans to tell her family that she is having a miscarriage, and does not want to tell her husband or anyone else that she is having an abortion. She had her period about nine weeks ago. You review her menstrual history. Since she stopped breastfeeding, she has had regular periods. The woman has noticed that her breasts became larger and tender about five weeks ago, and she has had occasional nausea since then. She has never used contraception. You perform a bimanual exam and the uterus is retroverted and feels about nine-week size.

Question: *Do you feel confident she is within the eligible range for MA?*

For Trainers

MA Clinical Assessment Case Studies Answer Key

Discussion:

Depending on the gestational eligibility criteria in this particular setting, the woman is a candidate for MA if it is provided through nine weeks. Even if the clinician's assessment by bimanual exam and LMP is a slight underestimation, using one of the very effective regimens for MA has a high chance of success.

Other than the straightforward clinical considerations of this case, there should be some discussion with the woman about why she wants to keep the abortion secret from her family, including her husband. It is important to discuss the possibility of domestic violence occurring in the home. It is impossible for a family member to tell the difference between a spontaneous miscarriage and a medical abortion, but that entails hiding the misoprostol and ensuring that no one tells the husband that the woman was seen in the clinic where abortion services are provided. Women who do not disclose to their partners that they are having an abortion are more likely to be victims of abuse than women who do disclose (Woo 2005).

Case Study 5

A woman is 28 years old with four children. She does not want another child. Her periods have always been irregular. Sometimes her period lasts a day or two while at other times she bleeds for a week. Sometimes she has a period every month but sometimes her period skips a month. She does not remember when her last period was. You try to help her think back to an event in her life that might help her recall the date of her last period, but this does not help her remember. She had severe bleeding with two of her deliveries but never had a blood transfusion. The woman appears to be somewhat pale and she states she often feels tired. You perform a bimanual exam and her uterus is anteverted, easily palpable and feels eight -week sized.

Question: *Do you think she is eligible for MA?*

Discussion:

The woman had severe bleeding with two deliveries, but her menstrual periods are not severe (probably ruling out underlying coagulopathy or blood disorder). It is useful to check the woman's blood for anemia, if that can be done.

The woman is within the gestational eligibility for MA, but it would be advisable for her to either take the misoprostol in the clinic and remain there until expulsion, or take it at home only if her home is not remote from a facility that can provide urgent care with MVA if she experiences excessive bleeding.

For the long term, inform the woman of iron-rich foods and provide iron supplementation if possible. Provision of oral contraception for the long term to help resolve anemia by decreasing menstrual flow, regardless of her contraceptive needs, would also be a good option to discuss.

For Trainers

MA Clinical Assessment Case Studies Answer Key

Case Study 6

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

Question: *What do you do next?*

Discussion:

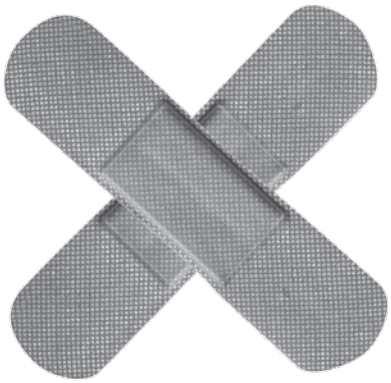
There are several possibilities for the discrepancy of bimanual exam and her estimated LMP. She may have uterine fibroids that cause the uterus to feel larger by palpation. She may be pregnant with twins or multiple gestation, in which case she would still be eligible for MA if she is eight weeks LMP. Or she may be 10 weeks pregnant.

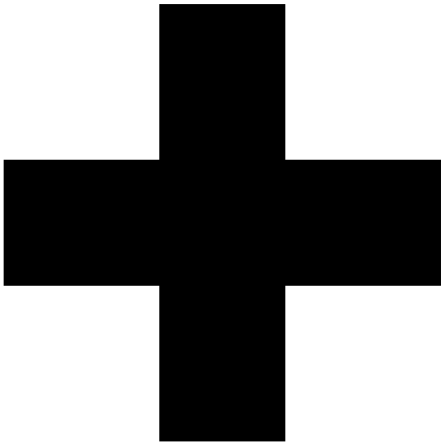
An ultrasound is needed to determine which situation is true. She should be informed of her choices: 1) ultrasound may be able to determine that she meets the criteria for MA (if ultrasound is reasonably available), or 2) vacuum aspiration without the need for further assessment or ultrasound or 3) MA past nine weeks, with a slightly reduced efficacy, and ask her if that would be her preference. MA beyond nine weeks has been studied in settings in which women can remain in the health setting for four hours after receiving misoprostol where they can be monitored until the abortion is complete.

For Trainers

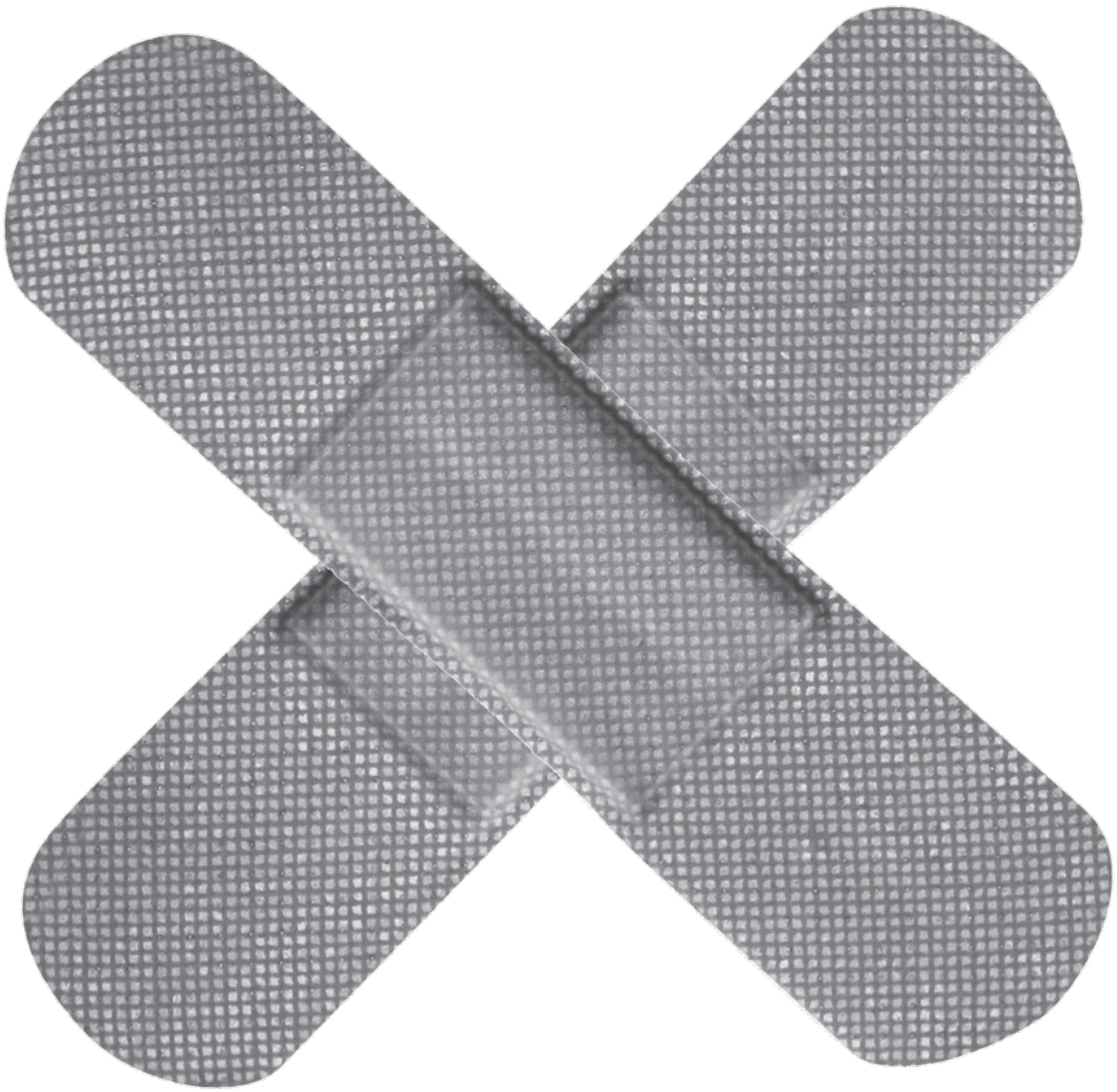
Side-effects Continuum Instructions

Instructions : Draw or post the pictures below in a "continuum" at the front of the room.
(***Note:*** *color versions of these visuals are available on the CD-ROM in large size*)



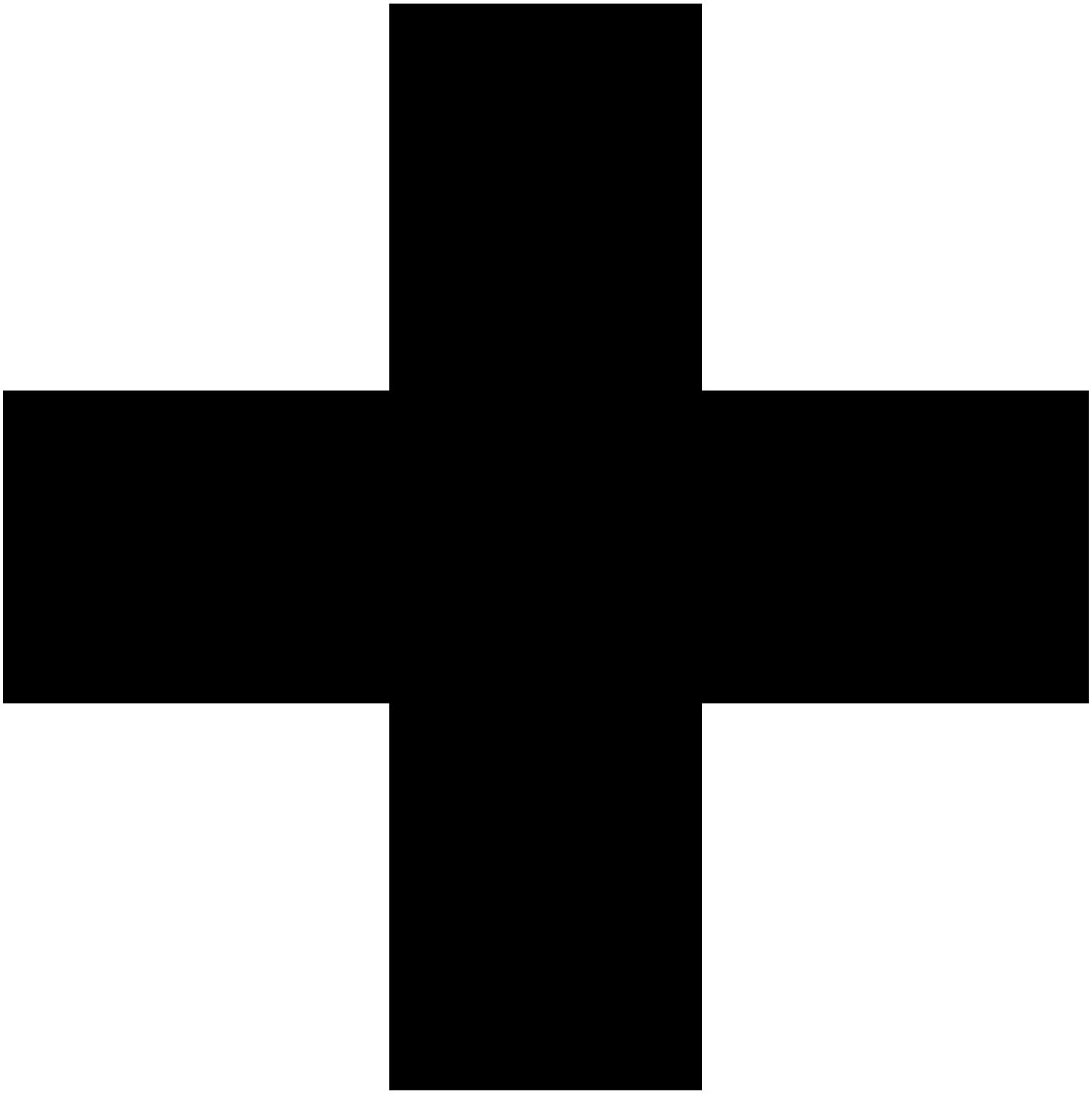


Normal



Call Clinic

Go to E.R.



For Participants

Side-effects Continuum Strips

Trainer Instructions: Copy this sheet and cut it into separate strips for each side effect situation. Place strips in a basket, bowl or envelope.

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

Vomiting and diarrhea 24 hours after taking misoprostol

Woman worries during MA and thinks she should go to the emergency room

Fever and chills the day misoprostol is taken

One week after taking misoprostol, woman soaks through two pads for two hours in a row

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

Severe nausea and vomiting 24 hours after taking misoprostol

continued on page 60

For Participants

Side-effects Continuum Strips *(continued from page 59)*

Trainer Instructions: Copy this sheet and cut it into separate strips for each side effect situation. Place strips in a basket, bowl or envelope.

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

Sudden feeling of faintness or already fainted

Foul-smelling vaginal odor and discharge with a fever or accompanied by severe abdominal pain

Bleeding in small amounts for three weeks after the MA

For Trainers

Side-effects Continuum Answer Key

Common Side Effects:

- Cramping and vaginal bleeding saturating menstrual pads (but less than two pads per hour for two consecutive hours) - this is an expected effect, not a side effect
- Fever and chills the day misoprostol is taken
- Passing of heavy blood clots from vagina within four hours of taking misoprostol
- Bleeding in small amounts for three weeks after the MA

Call Clinic:

- Woman worries during MA and thinks she should go to the emergency room
- Cramping that has improved a little with ibuprofen, but woman wants something more for pain

Call Clinic or Go to E.R.:

*(**Note:** these signs could fall under either category and still be correct)*

- Vomiting and diarrhea 24 hours after taking misoprostol
- Severe nausea and vomiting 24 hours after taking misoprostol

Go to E.R.:

- One week **after** taking misoprostol, woman soaks through two pads for two hours in a row
- Weakness and feeling very sick, unable to easily get out of bed
- Sudden feeling of faintness or already fainted
- Foul-smelling vaginal odor and discharge with a fever or accompanied by severe abdominal pain

Unit Four: Informed Consent, Information and Counseling

Time

Three hours

Unit Objectives

By the end of this unit, participants will be able to:

- Articulate their own comfort levels discussing, advocating for and providing MA services
- Discuss how these varying comfort levels relate to societal norms on MA and their personal level of comfort providing MA services
- Provide options counseling to women seeking MA services
- Obtain informed consent for MA
- Provide counseling to a woman prior to her leaving the clinic
- Provide emotional support to women seeking MA services
- Provide postabortion contraceptive counseling
- Help women manage MA side effects, identify warning signs and make a follow-up care plan

Advance Preparations

- ☐ Prepare flipchart with Unit Four Objectives.
- ☐ Prepare three signs on paper: "A Lot," "A Little" and "Not At All."
- ☐ Review and if needed revise comfort continuum statements to be most relevant for participants.
- ☐ Copy counseling handouts for group presentation work.
- ☐ Copy counseling and information handouts for role plays.
- ☐ Choose and copy the MA skills checklist (1 or 2) of the relevant regimen to be used by learners.
- ☐ Cut up the six Contraceptive Counseling Scenarios and place in a bowl, basket, or envelope.
- ☐ Copy handout: *Ipas Best Practices in Medication Abortion - Starting Contraception after First-Trimester Medication Abortion* (on CD-ROM).
- ☐ ***Optional:*** Prepare Four Corners activity (in appendices).

Instructions and Materials

A. Comfort Level with Medical Abortion (30 minutes)

Materials:

- Blank flipchart paper and stand, markers, basket or bowl, envelopes and tape
- Pre-prepared flipchart: Unit Four Objectives (list)
- Three paper signs labeled "A Lot," "A Little" and "Not At All"
- Comfort continuum statements

1. Post and review flipchart: *Unit Four Objectives*.

2. Introduce the Comfort Continuum Activity[1]. Explain that this activity asks participants to reflect on their level of comfort discussing, advocating for and providing MA services.

3. Tape the three signs on the wall or floor in an open area where there is enough space for participants to move around. Place the signs in order in a row to indicate a continuum:

Not At All → **A Little** → **A Lot**

4. Read aloud the statements one at a time, and ask participants to physically move to the point along the continuum that best represents their feelings. Encourage participants to be honest about their feelings and to resist being influenced by where others are standing.
(***Note:*** *You do not have to read all the statements, but choose those that are most relevant)*

5. After participants have arranged themselves, ask volunteers at different points along the continuum to explain why they are standing there.
   - If, based on someone's explanation, participants want to move to another point on the continuum, encourage them to do so.
   - After finishing all the statements, ask participants to return to their seats and invite two or three participants to share their feelings about the activity.

7. Refer to the reasons participants gave about their place on the continuum as you facilitate a brief discussion about the different responses and levels of comfort in the room. Some discussion questions could include:
   - *What observations do you have about your responses? Other people's responses?*
   - *Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?*
   - *What about your responses surprised you? How about other people's responses?*
   - *What did you learn about your own and others' comfort levels on MA?*
   - *What observations do you have about the group's overall level of comfort with MA (not individual people's responses)?*

[1] Activity adapted from: Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences.* Chapel Hill, NC: Ipas.

8. Discuss how different levels of comfort with MA impact societal norms, women's feelings about themselves when they have a MA and providers' feelings about performing MA.
   - Discuss how their comfort levels impact the provision and quality of MA services.
   - Emphasize what large impact providers' attitudes have on their provision of services and women's experience and satisfaction with those services.

Optional Activity: Four Corners

For trainers who have undergone VCAT training or have other experience using the Four Corners Activity, this activity has been adapted for medical abortion and is in the appendices. The Four Corners activity is not easy to facilitate for those who have never been trained in its use, so prior experience is highly recommended to maximize its potential and eliminate wasted time or frustration.

B. Core Components of Counseling (One hour, 15 minutes)

Materials:

- Handouts on core components of counseling:
  - *Group1 – Options counseling*
  - *Group 2 – Counseling prior to leaving the clinic*
  - *Group 3 – Providing emotional support*

1. Explain that clinicians who provide MA services should know how to offer thorough counseling that goes beyond explaining the drug regimens. Counseling should be respectful of every woman's rights and needs, regardless of her age, marital or HIV/AIDS status.

2. Describe that the next activity focuses on three important areas of counseling: options counseling, counseling prior to leaving the clinic and providing emotional support.
   - Divide participants into three groups and assign each an area of counseling to focus on.
   - Distribute the appropriate counseling handouts assigned to each group.
   - Tell participants that they have 30 minutes to prepare a 10-minute interactive discussion or presentation that covers their topic area of counseling.
   - Tell participants that they may prepare flipcharts or other visual aids as part of their presentation, and remind them to consult the *MA Study Guide* as needed.
   - Circulate among the groups to provide assistance.

3. After the 30 minutes of preparation, ask each group to make its 10-minute presentation, followed by a few minutes for questions and answers on their topic.

4. Address any remaining questions or state any key points that were missed.

C. Counseling Role Plays (50 minutes)

Materials:

- Handouts:
  - *Counseling and Information Role Plays*
  - *MA Skills Checklist 1: Mifepristone and Misoprostol Regimen or MA Skills Checklist 2: Misoprostol-only Regimen*

1. Explain that role playing can help participants practice their counseling skills and integrate new knowledge.

2. Divide participants into groups of three, and explain how the role-play activity will work.
   - Each group should complete three role plays, so each member has the opportunity to play each role once.
   - During a role play, one person plays the "provider", a second person plays the "woman" and a third person serves as "observer," using the *MA Skills Checklist* to take notes. *(**Note:** Be sure to distribute the checklist for the MA regimen appropriate to the workshop)*
   - For each round, the "woman" should choose a role play from the Counseling and Information Role Plays handout. Each group should use at least one case of an adolescent or young woman.
   - Each "woman" should take one or two minutes to read through her role play, create the character's name, and come up with other personal information about the character.
   - When the "woman" is ready, the group has about eight minutes to conduct the first role play.
   - After the role play, the "observer" and then the "woman" together have about three minutes to give specific feedback to the "provider."
   - Groups should repeat this process, switching roles until each person has had a chance to play the "woman," the "provider," and the "observer." *(**Note:** it may be helpful to ring a bell or announce when 13 minutes is up and the groups should switch to the next role play)*

3. Bring the groups together after they have completed three role plays. Ask the full group the following summary questions:
   - *What was challenging about the counseling sessions?*
   - *What went well?*
   - *What are some non-verbal behaviors the counselor used or could use to show respect and concern for the woman?*
   - *What would help participants to become more comfortable in counseling?*

D. Postabortion Contraceptive Counseling (25 minutes)

Materials:

- Bowl, basket or envelope
- Contraceptive Counseling Scenarios strips
- Handouts:
  - *Contraceptive Counseling Key Considerations*
  - *Best Practices in Medication Abortion: Starting Contraception After First-Trimester Medication Abortion (on CD-ROM)*

1. Remind participants that women seeking MA services need to know the following:
   - Women can become pregnant again as early as 10 days after the MA procedure.
   - Most women can begin contraception before the MA follow-up visit.

2. Distribute the handout *Ipas Best Practices in Medication Abortion: Starting Contraception after First-Trimester Medication Abortion* to participants as a reference for the next activity.

3. Facilitate an interactive activity about contraceptive counseling, using the seven Contraceptive Counseling Scenarios.
   - Explain that this activity will examine different scenarios about contraceptive counseling for women seeking MA.
   - Ask a volunteer to randomly pick a scenario from the bowl, basket or envelope and read it aloud to the whole group.
   - Then invite the group to discuss and consider the elements of the scenario, key considerations, and possible contraceptive counseling approaches.
   - After the discussion is over, hand out the Contraceptive Counseling Key Considerations. *(**Note:** The scenarios could also be explored in two-person role plays or groups of three rather than in the large group but that may require more time)*

4. Answer any remaining questions about counseling.

Unit Four: Materials

1. Comfort Continuum Statements *(for trainers)*

2. Group Work Handouts on Counseling *(for participants)*

3. Role Plays for Counseling and Information *(for participants)*

4. MA Skills Checklists *(for participants)*

5. Contraceptive Counseling Scenarios *(for participants)*

6. Contraceptive Counseling Scenarios Key Considerations *(for trainers)*

For Trainers

Comfort Continuum Statements[2]

Trainer instructions: Below are statements appropriate for health-care providers and health workers. You can choose some of the following statements or develop other statements that are more relevant in your country or setting.

1. How comfortable are you with safe and legal MA services being provided in your country?

2. How comfortable are you discussing MA with colleagues at work?

3. How comfortable are you discussing MA outside of your work setting?

4. How much disapproval would you expect to feel from your family and friends if you provided (or assisted with) MA services?

5. How comfortable are you performing (or assisting with if you are not authorized to perform) a medical abortion?

6. How comfortable are you with women choosing to use misoprostol at home or in a safe space rather than in the clinic?

7. How comfortable are you receiving phone calls from women off-hours (possibly nights or weekends) if they need reassurance or are worried?

8. How comfortable are you with the amount of bleeding women may experience with MA and that they will be assessing the bleeding themselves at home?

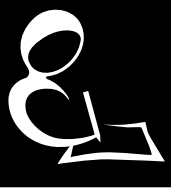
9. How comfortable are you with telephone follow-up after MA if the woman does not return for her scheduled follow up visit?

10. How comfortable are you providing (or assisting with) MA for every woman who desires it, regardless of her reasons?

11. How comfortable are you with adolescent and young women using MA?

12. How comfortable are you advocating for women's access to MA?

[2] Activity adapted from: Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences.* Chapel Hill, NC: Ipas.



For Participants

Group 1: Options Counseling

Instructions: Prepare and facilitate an interactive activity reviewing the counseling that a woman should receive before undergoing MA. Be sure to include all the information that should be provided to obtain informed consent. Your team may prepare posters, flipcharts or other visual aids as part of your activity. Refer to the *Medical Abortion Study Guide*, the *CD-ROM of Ipas IEC materials and job aids for Medical Abortion*, and the information below as needed. Be as creative and participatory as possible; avoid just giving a lecture.

Overview

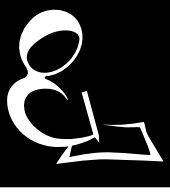
Counseling and informed consent must take place during the initial client visit. This helps ensure that women:

- feel comfortable with health-care staff
- fully understand all of their options, and can work with providers to select the best plan for them
- provide their informed consent for any care they receive
- clearly understand how to take care of themselves after the procedure, including managing normal side effects, identifying warning signs of complications, and seeking follow-up care

Providers should encourage women to contact the clinic where they received treatment if they have concerns or problems, rather than seeking care elsewhere. This is because the staff there will be familiar with MA protocols and side effects. Treating women (regardless of age, marital or HIV/AIDS status) respectfully and making sure women are comfortable with the care they receive will make women more likely to return to the same place if they experience problems.

During the counseling session

- Meet with the woman in a setting that ensures her privacy and confidentiality.
- Ask the woman if there is someone with her at the clinic who she would like to include in the counseling session (for support and to help her remember what you discuss).
- Provide the woman with basic information about all her options, including continuing the pregnancy or terminating the pregnancy.
- For young women who have not received sexuality education or who have suffered sexual violence, it may also be necessary to discuss how and why they became pregnant. If an overview of anatomy and pregnancy seems needed, provide the information in a respectful and appropriate way.
- If a woman decides to terminate her pregnancy, review all her available options of abortion methods, including MA.
- Discuss taking MA at home or in a safe space versus at the clinic if that choice is available in your setting. Be mindful that adolescents and young women may have different concerns than adult women do. For example, privacy can mean both "at home" and "away from home" depending on the woman's situation. If a woman does not want to take MA at home or in the clinic, work with her to identify a suitable safe space.
- Make sure that the woman is informed about the small risk of failure, including:
  - a small risk that the medications will not work
  - a slight risk that the medications could cause birth defects if the pregnancy continues
  - the need to receive VA if the MA does not work



For Participants

Group 1: Options Counseling *(continued)*

- Explain the MA process and what the woman should expect, including:
  - how long the MA process usually takes
  - normal expected effects
  - rare but possible complications (including how often they occur)
  - the importance of access to emergency care in case the woman does experience complications
- Consider factors that might prevent a woman from being a good candidate for MA such as:
  - She is opposed to bleeding heavily
  - She is uncomfortable with continued bleeding and/or with spotting over the course of a few weeks
  - She lacks access to emergency care in the rare event that it is necessary
  - She wants confirmation of pregnancy termination immediately
  - She prefers to have the abortion within the clinic setting (which may not always be an option with MA)

Counseling tools

During counseling, use information sheets and pamphlets to share information with the woman. As much as possible, these should include visual information and cues to help women understand and retain information, including women with limited literacy skills (see examples on the CD-ROM *Ipas IEC materials and job aids for Medical Abortion)*. Give the woman copies to take with her, even if she cannot read; she may wish to have someone else review them with her if she has further questions. Information sheets should include:

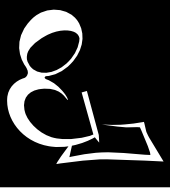
- what to expect during the MA process
- preventing and managing normal side effects
- risks for complications and method failure

You can also use the information sheets as a guide while you are learning how to counsel women about MA, or use them as a tool to monitor and supervise other counselors.

Informed consent

Once a woman has been fully counseled, obtain her informed consent to complete the procedure. Be sure to confirm her decision to seek MA. Should the woman decide not to have the MA, inform her that she will receive competent care of her choice.

Remind participants that as providers they have a responsibility to ensure what is in the best interest of a minor and to recognize that minors have varying levels of maturity that do not always correspond with chronological age. Providers should listen and talk with adolescents to gauge their level of maturity and understanding. With information and support, minors are able and have the right to make health-care decisions and provide informed consent for themselves (Landsdown 2005).



For Participants

Group 2: Counseling Prior to Leaving the Clinic

Instructions: Prepare and facilitate an interactive activity reviewing the counseling information a woman should receive before leaving the clinic. Include information about what she can expect over the next few days when taking the pills and everything she should know before leaving the clinic. Your team may prepare posters, flipcharts or other visual aids as part of your activity. Refer to the Medical Abortion Study Guide, the CD-ROM of Ipas IEC materials and job aids for Medical Abortion, and the information below as needed. Be as creative and participatory as possible; avoid giving a lecture.

Overview

Before a woman leaves the clinic, she needs clear instructions about what to expect in the days following the MA procedure, and information about how to stay healthy and comfortable. Women who have been well informed and properly counseled are more likely to have a successful, problem-free MA process.

During the counseling session

- Provide the woman with information about what to expect over the next few days, and help her develop a plan for staying healthy and comfortable, including:
  - how to manage normal side effects
  - how to prevent and manage pain
  - how to recognize warning signs of possible complications
  - when and where to seek medical help for complications
  - when to return for a follow-up visit, or how to seek follow-up care by phone *(**Note:** in-person follow-up visits are required for women who use misoprostol-only regimens)*
- Explain to women that they might want to keep track of their side effects and bleeding pattern. This information can help the woman and the provider determine if she is still pregnant at the follow-up visit. It also can help the woman assess whether she needs to seek health-care services for possible problems. In particular, she should pay attention to her bleeding and cramping after taking misoprostol, and determine whether any pregnancy symptoms she had prior to taking the pills have gone away after taking the pills.
- Inform the woman that she can become pregnant again as early as 10 days after MA, and that most women can begin contraception before they return for their follow-up visit.

Counseling tools

If possible, provide the woman with information sheets or pamphlets that summarize the information you've given her. The use of take-home materials with graphic or pictorial information is especially helpful in helping women with limited literacy skills to understand and retain key information (see examples on the CD-ROM *Ipas IEC materials and job aids for Medical Abortion*). The information should include:

- Regularly updated clinic contact telephone numbers
- Addresses for clinics where the woman can seek information and emergency care

If a woman does not have access to a telephone, use the counseling unit to help her to identify other options that can help her access information and emergency assistance. These might include linking her to village health workers or to women's groups.

For Participants

Group 3: Providing Emotional Support

Instructions: Prepare and facilitate an interactive activity identifying and demonstrating strategies for providing emotional support to women during and after an MA procedure. Be sure that your activity shows how to help women set up a support plan for when they leave the clinic. Your team may prepare posters, flipcharts, or other visual aids as part of your activity. Refer to the Medical Abortion Study Guide, the CD-ROM of Ipas IEC materials and job aids for Medical Abortion, and the information below as needed. Be as creative and participatory as possible; avoid just giving a lecture.

Recommended activities

Facilitate a brainstorming activity:

- Ask participants to identify emotions and concerns that a woman might feel or have when she seeks MA.
- Ask participants to identify emotions and concerns that an adolescent or young woman might feel or have when she seeks MA (in addition to, or different from, those identified above).
- Write down these ideas on a piece of flipchart paper.

Ask participants to share strategies that providers can use to demonstrate empathy and provide emotional support to women seeking MA services, including developing a plan for social and emotional support after women leave the clinic (see examples below).

- As the group identifies strategies, provide concrete examples of each behavior (e.g., open-ended questions, body language and tone of voice).
- Ask participants to provide demonstrations or examples.

Emotional support strategies

1. Ask women open-ended questions about their concerns and feelings.
   - An open-ended question is not a "yes or no" question (*i.e., not "Do you have any questions?"*)
   - An open-ended question elicits more information (*i.e., "What questions do you have?"*)
2. Listen carefully and attentively.
   - Give women time to express their concerns
   - Avoid interrupting
3. Use body language and tone of voice to demonstrate empathy and put women at ease.
4. Help women develop strategies for managing their stress, including developing a plan for seeking emotional support after they leave the clinic.
5. Try to address all questions and concerns.
   - Provide complete and simple information about the procedure and what to expect afterwards
   - Provide information sheets or pamphlets
6. Suggest that women include a partner or friend in the counseling session (if she so wishes and gives her consent) to provide support and assistance during and after the MA.

For Participants

Counseling and Information Role Plays

***(Note:** there are many more role plays here than needed for the activity, so choose from the list based on your preferences. Be sure your group uses at least one case of an adolescent or young woman)*

1. You are a pregnant 15-year-old woman who has not had any children yet. You have come to the clinic with your sister, because you would like to terminate your pregnancy. You are afraid your father will find out you are pregnant.

2. You are a 40-year-old woman who has four children. Your husband travels much of the time and you do not want to have another child. However, your husband would be very angry if he knew you were pregnant and considering having an abortion.

3. You are a young, unmarried woman with no children. You do not understand how you got pregnant or how MA works. During your session, you ask your counselor, "Will the drugs hurt the baby?"

4. You are married with a one-year-old child. You are pregnant but do not want another baby so soon. Your mother-in-law knows you are pregnant and is opposed to abortion.

5. You are 17 years old and have been raped and are now pregnant. You are very afraid of being touched and don't want to keep the pregnancy. Your sister is at the clinic with you.

6. You are a 32-year-old woman who has three children. Your husband is a truck driver who is gone most of the week. You got pregnant while breastfeeding your six-month-old daughter because you thought you would be "safe" from pregnancy and didn't use contraception. You want to have an abortion but are afraid of surgery.

7. You are a 28-year-old woman who lives two hours from the clinic. Your last menstrual period was near your birthday—which was nine weeks ago. You don't want your husband to know you are pregnant or considering an abortion.

8. You are an 18-year-old woman who has come to the clinic with your mother who does not know you are pregnant. You don't want her to be in the room with you when you see the nurse. You want to have an abortion but are afraid your mother won't let you.

9. You are 39 years old with two children, ages 14 and 16. You have also had one miscarriage at around nine weeks. By bimanual exam and history of LMP, you are around seven weeks pregnant. You are concerned about keeping this abortion private from your children. Your husband knows and is supportive. You would like strategies to ensure the most privacy and comfort during your abortion.

10. You are 21. You are about eight weeks pregnant. You have never been pregnant before and have a history of painful periods. You don't want to continue this pregnancy. You live with your mother and aunt. You don't want them to know about the abortion.

For Participants
Counseling and Information Role Plays

11. You are 24 and live alone. You are new to the city and haven't made many friends here. You have a job with a schedule that changes a lot. You are eight weeks pregnant by LMP. This is your second abortion (the first was a MVA).

12. You are 26 and a single mother with two children (ages five and eight). Your former husband left you but he comes frequently to see the children. You are seven weeks pregnant from a new boyfriend who your children don't know about. You want to end this pregnancy but you are worried about your former husband finding out about the abortion and using this information to hurt you, or take the children away.

13. You are 15 years old, and are six weeks pregnant by LMP. Your mother is with you today, and really wants you to have a MA because she's worried about the surgical abortion affecting your future fertility. You are not sure what to do.

14. You are 22, single, and accompanied by your boyfriend. You are nine weeks pregnant by LMP and bimanual exam, and really want to have a MA. Your boyfriend is very worried about whether this medicine is safe and about whether you are going to be in a lot of pain.

15. You are 15 years old and are here with your grandmother (with whom you live most of the time). This is your second abortion; your first pregnancy was the result of rape by your stepfather and is why you moved in with your grandmother.

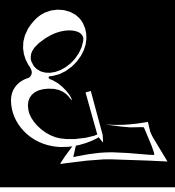
16. You are 25 and about to be married to a well-known man in town. You are very worried about confidentiality. You got pregnant with another man when you were briefly separated from your fiancé. You are eight weeks pregnant, and this is your first pregnancy. Your schedule is demanding, and you have already had to reschedule this appointment twice.

17. You are 24 years old, and have come in with your husband. You have a 10-month-old and two-year-old and do not want another child so soon. Your mother-in-law lives with you. The mother-in-law knows about the pregnancy and is opposed to abortion. You are seven weeks pregnant and are still breastfeeding your daughter occasionally.

18. You are 46 years old and six weeks pregnant. Your periods have been irregular and lighter for the past year as you start to go through perimenopause. You had a positive pregnancy test this week. You don't want to tell your husband because you feel embarrassed. You didn't think you could get pregnant anymore and so you stopped using birth control. You want to have a MA because you think it's better to end the pregnancy before it's too late.

19. You are a 37-year-old mother of two and are eight weeks pregnant. You had a miscarriage last year. You want to have a MA.

20. You are 21 years old and have three children. You are seven weeks pregnant and want to "get this over with right away." You live far from the hospital and want to take the medicines for MA at home because there is nobody who can take care of your children while you are away. Your husband has to be out most of the time because of work.

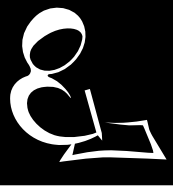


For Participants

MA Skills Checklist 1: Mifepristone and Misoprostol Regimen

First Clinic Visit	Yes	No	Comments
Ensures privacy during the visit			
Greets woman in a friendly, respectful manner			
Confirms with her that she wants to terminate her pregnancy and is not being coerced to do so against her will			
Explains what to expect during the clinic visit			
Asks if she came with someone and if she would like that person to join her in the information and counseling session			
Explores what kind of support she has for her decision			
Determines whether someone can be with her during the MA process			
Asks about medical conditions and allergies to any medicines			
Asks about her general health and reproductive health history			
If routine in local protocols, determines Rh status and gives Rh-immunoglobulin to Rh-negative women (if available and feasible)			
If routine in local protocols, performs pre-MA hemoglobin or hematocrit if indicated and equipment available *(Note: this may be part of local protocols but may not be feasible or routine in many settings)*			
Confirms that she is eligible for MA through clinical assessment			
Explains which abortion methods are available, including characteristics, effectiveness and the timing/visits required			
Explores views on abortion options and what method is best for her			
If she chooses MA, provides more information on it in simple terms			
Clarifies her feelings on possibility of having heavy bleeding at home			
Explains how to take mifepristone and misoprostol			
Explains what to expect after taking the medications			
Explains how to take pain management medications (analgesics) and suggests other methods to reduce pain (e.g. hot water bottle)			
Ensures she understands:			
• Common side effects and symptoms			
• Warning signs indicating the need to return to the clinic			
Explains what to do in case of questions or problems at home			
Provides contact information if problem or emergency arises			

(continued on pages 78-80)



For Participants

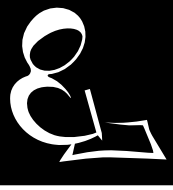
MA Skills Checklist 1: Mifepristone and Misoprostol Regimen

First Clinic Visit *(continued)*	Yes	No	Comments
Explains that if the MA should fail, further steps (per local protocol) will be necessary to terminate the pregnancy			
Asks the woman whether she has additional questions			
Obtains informed consent			
Discusses with the woman:			
• Information about return to fertility, sexuality and contraception			
• Contraceptive methods, if desired, with instructions for beginning			
Has woman swallow the mifepristone pills			
If the woman will take the misoprostol pills at home and does not need to return to get them, provide misoprostol pills to take home			
Makes an appointment for follow-up visit within 14 days			
Possible Visit for Misoprostol *(if misoprostol was not given on the first visit for home use)*	**Yes**	**No**	**Comments**
Ensures privacy for counseling session			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the clinic visit			
Inquires about what has happened since taking the mifepristone (bleeding, side effects, etc.)			
Provides misoprostol for in clinic or to take home (per protocol)			
If the woman leaves the clinic before she aborts: • Gives verbal and written instructions for aborting at home • Gives supplies (pain medications) • Makes a follow-up appointment for within 14 days (if not already scheduled)			
If the woman aborts at the clinic: • Performs a bimanual exam (per clinic protocol) or other measures to confirm completion			
Reviews after-care instructions			

For Participants

MA Skills Checklist 1: Mifepristone and Misoprostol Regimen

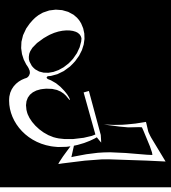
Possible Visit for Misoprostol *(continued)* *(if misoprostol was not given on the first visit for home use)*	Yes	No	Comments
Provides information on warning signs that indicate the need to return to the clinic or seek medical assistance			
Provides contact information for emergencies			
Asks the woman whether she has additional questions			
Follow-Up Visit	**Yes**	**No**	**Comments**
Ensures privacy for the visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up clinic visit			
Inquires about the woman's experience with the abortion process, asking her if she thinks she is no longer pregnant			
Assesses status of the abortion by: • Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping) • Asking about current cramping and current amount of bleeding • Conducting a physical examination			
If it is unclear whether the woman is still pregnant, discuses options:			
• Have another or more experienced clinician do an exam to check			
• Ask the woman to return in one week and re-check her (provided she would not be too far along then to receive a vacuum aspiration if needed)			
• Perform vacuum aspiration now			
• Perform an ultrasound, if available			
If the woman is no longer pregnant, provides:			
• Information on how to contact clinic if she has questions/problems			
• Information about return to fertility and contraception			
• A contraceptive method if desired by the woman			
If bleeding is prolonged or heavier than usual discusses treatment options:			
• Expectant management (depending on how heavy bleeding is)			
• Additional dose of misoprostol			
• Vacuum aspiration			



For Participants

MA Skills Checklist 1: Mifepristone and Misoprostol Regimen

Follow-Up Visit *(continued)*	Yes	No	Comments
If the woman is still pregnant, discusses options:			
• Vacuum aspiration			
• Repeat dose of misoprostol (~1/3rd chance of success) as long as she's willing to return for assessment again in seven-14 days and have a vacuum aspiration at that time if she's still pregnant			
Provides information and makes referrals if needed about other reproductive health issues including domestic violence, cancer screening and HIV/AIDs			
Asks the woman whether she has additional questions			



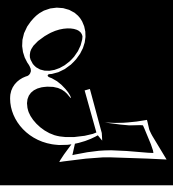
For Participants

Medical Abortion Skills Checklist 2: Misoprostol-only Regimen

Instructions: Check whether the skill was performed or not and add comments as needed.

First Clinic Visit	Yes	No	Comments
Ensures privacy during the visit			
Greets woman in a friendly, respectful manner			
Confirms with her that she wants to terminate her pregnancy and is not being coerced to do so against her will			
Explains what to expect during the clinic visit			
Asks if she came with someone and if she would like that person to join her in the information and counseling session			
Explores what kind of support she has for her decision			
Determines whether someone can be with her during the MA process			
Asks about medical conditions and allergies to any medicines			
Asks about her general health and reproductive health history			
If routine in local protocols, determines Rh status and gives Rh-immunoglobulin to Rh-negative women (if available and feasible)			
If routine in local protocols, performs pre-MA hemoglobin or hematocrit if indicated and equipment available *(Note: this may be part of local protocols but may not be feasible or routine in many settings)*			
Confirms that she is eligible for MA			
Explains which abortion methods are available, including characteristics, effectiveness and the timing/visits required			
Explores views on abortion options and what method is best for her			
If she chooses MA, provides more information on it in simple terms			
Clarifies her feelings on possibility of having heavy bleeding at home			
Explains how to take misoprostol			
Explains what to expect after taking the misoprostol			
Explains how to take pain management medications (analgesics) and suggests other methods to reduce pain (e.g. hot water bottle)			
Ensures she understands:			
• Common side effects and symptoms			
• Warning signs indicating the need to return to the clinic			
Explains what to do in case of questions or problems at home			
Provides contact information if problem or emergency arises			

(continued on pages 82-83)



For Participants

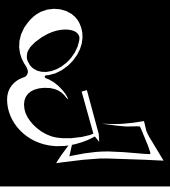
Medical Abortion Skills Checklist 2: Misoprostol-only Regimen

First Clinic Visit *(continued)*	Yes	No	Comments
Explains that if the MA should fail, vacuum aspiration will be necessary to terminate the pregnancy			
Asks the woman whether she has additional questions			
Obtains informed consent			
Discusses with the woman:			
• Information about return to fertility, sexuality and contraception			
• Contraceptive methods, if desired, with instructions for beginning			
Provides misoprostol in clinic or to take home (per protocol)			
Makes an appointment for follow-up visit within 14 days			
Follow-Up Visit	**Yes**	**No**	**Comments**
Ensures privacy for the visit			
Greets the woman in a friendly, respectful manner			
Explains what to expect during the follow-up clinic visit			
Inquires about the woman's experience with the abortion process, asking her if she thinks the abortion is complete			
Assesses the status of the abortion by:			
• Taking a history of the abortion process (amount and duration of bleeding, side effects, cramping)			
• Asking about current cramping and current amount of bleeding			
• Conducting a physical examination			
If it is unclear whether the woman is still pregnant, discuses options:			
• Have another or more experienced clinician do an exam to check			
• Ask the woman to return in one week and re-check her (provided she would not be too far along then to receive a VA if needed)			
• Perform VA now			
• Perform an ultrasound, if available			
If the woman is no longer pregnant, provides:			
• Information on how to contact clinic if she has questions/problems			
• Information about return to fertility and contraception			
• A contraceptive method if desired by the woman			

For Participants

Medical Abortion Skills Checklist 2: Misoprostol-only Regimen

Follow-Up Visit *(continued)*	Yes	No	Comments
If the bleeding is prolonged or heavier than usual, discusses options:			
• Expectant management (depending on how heavy bleeding is)			
• Additional dose of misoprostol			
• Vacuum aspiration			
If the woman is still pregnant, discusses and provides (or refers her) for the recommended vacuum aspiration			
Provides information and makes referrals if needed about other reproductive health issues including domestic violence, cancer screening and HIV/AIDs			
Asks the woman whether she has additional questions			



For Participants

Contraceptive Counseling Scenarios

Trainer Instructions: Copy and cut this handout into strips, with one scenario per strip. Fold the strips and place them in a bowl, basket or envelope.

Scenario 1
A 20-year-old woman in good overall health had a MA with no complications. She does not want to get pregnant again. She does not trust methods with hormones and is interested in the IUD. She does not want her parents to know that she is using contraceptives. You think she may be a commercial sex worker.

Scenario 2
A 27-year-old woman who had a MA is back for her two-week follow-up visit. She was given condoms to use if needed before the return visit, but she says she didn't have sex during that time because she was still bleeding. She is still having light spotting but says she wants to start using a contraceptive because she thinks she'll have sex with her husband soon and doesn't want to become pregnant again right away.

Scenario 3
A 39-year-old woman with four children came to your facility seeking a MA. She and her husband decided before she came that she should get permanent contraception. She came to this facility for abortion care because she heard that you also perform female sterilization. She lives very far from the facility and does not know when she will be able to return.

Scenario 4
A 21-year-old woman with no children had a successful MA two weeks ago. She is monogamous with her current partner, denies sexual activity since her MA and desires an IUD or implant for contraception because she does not want children for several years. She reports feeling well and is continuing to have light bleeding.

Scenario 5
A married 36-year-old woman has had a recent MA. She says that she wants to have one more child but she wants to wait at least one year. She smokes and has high blood pressure. When you mention the IUD, she says that she is not interested because it might get lost inside her body.

Scenario 6
A 32-year-old woman with three children says that this is the second time she has had a MA. After the first abortion, she did not want contraceptive information because she had been using natural family planning for years. She and her husband believe that contraceptives cause cancer.

Scenario 7
A 16-year-old woman in good overall health had a MA with no complications. She does not want to get pregnant again, but is scared that contraceptive methods are dangerous and cause you to "lose your ability to have a child when you get married." She also does not want her parents to know that she is using contraceptives.

For Trainers

Contraceptive Counseling Scenarios Key Considerations

Instructions: Check whether the skill was performed or not and add comments as needed.

Scenario 1

A 20-year-old woman in good overall health had a MA with no complications. She does not want to get pregnant again. She does not trust methods with hormones and is interested in the IUD. She does not want her parents to know that she is using contraceptives. You think she may be a commercial sex worker.

Key Considerations:

1. Discuss discreet options including long-acting options such as IUDs
2. Screen for domestic and sexual violence
3. Provide STI/HIV screening and education
4. Discuss barrier methods that protect against STIs/HIV
5. Dispel myths about hormonal contraception

Scenario 2

A 27-year-old woman who had a MA is back for her two-week follow-up visit. She was given condoms to use if needed before the return visit, but she says she didn't have sex during that time because she was still bleeding. She is still having light spotting but says she wants to start using a contraceptive because she thinks she'll have sex with her husband soon and doesn't want to become pregnant again right away.

Key Considerations:

1. Discuss bleeding expectations post-MA
2. Discuss contraceptive options including long-acting reversible methods

---

Scenario 3

A 39-year-old woman with four children came to your facility seeking a MA. She and her husband decided before she came that she should get permanent contraception. She came to this facility for abortion care because she heard that you also perform female sterilization. She lives very far from the facility and does not know when she will be able to return.

Key Considerations:

1. Since she lives very far from the facility, consider whether there is a back-up for MVA if it is necessary or whether she will be able to return for MA follow-up (depending on which method she chooses)
2. Discuss long-acting reversible methods versus permanent methods
3. Provide an interim method of contraception until sterilization can be scheduled

For Trainers

Contraceptive Counseling Scenarios Key Considerations *(continued)*

Scenario 4

A 21-year-old woman with no children had a successful MA two weeks ago. She is monogamous with her current partner, denies sexual activity since her MA and desires an IUD or implant for contraception because she does not want children for several years. She reports feeling well and is continuing to have light bleeding.

Key Considerations:

1. Discuss when to initiate different types of contraception after MA
2. She may have an IUD or implant inserted today during this visit

---

Scenario 5

A married 36-year-old woman has had a recent MA. She says that she wants to have one more child but she wants to wait at least one year. She smokes and has high blood pressure. When you mention the IUD, she says that she is not interested because it might get lost inside her body.

Key Considerations:

1. Discuss progestin-only methods (pills, injections, implants) and barrier methods
2. Dispel myths regarding IUDs
3. Discuss smoking cessation
4. Mention pre-conceptual counseling (folic acid, immunizations)

Scenario 6

A 32-year-old woman with three children says that this is the second time she has had a MA. After the first abortion, she did not want contraceptive information because she had been using natural family planning for years. She and her husband believe that contraceptives cause cancer.

Key Considerations:

1. Discuss contraceptive options, non-contraceptive benefits and dispel myths
2. Discuss non-hormonal contraceptives, if this is the woman's decision, including the IUD and sterilization, depending upon her desire for future children
3. Discuss bleeding expectations and when she might be able to start using natural family planning post-MA

Scenario 7

A 16-year-old woman in good overall health had a MA with no complications. She does not want to get pregnant again, but is scared that contraceptive methods are dangerous and cause you to "lose your ability to have a child when you get married." She also does not want her parents to know that she is using contraceptives.

Key Considerations:

1. Discuss discreet options and dispel myths, including the myth that an MA harms future fertility or affects future children a woman may have
2. Discuss short-term methods versus long-acting reversible methods
3. Screen for domestic and sexual violence
4. Discuss barrier methods that protect against STIs/HIV

Unit Five: Follow-up Care

Time

One hour, 30 minutes

Unit Objectives

By the end of this unit, participants will be able to:

- Describe the purpose and key components of follow-up care
- Discuss methods for determining if a woman is still pregnant after taking MA
- Describe management approaches for "problematic bleeding" at follow-up
- Demonstrate skills in providing follow-up to women by phone
- Explain ways in which outreach workers can provide follow-up care

Advance Preparations

- ☐ Prepare flipchart with Unit Five Objectives.
- ☐ Copy Medical Abortion Phone Follow-up Role Plays.

Instructions and Materials

A. Providing Follow-Up Care (10 minutes)

Materials:

- Blank flipchart paper and stand, markers
- Pre-prepared flipchart: Unit Five Objectives (list)

1. Post and review flipchart: Unit Five Objectives
2. Explain that in-person follow-up is recommended after MA. Follow-up after vacuum aspiration is considered optional.
3. Summarize the purpose of the MA follow-up visit:
   - Examine the woman's overall health status
   - Evaluate that she is no longer pregnant (because the medications may be associated with birth defects if the pregnancy is not successfully aborted)
   - Assess that the woman's bleeding is within normal range
   - Determine whether heavy bleeding is affecting her health, or if an infection is present
   - Begin effective contraception or ensure previously initiated contraception is being used

4. Review the key components of the follow-up visit:
   - In-person visit is recommended two weeks after MA (***Note:*** *See Activity D below for information about follow-up by phone*)
   - Clinician works with the woman to determine that she is no longer pregnant through pelvic examination and bleeding and symptom history
   - Clinician can also provide contraception, if desired, and address any remaining questions or concerns

B. Confirming the MA Worked (15 minutes)

1. Ask participants to divide into pairs.

2. Ask each pair to spend a few minutes discussing:
   - Ways to confirm that the MA worked (she is no longer pregnant)
   - Specific questions to ask a woman to assess whether she is still pregnant

3. After a few minutes, ask some pairs to share their ideas, writing them on a flipchart at the front of the room.

4. The final list of steps and key questions should include:
   - Assess pregnancy symptoms experienced prior to and after the abortion, asking:
     - *"Do you still feel pregnant?"*
     - *"Have any pregnancy-related symptoms and signs (such as morning sickness and breast tenderness) gone away?"*
   - Assess the amount and timing of vaginal bleeding and cramping. Review the woman's symptoms, asking:
     - *"How many pads did you use?"*
     - *"Are you still bleeding?"*
   - Review adherence to the MA protocol:
     - *"Tell me how you took the pills."*
   - Perform a pelvic exam, and compare it to the exam completed before taking mifepristone. For example:
     - If the woman was up to seven weeks at the clinical assessment, the uterus should feel non-pregnant at a two week follow-up.
     - If the woman was eight weeks or more, the uterus should be smaller at the two week follow-up.
   - The MA most likely worked if:
     - the woman's pregnancy symptoms have stopped
     - her bleeding pattern is normal
     - her uterine size is non-pregnant or smaller than before
   - If there is still in doubt about whether the MA worked, discuss treatment options:
     - Have another or more experienced clinician do an exam to check

- ▸ Ask the woman to return in one week and re-check her (provided she would not be too far along then to receive a VA if needed)
- ▸ Perform VA now
- ▸ Perform an ultrasound, if available

- If there is doubt about whether a pregnancy is still ongoing, the above options have not been extensively studied but they have been successfully used in various low-resource settings. Providers in each setting must consider which options are most readily available and realistic. The only measure that has been studied for determining whether a pregnancy is ongoing is ultrasound.

C. What to Expect after MA (20 minutes)

1. Review what providers and women can expect under "normal" circumstances from the time women take their medicines (as instructed) until the follow-up visit.
   - Usually, the woman starts feeling better the day after taking misoprostol and, by the time of the follow-up visit, will not feel pregnant.
   - Bleeding and cramping can be significant the first day after taking misoprostol but these symptoms diminish over the next week.
   - Bleeding for several weeks can vary from a menstrual type flow to light spotting.

2. Explain that some women experience bothersome or problematic bleeding at follow-up, even when they no longer have pregnancy symptoms and their uterine size is smaller.
   - If bleeding is problematic but not severe, there are several options:
     - ▸ Wait and watch for a few weeks
     - ▸ Repeat the dose of misoprostol
     - ▸ Perform vacuum aspiration
   - The vacuum aspiration option should be available to women who are tired of the bleeding and request vacuum aspiration.
   - Problematic bleeding depending on the severity may be a reason to perform a vacuum aspiration.

3. Ask participants to describe different patterns of problematic bleeding and recommend strategies for managing them. Write participants' recommendations on flipcharts. Ensure that responses include:
   - Persistently Heavy Bleeding (continuous bleeding like a menstrual cycle since taking misoprostol)

   Strategies:
   - ▸ If the woman has clinical symptoms of low blood volume due to bleeding (fatigue, weakness especially upon standing, racing pulse, feeling faint), and/or if hemoglobin or hematocrit has dropped significantly from the initial value, vacuum aspiration should be performed.
   - ▸ In cases of prolonged or erratic bleeding - when a woman is clinically stable - a repeat dose of misoprostol may be offered as long as the woman is willing to return in one to three days for assessment to determine that bleeding is diminishing.
   - ▸ Although it is common practice to give a second dose of misoprostol, the evidence is not clear whether this decreases bleeding.

- ▸ Increased fluid intake (oral hydration) and iron-rich foods or iron supplements should be strongly encouraged.

- Erratic Bleeding (days of very little or no bleeding followed irregularly by heavy, gushing bleeding)

Strategies:

- ▸ If the woman is symptomatic of anemia, consider performing vacuum aspiration.
- ▸ Increased fluid intake (oral hydration) and iron-rich foods or iron supplements should be strongly encouraged.

- Delayed Bleeding (very rarely, after a normal follow-up exam and several weeks of little or no bleeding, a woman will experience sudden, heavy bleeding)

Strategies:

- ▸ Treat the woman according to the severity of clinical presentation.
- ▸ Hemorrhage (***Note:*** *discussed in Unit Six: Problems, Complications and Emergencies.*)

D. Phone Counseling (45 minutes)

Materials:

- Medical Abortion Phone Follow-up Role Plays

1. Explain that there are two situations in which follow-up counseling can be provided effectively over the phone, but only if proper information, guidance and counseling first have been provided at the initial visit:
   - When women do not return to the clinic for their follow-up visit
   - When women call the clinic after taking MA with questions or concerns
2. Ask the group to brainstorm some potential challenges in providing information and counseling to women over the phone (versus in person). Possible challenges include:
   - Lack of non-verbal cues (nods, body language)
   - No direct observation to facilitate understanding
   - Language barriers
3. Tell participants that the majority of phone calls about MA involve straightforward questions for which a woman seeks reassurance. Typical questions include:
   - Whether a woman is bleeding enough
   - Whether a follow-up visit is needed
   - Whether activities such as sexual activity, bathing or swimming are allowed
4. Tell participants they will now practice providing effective counseling in a "phone role play" activity.
   - Divide participants into eight groups.
   - Give each group a different role play.
   - Ask the groups to spend five minutes preparing the role play. They should choose one group

member to play a "woman" calling the clinic for help, and another group member to play a "provider" who will offer counseling over the phone. The provider should focus on providing support and asking probing questions. They should prepare role plays to last only a few minutes (no more than five).

- Bring members of the first team to the front of the room.
- Have the "woman" and the "provider" sit facing away from each other (back-to-back); ask them to complete the role play, simulating a phone conversation.
- At the end of the role play, briefly review the case and the recommended course of action.
- Complete this process with all eight groups.

5. After all the groups have completed their role plays, discuss the following questions with the full group:
   - *What was challenging about counseling over the "phone"?*
   - *What effective strategies did the providers use to address these challenges?*
   - *How did it feel to be the caller?*
   - *Did the providers address all of your concerns as caller?*

6. Where phone access is not possible or easy, outreach workers can sometimes help provide follow-up care. However, because abortion is still highly stigmatized in many settings, outreach workers should take great care to protect women's privacy and confidentiality when conducting outreach visits.

7. Discuss recent study on telephone follow-up.
   - A recent study showed that asking certain questions over the phone and performing a urine pregnancy test 30 days after the mifepristone was a feasible alternative to routine follow-up (Perriera 2009). Women were called approximately a week after taking mifepristone. The standardized questions they were asked were:
     1. *Did you have cramping and bleeding heavier than a period?*
     2. *Did you pass clots or tissue?*
     3. *What was the highest number of pads you soaked per hour?*
     4. *Do you still feel pregnant now?*
     5. *Do you think you passed the pregnancy?*
   - If the woman or the clinician did not think the pregnancy had passed after asking these questions, the women was asked to return to the clinic within seven days. Of the women who were contacted, only 6 percent were asked to return to the clinic for follow-up (eight out of 133 women). Of those eight women, only two had an ongoing pregnancy. At 30 days, 116 women performed a urine pregnancy test at home. 29 women had a positive or inconclusive test and were asked to return to the clinic. 26 women returned to the clinic, and of these, there were no continuing pregnancies. Through the phone screening and the pregnancy test, 72 percent of women were successfully evaluated without having to return to the clinic.

8. Ask learners whether they think a trained outreach worker could ask these questions to women who had MA but did not return for the follow-up. Discuss whether they think outreach workers could perform urine pregnancy tests and correctly read the tests.

9. Discuss how, in participants' settings, outreach workers might help to assess whether a woman who had MA should return to the clinic for assessment.

Unit Five: Materials

1. Phone Follow-Up Role Plays *(for participants)*

For Participants

Medical Abortion Phone Follow-up Role Plays

Case 1

Woman: You are 19 years old and having a MA of an eight -week pregnancy. You took your misoprostol six hours ago. For the last two hours, you have been bleeding heavily and soaked through one large pad. You do not feel bad—just worried due to all the bleeding. You decide to call the clinic to make sure everything is all right.

Provider: This woman's situation sounds like a normal bleeding pattern after MA. It is important to confirm that she has no symptoms of excessive blood loss (dizziness, feeling faint or very weak). Reassure her that bleeding is a normal part of the process. The bleeding suggests that the medication is working and it should decrease in the next few hours. Suggest that you can call her in a few hours to check on her status.

Case 2

Woman: You are a 25-year-old mother of two small children who was eight weeks pregnant when you took misoprostol three days ago. You had bleeding heavier than a menstrual period for a day and now your bleeding is like a normal menstrual period. You bought a pregnancy test at the pharmacy and the result is positive. You are very worried that the MA failed.

Provider: Pregnancy hormones (hCG) drop sharply when a woman has a successful MA. However, the hormonal level is at its height at eight to nine weeks in pregnancy, and it may take weeks for the level to drop lower than the sensitivity of the urine test. Reassure the woman that the pregnancy test does not mean the MA was unsuccessful. Tell her that the pregnancy test is not accurate this early after the MA and advise her not to do any more pregnancy tests before you see her at the follow-up visit. Reassure her that you will assess whether the MA was successful.

Case 3

Woman: You are 35 years old and are having a MA. You took your misoprostol under the tongue (sublingually) at the clinic this morning. As soon as you returned home one hour later, you began vomiting. You have felt sick over the last few weeks but not like this, and you are afraid you may have vomited the pills the nurse gave you. You call the clinic to see if you should be worried.

Provider: If it has been more than 30 minutes since she took misoprostol, there is likely enough misoprostol in her bloodstream to complete the abortion. If a woman vomits immediately after ingesting misoprostol, an additional dose should be given. Reassure her that vomiting can be a side effect of misoprostol. Ask her if she would like a family member to pick up a prescription for an anti-emetic (since she has already vomited, a rectal suppository may be the best route). For women who are experiencing frequent vomiting with their pregnancy, it may help to give them crackers to settle their stomach before giving them the misoprostol.

For Participants

Medical Abortion Phone Follow-up Role Plays

Case 4

Woman: You are an 18-year-old woman who was eight weeks LMP when you received MA. You call the clinic today, two days after taking misoprostol, because your bleeding was only as heavy as a normal period. You are worried that you did not bleed as much as you were told to expect and thus the MA did not work.

Provider: Women experience a range of bleeding when undergoing MA. Many women bleed more than normal menstrual period but for some, bleeding is lighter than a menstrual period. Ask the young woman if her pregnancy symptoms have gone away or are subsiding. Reassure her that bleeding like a normal period is within the range of bleeding expected, and that the MA was probably successful. Remind her to return for her follow-up visit. While it is good to prepare women for bleeding that is significantly heavier than a menstrual period, possibly with large clots, it is always helpful to explain that a range of bleeding is possible, from bleeding lighter than a menstrual period to bleeding that is much heavier than a normal period. As long as there is some bleeding, it is a reassuring sign that the MA is working.

Case 5

Woman: You are 22 and having a MA of a seven-week pregnancy. You took your misoprostol four hours ago. You have such bad cramps that it is hard to stand. You have taken paracetemol but it has not helped the cramping. Additionally, you have soaked through two large pads in the last hour, and you remember the doctor saying something about this being bad.

Provider: This woman is experiencing uncontrolled pain which likely is a sign of the pregnancy passing, but it might be a rare occurrence such as tissue trapped in the os or, more unlikely, an ectopic pregnancy. Over the phone, try to get a description of her pain and assess whether she has access to clinical follow-up care. Is it a sharp pain localized to one part of her body or is it cramping pain like when she has her period? If available, advise her to take ibuprofen (which works better than paracetemol). She might also try applying a hot water bottle or hot cloth to the painful area. It sounds like she is worried and this anxiety can increase pain, so try to answer any questions about bleeding or other concerns. The bleeding is only a problem if it continues at this rate for several hours and if she is symptomatic (dizzy, weak, faint). If she tries all of this, and the bleeding and pain do not improve in the next hour, ask her to come to the clinic for evaluation and stronger pain medicines if necessary.

Case 6

Woman: You are 21 and having a MA of a seven-week pregnancy. You took the misoprostol at home as instructed and started bleeding as the clinic staff described. Your bleeding started as dark clots but now is bright red and you have soaked six pads in the last three hours. You felt dizzy and light-headed the last time you got up to change your pad and now you are very worried.

Provider: This woman is experiencing very heavy bleeding that needs urgent treatment which cannot be provided over the phone. The woman is experiencing symptoms of blood loss such as dizziness suggesting this is severe bleeding or hemorrhage. Ask if a family member is with her. Someone should accompany her to the clinic immediately. She will probably need vacuum aspiration (unless the bleeding has completely subsided by the time she reaches the clinic). You can offer to speak with a friend or relative about why she must be taken to the clinic immediately.

For Participants

Medical Abortion Phone Follow-up Role Plays

Case 7

Woman: You are 17 years old and your friend is with you as you undergo an MA. You took the misoprostol 10 minutes ago but nothing has happened. You and your friend are both very worried that the MA is not working.

Provider: Bleeding and cramping may start within thirty minutes to several hours of taking misoprostol. Reassure the young woman and her friend that 10 minutes is not enough time for the medicines to have taken effect. If she has had no bleeding within 24 hours, tell her to call you back. Remind her to take ibuprofen if she experiences painful cramping. Be mindful in your response that the adolescent is genuinely worried and that even though this is not a clinical emergency, the concern is real to her.

Case 8

Woman: You took your 15-year-old daughter to the clinic five days ago, where she had a MA. She has been bleeding, but not too heavily, so she is not sure she has passed the pregnancy. Tonight she cannot sleep and is hot and dizzy. She has a fever as well as a vaginal discharge in addition to her light bleeding. You are worried so you call the clinic.

Provider: The daughter likely has an infection and should seek immediate attention for antibiotics and possible vacuum aspiration. Over the phone, you should assess the daughter's bleeding and fluid intake over the last few days. Also, ask if she placed anything in her vagina other than the medicines given her. Emphasize the importance of seeking health care immediately.

Unit Six: Problems, Complications and Emergencies

Time

One hour, 15 minutes

Unit Objectives

By the end of this unit, participants will be able to:

- Demonstrate an ability to identify and manage MA problems, complications and emergencies
- Describe elements of a good emergency response system

Advance Preparations

- ☐ Prepare flipchart with Unit Six Objectives.
- ☐ Cut up Medical Abortion Problems, Complications and Emergencies Case Studies into strips.
- ☐ Copy Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key

Instructions and Materials

A. Overview of Problems and Complications (10 minutes)

Materials:

- Blank flipchart paper, markers, masking tape, basket, and easel
- Pre-prepared flipchart: Unit Six Objectives (list)

1. Post and review flipchart: Unit Six Objectives
   - Explain that problems and complications from MA are rare. Review the following key points:
   - Most women who take MA do not experience problems or complications.
   - When complications occur, timely treatment can prevent them from becoming true health emergencies.
   - One of the most important ways to ensure the timely and effective management of complications is to make sure women know how to recognize warning signs of complications, and know when and where to seek treatment.
2. Occasional complications of MA include:
   - Hemorrhage
   - Infection

4. Two other problems are possible but are not complications of MA:
   - Continuing pregnancy after MA (also known as "ongoing pregnancy") should be viewed as a treatment failure.
   - Ectopic pregnancy is a different type of emergency that MA will not resolve.

5. When women experience complications, continuing pregnancy, or ectopic pregnancy:
   - Clinicians should provide clear, timely and accurate information about what to expect and about all treatment options.
   - Women should be included in decisionmaking about their treatment options.
   - Women should be provided with clear instructions and educational materials to help them adhere to treatment instructions and manage their stress and pain.

B. Case Studies (50 minutes)

Materials:

- Handouts:
  - ▸ *Medical Abortion Problems, Complications and Emergencies Case Studies*
  - ▸ *Medical Abortion Problems, Complications and Emergencies Answer Key*

1. Remind participants that most client concerns and phone calls are not about true complications. Most questions and concerns that women have simply require reassurance. However, it is important to be able to distinguish potential emergencies from questions that can be managed with reassurance.

2. Tell participants that they are going to discuss case studies to practice diagnosing and managing problems, complications and emergencies after MA.
   - Divide participants into five small groups, and assign each group two case studies (without the answer key).
   - Ask each group to diagnose the situation described in their case study and recommend appropriate treatment options.
   - Remind participants that they may refer to the *MA Study Guide* as they prepare their answers.
   - Ask each group to prepare a flipchart with a brief summary of the diagnosis and recommended management strategies.
   - After 5-10 minutes, bring the whole group back together and ask each group to briefly present their case study.
   - Using the answer key as a guide, seek consensus from the group about the diagnosis and management of each case.
   - Summarize the symptoms and recommended management strategies for each situation, adding any missing information if needed.
   - Distribute the answer key to all participants for future reference.

C. Responding to Medical Emergencies (15 minutes)

1. Review the role and components of emergency response systems.
   - Although severe complications after MA are rare, all facilities should be prepared to handle or refer severe complications and medical emergencies.

- All facilities should have emergency response plans in place so that they can respond quickly and efficiently when emergencies occur.
- Sometimes the woman may need to be transferred to higher levels of care.

2. Ask participants if they have emergency response plans at their facilities. Ask them to share the different components of an emergency response plan, including key personnel and referral systems. Write ideas on a flipchart. Key points include:
   - On-call clinicians (for 24-hour response)
   - Established relationships with referral facilities
     - ▸ Memorandums of understanding or formal facility-to-facility relationships
     - ▸ Easily accessible emergency contact numbers for information sharing in case of emergency transfer
     - ▸ Systems for sharing medical records between facilities
   - Emergency transport systems
   - Emergency supplies
   - Written emergency plans
   - Drills or practice for emergencies by health-care staff
3. Ask participants what they have done (or what could be done) to establish and strengthen relationships with referral facilities. Add these ideas to the flipchart. Ideas may include:
   - Visits between facilities
   - Information-sharing
   - Orientation on MA

Unit Six: Materials

1. Medical Abortion Problems, Complications and Emergencies Case Studies *(for participants)*

2. Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key *(for trainers and participants)*

For Participants

Medical Abortion Problems, Complications and Emergencies Case Studies

Case Study 1

A 19-year-old woman who was approximately seven weeks pregnant when she had a MA contacts the clinic because she continues to have vaginal bleeding 30 days after a MA. She had a follow-up visit two weeks after taking misoprostol and no longer felt pregnant at that visit. She had heavy cramping and bleeding the day she took misoprostol and diminished bleeding with some spotting thereafter, but is worried because she is now using three pads every day. Her bleeding alternates between a light to moderate period but the pads are not saturated. The bleeding is gradually growing lighter over time. She is not feeling lightheaded or dizzy.

Question: *What is the likely diagnosis and what advice can you offer her?*

Case Study 2

A young woman calls you at midnight two hours after taking misoprostol and she is alarmed. She is bleeding like a heavy period, soaking one pad per hour, but what is upsetting her is that she is passing clots the size of lemons (or clots the size of a small person's fist). She has intense cramps right before she passes a clot, and then once the clot passes, the cramps decrease. She has never seen clots this big and is worried she needs emergency help.

Question: *What is the likely diagnosis and what advice can you offer her?*

Case Study 3

A 26-year-old woman who was eight weeks pregnant when she received her MA returns for her follow-up visit two weeks later. She had little bleeding after taking the misoprostol and is wondering if there is anything wrong. When you review the MA protocol with her she reports taking the medicines correctly and has had no vomiting. She is in no pain but complains of breast tenderness. You do a pelvic exam and her uterus is larger than at your last exam.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

Case Study 4

A 35-year-old woman is approximately eight weeks pregnant as indicated by LMP and wants a MA. She is having some spotting and wonders if she is having a miscarriage. On pelvic exam you feel a retroverted uterus approximately six–eight week size and speculum exam shows a closed cervical os with no blood. She has no uterine or pelvic tenderness. She is given the medicines for MA with full instructions about how to take them. She returns to the clinic after three days and reports that she had very little bleeding after she took the medicines. The main reason she is returning is because she is having some sharp left lower abdominal pain, but not like menstrual pain, and she continues to feel pregnant. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at your site.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

For Participants

Medical Abortion Problems, Complications and Emergencies Case Studies

Case Study 5

A 20-year-old woman was nine weeks LMP at the time she received MA. Her bleeding was heavier than a period for three days, and she noticed some clots in the first four hours after taking misoprostol. She had cramps which she described as severe, but they were helped with ibuprofen. She is in the clinic for follow-up two weeks after her MA. You perform a pelvic examination and her uterus is non-tender and is non-pregnant size. However, her pregnancy test is still positive.

Question: *What is the likely diagnosis and what advice do you give her?*

Case Study 6

The sister of a 22-year-old woman contacts the clinic because her sister has soaked seven pads in the last three hours after taking misoprostol two hours ago at approximately eight weeks of pregnancy. She says her sister is very weak, cannot stand without becoming dizzy, and is worried.

Question: *What is the likely diagnosis and what advice do you give to the woman about her sister?*

Case Study 7

A 28-year-old woman reports abdominal tenderness four days after taking misoprostol. She first noticed it when her small son was sitting on her lap. She is concerned because the pain is now severe. She has a fever and feels generally unwell. She had a mild fever and chills after taking the misoprostol, but thought this was a side effect of the medicines.

Question: *What is the likely diagnosis and what advice do you give her?*

Case Study 8

A 17-year-old woman was eight weeks at the time she received MA. She is returning for her follow-up visit two weeks later. She had a day of very heavy bleeding the day she used misoprostol, but the bleeding steadily declined after the first day. She resumed her normal activities the day after using misoprostol. She feels that she is no longer pregnant but complains of intermittent cramping. When you perform a pelvic examination, the uterus is non-pregnant size and non-tender. Her bleeding is like a light menstrual period. You look at her cervix and see that her os is open and there appears to be a rubbery clot or piece of tissue in the os.

Question: *What is the likely diagnosis and what advice do you give her?*

For Participants

Medical Abortion Problems, Complications and Emergencies Case Studies

Case Study 9

A 21-year-old woman with three small children requested a MA at about seven weeks LMP. By pelvic examination, her uterine size was about eight weeks. Her husband calls you three hours after she took misoprostol, very upset that she is bleeding so heavily. He knew she was having an abortion with pills but he is frightened that this is dangerous for her. You ask to speak to the woman. She tells you that she is bleeding like a very heavy period. She soaked two pads for an hour and is now saturating one pad per hour. She noticed large clots and had intense cramps for about an hour. Then she took ibuprofen, which helped. She feels she expelled the pregnancy and now her bleeding and cramping are diminishing. Her husband's anxiety is worrying her, but she herself does not think what is happening is different from the experience she was told to expect.

Question: *What is the likely diagnosis and what advice can you offer?*

Case Study 10

A 16-year-old woman seeking a MA came to your clinic with her mother and after counseling and consent, received mifepristone. Her mother planned to be home to support her on the day she took misoprostol. The young woman's father, the mother's husband, was expected to be away for at least a week. He unexpectedly returned home the day before the young woman was supposed to take the misoprostol. They are both very worried that the father will find out that the young woman was pregnant and will be very angry and perhaps even become violent with them or the young woman's boyfriend. The young woman calls to ask what she should do.

Question: *What is the likely diagnosis and what advice can you offer?*

For Trainers and Participants

Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key

The majority of women undergoing medical abortion do not have any problems or complications. Problems following MA, if they occur, can range from minor to true emergencies. Major complications are rare, but can sometimes be avoided by intervening at the right time with the proper treatment.

Case Study 1

A 19-year-old woman who was approximately seven weeks pregnant when she had a MA contacts the clinic because she continues to have vaginal bleeding 30 days after a MA. She had a follow-up visit 2 weeks after taking misoprostol and no longer felt pregnant at that visit. She had heavy cramping and bleeding the day she took misoprostol and diminished bleeding with some spotting thereafter, but is worried because she is now using 3 pads every day. Her bleeding alternates between a light to moderate period but the pads are not saturated. The bleeding is gradually growing lighter over time. She is not feeling lightheaded or dizzy.

Question: *What is the likely diagnosis and what advice can you offer her?*

Diagnosis: Prolonged Bleeding

Discussion: Many clinicians (and sometimes the women themselves) are concerned about prolonged bleeding, especially if it was not anticipated. Bleeding time is variable with MA, but can continue for as long as 45 days. This woman needs reassurance that she is having variable bleeding that is a normal part of MA. She has no signs of hypovolemia. As long as the general pattern of bleeding is that it is diminishing over time, this is normal. If a pre-procedure hemoglobin was performed, it would be helpful to compare it with the current hemoglobin.

The woman should be informed of three choices to manage problematic prolonged bleeding:

1. Wait and watch (reassurance)
2. A second dose of misoprostol to assist with uterine contractility and expel residual tissue (if any). Although a second dose of misoprostol is widely used for this purpose, its efficacy has not been specifically studied. If she is given a second dose of misoprostol for prolonged bleeding, she should be contacted or assessed again about a week later to determine if bleeding has diminished.
3. Vacuum aspiration

Encourage iron-rich foods and provide iron tablets if available.

For Trainers and Participants

Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key *(continued)*

Case Study 2

A young woman calls you at midnight two hours after taking misoprostol and she is alarmed. She is bleeding like a heavy period, soaking one pad per hour, but what is upsetting her is that she is passing clots the size of lemons (or clots the size of a small person's fist). She has intense cramps right before she passes a clot, and then once the clot passes, the cramps decrease. She has never seen clots this big and is worried she needs emergency help.

Question: *What is the likely diagnosis and what advice can you offer her?*

Diagnosis: Normal MA process

Discussion: Comprehensive information prior to the MA could have helped this woman avoid unnecessary anxiety and an after-hours phone call. Her bleeding (heavier than a period, soaking one pad per hour) is normal after taking misoprostol and it is common to see large blood clots. Reassure her that the medicines are working and that she is almost certainly in the process of aborting the pregnancy, and that what she is experiencing is normal. Remind her of the warning signs that should prompt her to call you. If you're willing, tell her to call you in two hours to report how she is doing. In most cases, having a reassuring, experienced person available to women is all that is needed. Ibuprofen may provide some pain relief so remind her to take it as directed.

Case Study 3

A 26-year-old woman who was eight weeks pregnant when she received her MA returns for her follow-up visit two weeks later. She had little bleeding after taking the misoprostol and is wondering if there is anything wrong. When you review the MA protocol with her she reports taking the medicines correctly and has had no vomiting. She is in no pain but complains of breast tenderness. You do a pelvic exam and her uterus is larger than at your last exam.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

Diagnosis: Ongoing pregnancy

Discussion: These symptoms indicate a failed MA. The pelvic exam suggests a growing pregnancy. Vacuum aspiration is recommended. Aspiration of pregnancy tissue will rule out ectopic pregnancy and complete the abortion.

For Trainers and Participants

Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key *(continued)*

Case Study 4

A 35-year-old woman is approximately eight weeks pregnant as indicated by LMP and wants a MA. She is having some spotting and wonders if she is having a miscarriage. On pelvic exam you feel a retroverted uterus approximately six to eight-week size and speculum exam shows a closed cervical os with no blood. She has no uterine or pelvic tenderness. She is given the medicines for MA with full instructions about how to take them. She returns to the clinic after three days and reports that she had very little bleeding after she took the medicines. The main reason she is returning is because she is having some sharp left lower abdominal pain, but not like menstrual pain, and she continues to feel pregnant. Blood pressure, pulse and temperature are all within normal range. No ultrasound is available at your site.

Question: *What is the likely diagnosis and what treatment options do you recommend?*

Diagnosis: Possible Ectopic pregnancy

Discussion: These symptoms indicate a possible ectopic pregnancy and this woman needs immediate medical attention. The initial pelvic exam may have been difficult because of the position of her uterus and uterine enlargement is common even if the pregnancy is ectopic. The pain and lack of history of expulsion of the pregnancy (little bleeding and cramping pain) suggest that there was not an intrauterine pregnancy (or a failed abortion of an intrauterine pregnancy). You may be able to feel an adnexal mass on exam, although it is rare to palpate an adnexal mass of ectopic pregnancy. An ectopic pregnancy can be life-threatening and the sharp pain may indicate that rupture is imminent. However, the woman's vital signs are stable and she does not appear to have a "surgical abdomen" (also known as "rigid abdomen") or signs indicating that she is in shock. The woman should either: 1) be given an MVA on site to identify whether an intrauterine pregnancy is present, and if so, perform the abortion or 2) if MVA on site is not immediately available, she should be transferred immediately to a facility that can confirm diagnosis with ultrasound and begin treatment if ectopic pregnancy is confirmed. If the woman is not in stable condition or has signs of a surgical abdomen, MVA should not be performed on site; she should be transported to the nearest facility with or without ultrasound where the woman can be assessed and surgery can be performed, if indicated.

Case Study 5

A 20-year-old woman was nine weeks LMP at the time she received MA. Her bleeding was heavier than a period for three days, and she noticed some clots in the first four hours after taking misoprostol. She had cramps which she described as severe, but they were helped with ibuprofen. She is in the clinic for follow-up two weeks after her MA. You perform a pelvic examination and her uterus is non-tender and is non-pregnant size. However, her pregnancy test is still positive.

Question: *What is the likely diagnosis and what advice can you offer?*

Diagnosis: Successful medical abortion

Discussion: A positive pregnancy test does not provide useful information two weeks after MA. Her urine beta hCG (pregnancy hormones) would have dropped sharply after a successful MA, but they are at their peak level around 8-9 weeks (Callen 2000). Even if the MA was successful (as all clinical findings indicate in this case), her pregnancy test would very likely still be positive. In other words, a negative pregnancy test would be reassuring but a positive test does not mean much (Perriera 2009). Pregnancy tests after MA generally add confusion, not clarification at the MA follow-up. This woman has had a successful MA and no further follow-up is required.

For Trainers and Participants

Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key *(continued)*

Case Study 6

The sister of a 22-year-old woman contacts the clinic because her sister has completely soaked through seven pads in the last three hours after taking misoprostol two hours ago at approximately eight weeks of pregnancy. She says her sister is very weak, cannot stand without becoming dizzy, and is worried.

Diagnosis: Hemorrhage

Question: *What is the likely diagnosis and what advice do you give to the woman about her sister?*

Discussion: The woman is experiencing excessive blood loss or hemorrhage, and requires medical attention immediately. The dizziness and consistent bleeding of more than two pads per hour over a few hours is concerning. Her sister should take her to a facility that offers vacuum aspiration; she may also need rehydration or a blood transfusion depending on her status and the site's capability to administer blood transfusion.

Case Study 7

A 28-year-old woman reports abdominal tenderness four days after taking misoprostol. She first noticed it when her small son was sitting on her lap. She is concerned because the pain is now severe. She has a fever and feels generally unwell. She had a mild fever and chills after taking the misoprostol, but thought this was a side effect of the medicines.

Question: *What is the likely diagnosis and what advice do you give her?*

Diagnosis: Infection

Discussion: These symptoms are consistent with a uterine infection or endometritis. The abdominal tenderness and persistent fever is not a typical side effect of the misoprostol. Transient fever caused by misoprostol should not last past the day the woman takes misoprostol. She should be evaluated by a clinician and given antibiotics for the infection.

For Trainers and Participants

Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key *(continued)*

Case Study 8

A 17-year-old woman was eight weeks at the time she received MA. She is returning for her follow-up visit two weeks later. She had a day of very heavy bleeding the day she used misoprostol, but the bleeding steadily declined after the first day. She resumed her normal activities the day after using misoprostol. She feels that she is no longer pregnant but complains of intermittent cramping. When you perform a pelvic examination, the uterus is non-pregnant size and non-tender. Her bleeding is like a light menstrual period. You look at her cervix and see that her os is open and there appears to be a rubbery clot or piece of tissue in the os.

Question: *What is the likely diagnosis and what advice do you give her?*

Diagnosis: Tissue trapped in the cervical os

Discussion: Occasionally a large clot or rubbery tissue can get trapped in the cervical os. This can be painful, sometimes very painful, and can result in persistent cramping. By the two-week follow-up visit, women are normally not experiencing cramping. The quickest and simplest treatment is to see if you can draw the tissue out of the cervix using a ring forceps or similar grasping instrument. If the tissue breaks up and cannot be pulled out, vigorous uterine massage may help dispel the clot. If uterine massage does not dispel the tissue lodged in the cervix, the woman can be managed either by: 1) giving a repeat dose of misoprostol to soften the cervix and cause uterine contractions to dispel the clot OR 2) vacuum aspiration. Either treatment is acceptable. Ask the woman which treatment she prefers. If you give her a repeat dose of misoprostol, as long as the cramping subsides within a day of the misoprostol and she feels fine, it is not necessary to schedule another follow-up visit.

Case Study 9

A 21-year-old woman with three small children requested a MA at about seven weeks LMP. By pelvic examination, her uterine size was about eight weeks. Her husband calls you three hours after she took misoprostol, very upset that she is bleeding so heavily. He knew she was having an abortion with pills but he is frightened that this is dangerous for her. You ask to speak to the woman. She tells you that she is bleeding like a very heavy period. She soaked two pads for an hour and is now saturating one pad per hour. She noticed large clots and had intense cramps for about an hour. Then she took ibuprofen, which helped. She feels she expelled the pregnancy and now her bleeding and cramping are diminishing. Her husband's anxiety is worrying her, but she herself does not think what is happening is different from the experience she was told to expect.

Diagnosis: Normal MA process, spousal anxiety

Discussion: The woman is having a normal MA. Her husband is anxious for her. This is common, especially if the husband (or friend, mother, or other support person) was not present in the clinic to hear information about the range of experience with MA. Reassure the woman and ask her if she wants you to speak to her husband. If she gives you permission to speak to her husband, talk to him, explaining the normal process of MA and the warning signs that should prompt seeking care. Reassure him that what his wife is experiencing is completely normal and that it means that the medicines almost certainly worked, and that the bleeding and cramping are decreasing. All these are good signs. Reassure him that either he or his wife can call again if they have questions or concerns. During initial counseling in the health center, having a husband or support person join the woman to listen to the counseling information can prevent unnecessary anxiety and increase the level of support the woman receives at home.

For Trainers and Participants

Medical Abortion Problems, Complications and Emergencies Case Studies Answer Key *(continued)*

Case Study 10

A 16-year-old woman seeking a medical abortion came to your clinic with her mother and after counseling and consent, received mifepristone. Her mother planned to be home to support her on the day she took misoprostol. The young woman's father, the mother's husband, was expected to be away for at least a week. He unexpectedly returned home the day before the young woman was supposed to take the misoprostol. They are both very worried that the father will find out that the young woman was pregnant and will be very angry and perhaps even become violent with them or the young woman's boyfriend. The young woman calls to ask what she should do.

Diagnosis: Possible danger of domestic violence

Discussion: Because of the father's unexpected return, and the misgivings about his reaction to the young woman's pregnancy and abortion, their home is no longer a safe place for her to take the misoprostol. Discuss various alternatives with the young woman, and if she gives permission to bring her mother into the conversation, include her mother in the conversation as well. Alternatives may be:

1) If the father works or will reliably be out of the house for several hours, take the misoprostol at that time.
2) Ask if there's another supportive and discreet family member, such as an aunt or grandmother, where the young woman may take the misoprostol and spend the day.
3) If feasible, offer the young woman the choice of coming to the clinic to take the misoprostol there and spend several hours at the clinic until the pregnancy has passed.
4) If feasible, offer the young woman the choice of MVA.

Unit Seven: Service Delivery

Time

One hour, 30 minutes

Unit Objectives

By the end of this unit, participants will be able to:

- Describe the MA service delivery requirements that need to be in place at sites to ensure high-quality, woman-centered care
- Identify and prioritize key aspects of high-quality MA services in their own setting, including needed changes and how to accomplish them
- Describe the benefits and challenges of using MA at home (or in a safe space) and in clinic settings
- List several barriers to accessing MA care and ways to overcome those barriers

Advance Preparations

- ☐ Prepare flipchart with Unit Seven Objectives.
- ☐ Copy handout worksheet: Preparing a Site to Provide MA
- ☐ If appropriate, gather information about local resources for MA providers, including professional associations and distributors of mifepristone and misoprostol. Distribute this information to participants at the end of the session.

Instructions and Materials

A. MA Service Delivery Considerations (45 minutes)

Materials:

- Blank flipchart paper and stand, markers, tape
- Presentation materials for groups (e.g. poster board, flipchart paper, markers, note cards, blank paper, magazines with images depicting women, scissors, etc.)
- Pre-prepared flipchart: Unit Seven Objectives (list)
- Worksheet: Preparing a Site to Provide MA Services

1. Post and review flipchart: Unit Seven Objectives
2. Explain that a number of service-delivery elements need to be in place to provide women with high-quality MA services, including:
   - Facilities

- Supplies
- Staff and referral systems
- Quality control mechanisms

3. Ask participants to name the different service-delivery components to consider when providing MA.
   - Write their answers on a flipchart.
   - Ask participants to look at the section of the *MA Study Guide* in Module Eight (Service Provision) titled: Providing Woman-centered Medical Abortion.
   - Ask for different volunteers to read each section aloud; for each section, invite participants to comment on and discuss the following:
     - ▸ *Are there any service-delivery components that are missing from the list?*
     - ▸ *Are there things on the list that are unnecessary in your setting and if so, why?*
   - For the section on "Staff Knowledge, Attitudes and Skills" remind participants that provider attitudes should be positive, helpful and non-discriminatory toward all women seeking MA, regardless of their age, marital or HIV/AIDS status.
   - Point out the linkage between good record keeping and confidentiality. Adult and young women alike have the right to confidentiality, and identify confidentiality as a key component of good care.

4. Hand out the worksheet, Preparing a Site to Provide MA Services.
   - Ask participants to take 15 minutes to think about the MA elements that are or are not currently in place in their own clinic sites, taking notes on the worksheets.
     *(**Note**: If several participants work at the same site, they should complete the worksheet as a team)*
   - Ask participants (or teams) to select two changes and improvements that their sites need to make immediately in order to begin or improve MA services.
   - Ask participants to list on a flipchart the specific steps and support needed to make the selected changes.
   - Post the flipcharts on the walls around the room.
   - Invite participants to walk around and look at each other's ideas. Reconvene the group (after 5-10 minutes) and spend about five minutes discussing common themes.
     *(**Note**: The exchange of ideas can be done during a tea break, with participants circulating during the break)*
   - Encourage participants to share any further ideas.

B. Taking MA at the Clinic or at Home (30 minutes)

1. By a show of hands, ask participants where MA services are generally offered in their country:
   - *Do women take misoprostol at the clinic? If so, do they stay there until they abort or do they go home?*
   - *Do women take misoprostol at home or in some other safe space?*

2. Remind participants that for some women who wish take misoprostol outside the clinic, the home is not the preferred setting. For example, for many adolescents, the home is not considered private. Women who feel this way may want to identify an alternative safe space outside the clinic.

3. Explain that participants will use a debate format to explore the challenges and benefits of providing MA services exclusively in the clinic versus allowing women to complete the MA process at home or in another safe space.
   - Place four chairs in the center of the room (two pairs facing each other).
   - Divide participants into two debate teams. Inform one team that they will argue in favor of providing MA only in the clinic (Clinic Team). The other team will argue in favor of only home use of MA (Home Team). Point out that home use here also implies another safe space outside the clinic.
   - Give the teams 10 minutes to prepare their arguments. Instruct each team to select two representatives to present the team's arguments to the group.
   - Let the teams know that they can refer to Module Eight of the *MA Study Guide* for information on home and clinic use of misoprostol.
   - After 10 minutes, ask the four representatives (two per team) to sit in the facing chairs in the center of the room.
   - Toss a coin or use some other method to decide which team will go first.
   - Allow each team three minutes for their opening arguments, and two "rebuttal" responses of two minutes each.
   - After two rebuttal rounds of debate, thank the teams and have them return to their seats.
   - Point out that there is no "winner" of this debate because there are good arguments on both sides.

4. Summarize key points from the debate, including the following:
   - Home and clinic settings both have benefits and challenges for MA service delivery.
   - When possible, it is recommended that clinics offer women both options and allow women to choose where they would like to undergo the MA process.
   - Having both options available has the potential to increase women's access to MA services.
   - In some settings, protocols and policies may restrict women's options.
   - If participants' sites offer MA in only one of the two settings, it is still helpful to know the benefits and challenges of both models in the event that protocols eventually change.

C. Barriers to MA Access (15 minutes)

1. Ask participants to brainstorm challenges or barriers women may face when seeking MA services.
   - List the group's responses on flipchart paper. Be sure responses include:
     - ▸ Narrow interpretation of legal indications or restrictive laws that limit access
     - ▸ Shortage of trained providers
     - ▸ Policies limiting which providers are allowed to give MA
     - ▸ Restrictions on how and where women can undergo MA
     - ▸ Provider attitudes
     - ▸ Cost
     - ▸ Availability of medicines
     - ▸ Beliefs and myths about MA

2. Divide participants into small groups and assign each group two or three of the listed barriers.
   - Ask the groups to discuss several ways to overcome their assigned barriers.
   - After five minutes, ask a spokesperson from each group to report back.
   - Summarize the key points.

Unit Seven: Materials

1. Preparing a Site to Provide MA services Worksheet *(for participants)*

For Participants

Preparing a Site to Provide MA Services Worksheet

Service Delivery Components	Currently at Your Facility	What to Change (if necessary)	What is Needed to Make the Change
Facilities and health services			
Medication and supply management			
Staff knowledge, attitudes and skills			
Client information			
Record keeping and confidentiality protocols			
Monitoring and evaluation			

Unit Eight: Clinical Practicum

Time

Four to six hours

Unit Objectives

By the end of this unit, participants will be able to:

- Describe the characteristics of a functioning clinic providing MA services
- Describe the clinical and counseling skills of practicing providers
- Demonstrate skills for providing high-quality MA services (as outlined in the Medical Abortion Skills Checklists)

Advance Preparations

- ☐ Several weeks before the training, identify a site or sites where participants can complete a hands-on clinical practicum to practice MA skills in a functioning clinic setting. Considerations for selecting a practicum site are listed in the appendices.
- ☐ Prepare flipchart with Unit Eight Objectives.
- ☐ Prepare practicum schedule and participant assignments on a flipchart.
- ☐ Copy MA Skills Checklists (in Unit Four materials) according to regimen to be used.
- ☐ Prepare additional activities for practice (such as role-plays and case studies).
- ☐ Prepare a flipchart titled "One Word".

Instructions and Materials

A. Practicum Overview (15 minutes plus facility tour)

Materials:

- Pre-prepared flipchart: Unit Eight Objectives (list)
- Practicum schedule written on a flipchart
- Handouts (according to regimen to be used):
  - ▸ *Medical Abortion Skills Checklist I: Mifepristone and Misoprostol Regimen*
  - ▸ *Medical Abortion Skills Checklist 2: Misoprostol-only Regimen*
- Additional activities for practice if no clients are available

1. Post and review flipchart: *Unit Eight Objectives*
2. Post flipchart and describe the practicum schedule and participants' assignments.
   - If participants will be divided into practice groups, form the groups and instruct them on how their groups will function (for example, how they will rotate roles in the group).
   - Explain that trainers will observe practicum participants and complete the Medical Abortion Skills Checklist (one or two according to regimen used) for each participant.
     *(**Note:** In some settings it is acceptable for participants in a practice group to fill in a checklist on fellow participants they are observing and then give that person their feedback after the skills practice is over)*
   - Explain when and where the trainers will give feedback. Note that while individual feedback ideally should be given immediately after each skill practice, this may vary.
   - After the practicum, trainers should meet privately with each participant to provide overall feedback on their skills.
   - Tell participants that alternative activities will be available at times when there is no opportunity to practice with real clients (such as when the caseload is low).
     *(**Note:** Prepare in advance role plays and case studies for participants to practice their skills when no real clients are available; ensure participants have the materials needed to do this so that time is not wasted waiting for real clients)*
3. Tour the practicum facility with the group.
   - Refer participants to their worksheet from Unit Seven, Preparing a Site to Provide MA Services, to guide their observations.
   - Call attention to relevant aspects of the site, including:
     - ▸ Staffing
     - ▸ Counseling areas and exam rooms
     - ▸ Location of toilets
     - ▸ Site factors or protocols that may impact participants' clinical practice
   - Solicit and discuss any outstanding questions, comments or concerns.
   - Release participants to their practicum assignments.

B. Supervised Clinical Practice (4-5 hours)

1. Utilize skills checklists to observe competency of participants in providing MA services.
2. Supervise learner groups and ensure that all is functioning smoothly; if there are times when no clients are available, monitor alternate activities for learner practice.

C. Post-practicum Debriefing (30 minutes)

Materials:

- Flipchart: *One Word* (leave blank)

1. Welcome participants back to the workshop and thank them for completing the practicum.

2. Post the flipchart titled, *One Word*.
   - Ask participants to think silently of one word that captures their practicum experience.
   - Ask participants to come to the front and write their word on the flipchart.
   - Ask if any volunteers would briefly speak about their word with the group.

3. Facilitate a discussion about the practicum using the following questions:
   - *What went well?*
   - *What was challenging?*
   - *Was there a particular interesting case?*
   - *What surprised you?*
   - *What did you learn?*
   - *What would you do differently?*
   - *How can you apply what you did in the practicum to your own work situation?*
   - *What challenges or barriers might you face?*
   - *What are some strategies to deal with those challenges?*

4. Provide feedback and identify next steps:
   - Summarize common themes and highlight unique points from participants' discussion.
   - Share what you and the other trainers observed about the practicum.
   - Ask for and answer any last questions about the practicum.
   - Ask participants to identify their most important next steps towards gaining MA skills.
   - Provide participants with specific recommendations for implementing and improving their skills when they return to their work sites.
     *(**Note:** this can also be done individually with participants who may need to focus on particular areas of improvement)*

After the Workshop:

- ☐ Provide feedback on each participant's skills to their site supervisor, if appropriate.
- ☐ Arrange follow-up visits with participants to support them in using their new skills and to help them problem-solve. Follow-up should occur as soon as possible after the workshop, preferably within a month.
- ☐ Provide opportunities for refresher courses and site-visit exchanges between participants.

Unit Nine: Final Assessment and Closing

Time

One hour, 30 minutes

Unit Objectives

By the end of this unit, participants will be able to:

- Determine whether their expectations and the workshop objectives were met
- Demonstrate knowledge level acquired through a post-test
- Give feedback about the MA workshop to the organizers

Advance Preparations

- ☐ Gather all the unit objectives, expectations and parking lot flipcharts and post at front of room
- ☐ Copy the MA Pre/post-test and Answer Key (in Unit One materials)
- ☐ Copy Final Evaluation Forms
- ☐ Consider how to close the workshop. The closing circle described in Activity B is one example. The closing ceremony may be conducted in whatever manner is appropriate to local practices.
- ☐ Prepare certificates of completion or competency according to local practices (on CD-ROM in Word®)

Instructions and Materials

A. Review expectations, objectives and parking lot (10 minutes)

Materials:

- Completed flipcharts from previous units:
  - ▸ Expectations
  - ▸ Unit objectives
  - ▸ Parking lot

1. Review the expectations flipchart and determine whether all expectations were met or not. If any were not met, discuss with participants if and how they can be met outside the course.
2. Have participants examine the various unit objectives flipcharts and express whether they felt they were met or not. If not, discuss ways they could be met outside the course.

3. Review the Parking Lot flipchart and address any outstanding issues.

B. Post-test and Evaluation (50 minutes)

Materials:

- Blank flipchart paper and stand, markers
- Handouts:
  - ▸ *Medical Abortion Pre/post-test*
  - ▸ *Medical Abortion Pre/post-test Answer Key*
  - ▸ *Final Evaluation Form*

1. Explain that participants will complete a post-test and final evaluation.
   - Distribute the post-tests and give participants approximately 30 minutes to complete the test.
   - After 30 minutes, collect the tests.
   - Distribute the Final Evaluation Form and ask participants to complete it; during that time, grade the post-tests and record the scores.
   - Collect the final evaluations.
   - Return each participant's scored post-test along with an answer key.
   - Answer any outstanding questions from the post-test.

C. Closing Circle (20 minutes)

1. Thank the group for their participation and contributions to the course. Acknowledge the experience and expertise in the group.
2. To formally close the workshop:
   - Have participants form a circle.
   - Ask participants to go around the circle and name one specific skill that the workshop helped them improve and one thing they will do differently as a result of the MA training.

D. Certificates (10 minutes)

Materials:

- Handout (depending on local regulations):
  - ▸ *Certificates of Completion* or *Certificates of Competence*

1. Distribute the *Certificates of Completion* or *Certificates of Competence* (according to local practices and regulations).
   - Call one participant at a time.
   - Encourage applause for each person for their hard work and commitment to MA care.

- Emphasize the investment made in each learner and the importance of them providing MA care to women when they return home.

2. Tell participants how you can be reached for more information, support and follow-up as they implement MA services in their sites.

3. Wish participants a safe journey home.

Unit Nine: Materials

1. Final Evaluation Form *(for participants)*

2. Certificates of competency or completion (on CD-ROM)

For Participants

Medical Abortion Workshop Final Evaluation Form

Dates: _____ Location: _____

Trainers:_____

Goal

To develop health care workers' knowledge and skills to provide medical abortion to women who request and are eligible for this abortion method.

Learning Objectives

By the end of this workshop, participants will be able to:

Unit One

- Discuss key content from the *MA Study Guide*
- Explain the role of MA in comprehensive reproductive health services for women
- Discuss the current context of abortion services in their country, including the legal status of abortion care and barriers to access

Unit Two

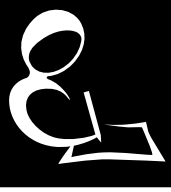
- Discuss eligibility, contraindications, precautions for use, and special considerations for MA
- Describe the efficacy, mechanisms of action, regimens, routes and timing of the medications used for MA

Unit Three

- List the care that should be provided to a woman prior to the MA procedure
- Describe strategies for dating pregnancy using last menstrual period (LMP) and bimanual exam
- List the signs and symptoms of ectopic pregnancy
- Demonstrate the ability to assess clinical eligibility for MA
- Describe the MA process, including expected effects, possible side effects and strategies for managing them
- Describe strategies for prevention and management of pain associated with MA
- Recognize warning signs for seeking care

Unit Four

- Articulate their own comfort levels discussing, advocating for and providing MA services
- Discuss how these varying comfort levels relate to societal norms on MA and their personal level of comfort providing MA services
- Provide options counseling to women seeking MA services
- Obtain informed consent for MA



For Participants

Medical Abortion Workshop Final Evaluation Form

- Provide counseling to a woman prior to her leaving the clinic
- Provide emotional support to women seeking MA services
- Provide post-abortion contraceptive counseling
- Help women manage MA side effects, identify warning signs and make a follow-up care plan

Unit Five

- Describe the purpose and key components of follow-up care
- Discuss methods for determining if a woman is still pregnant after taking MA
- Describe management approaches for "problematic bleeding" at follow-up
- Demonstrate skills in providing follow-up to women by phone
- Explain ways in which outreach workers can provide follow-up care

Unit Six

- Demonstrate an ability to identify and manage MA problems, complications and emergencies
- Describe elements of a good emergency response system

Unit Seven

- Describe the MA service delivery requirements that need to be in place at sites to ensure high-quality, woman-centered care
- Identify and prioritize key aspects of high-quality MA services in their own setting, including needed changes and how to accomplish them
- Describe the benefits and challenges of using MA at home (or in a safe space) and in clinic settings
- List several barriers to accessing MA care and ways to overcome those barriers

Unit Eight

- Describe the characteristics of a functioning clinic providing MA services
- Describe the clinical and counseling skills of practicing providers
- Demonstrate skills for providing high-quality MA services (as outlined in the *Medical Abortion Skills Checklists*)

Unit Nine

- Summarize key points from the *MA Study Guide* and workshop
- Determine whether their expectations and the workshop objectives were met
- Demonstrate knowledge level acquired through a post-test
- Give feedback about the MA workshop to the organizers

For Participants Medical Abortion Workshop Final Evaluation Form *(continued)*

Please rate the course on each item below using the following scale. Please use the comments section to provide more information about the rating and suggestions for improvement.

5 = strongly agree 4 = agree 3 = neutral 2 = disagree 1 = strongly disagree

Item	Rating	Comment
1. The course fulfilled its goal and objectives (see above).		
2. The course was well-organized.		
3. The trainers were responsive to participants' needs.		
4. The trainers used effective training methods.		
5. The training materials (handouts, slides, worksheets, tests, etc.) were effective.		
6. There were adequate opportunities for discussion.		
7. The physical facilities were conducive to learning and sharing.		
8. The logistical arrangements were satisfactory.		
9. I have a better understanding of MA because of this workshop.		
10. I will provide high-quality, woman-centered MA services after this training.		

What suggestions can you offer to improve this workshop in the future?

General comments and suggestions:

References

This manual provides the "how to train" guidance for the clinical content found in the Ipas Medical Abortion Study Guide. Clinical content in this Training Guide is only referenced if it represents an update to content in the Ipas Medical Abortion Study Guide or new material not found in the Study Guide. Please refer to the Study Guide for all other clinical references.

Barnhart, Kurt. 2009. Clinical practice: ectopic pregnancy. *New England Journal of Medicine*, 361(4):379-87.

Cable, Edward, Joseph A. Pepe, Susan E. Donohue, Richard W. Lambrecht, Herbert L. Bonkovsky. 1994. Effects of mifepristone (RU486) on heme metabolism and cytochromes P-450 in cultured chick embryo liver cells, possible implications for acute porphyria. *European Journal of Biochemisty*, 225(2): 651-7.

Callen, Peter. 2000. *Ultrasonography in Obstetrics and Gynecology*, 4th ed. Philadelphia, PA: W.B. Saunders Company.

Turner, Katherine L. and Kimberly Chapman Page. 2008. *Abortion attitude transformation: A values clarification toolkit for global audiences.* Chapel Hill, NC: Ipas.

Creinin, Mitchell and Kristina Gemzell- Daniellson. 2009. Medical abortion in early pregnancy. In *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*, eds. Maureen Paul, E. Steve Lichtenberg, Lynn Borgatta, David A. Grimes, Phillip G. Stubblefield and Mitchell D. Creinin, 124. West Sussex, UK: Wiley-Blackwell.

Fiala, Christian and Kristina Gemzell-Danielsson. 2006. Review of medical abortion using mifepristone in combination with a prostaglandin analogue. *Contraception*, 74(1): 66-86.

Fjerstad, Mary, James Trussell, Irving Sivin. 2009. Rates of serious infection after medical abortion (letter to the editor). *New England Journal of Medicine*, 361(2): 145-151.

JHPIEGO. 2001. Planning for a training course: Selecting a clinical site for a clinical skills course. *JHPEIGO Trainer News.* Baltimore, MD, JHPIEGO.

Kobrynski, Lisa. 2007. Anaphylaxis. *Clinical Pediatric Emergency Medicine*, 8(2): 110-116.

Land JA, JW Arends. 1992. Immunohistochemical analysis of estrogen and progesterone receptors in fallopian tubes during ectopic pregnancy. *Fertility and Sterility*, 58(2): 335-337.

Landsdown, Gerison. 2005. *The Evolving Capacities of the Child*. Florence, Italy: UNICEF Innocenti Research Center.

McInerney, Teresa, Traci L. Baird, Alyson G. Hyman, Amanda B. Huber and Merrill Wolf, ed. 2001. *A guide to providing abortion care*. Chapel Hill, NC, Ipas.

Perriera, Lisa, Beatrice Chen, Matthew Reeves, Heather Hohmann, Jennifer Hayes, Mitchell Creinin. 2009. Feasibility of telephone follow-up after medical abortion. *Contraception*, 80 (2): 197.

Sitruk-Ware Regine and Irvin M. Spitz. 2003. Pharmacological properties of mifepristone: toxicology and safety in animal and human studies. *Contraception*, 68(6): 409-420.

Wegs, Christina, Katherine Turner and Betsy Randall-David. 2003. *Effective training in reproductive health: Course design and delivery. Reference Manual.* Chapel Hill, NC, Ipas.

Winikoff, Beverly, Irving Sivin, Kurus Coyaji, Evelio Cabezas, Xiao Billian, Gu Sujuan, Du Ming-kun, Usha Krishna, Andrewa Eschen, Charlotte Ellertson. 1997. Safety, efficacy, and acceptability of medical abortion in China, Cuba and India: a comparative trial of mifepristone-misoprostol versus surgical abortion. *American Journal of Obstetrics and Gynecology*,176(2): 431-437.

Woo, J, P Fine, L Goetzl. 2005. Abortion disclosure and the association with domestic violence. *Obstetrics and gynecology*, 105(6): 1329-1334.

Appendices

A. Sample Schedule and Agenda

The units included in this Training Guide were designed to allow trainers to tailor a workshop agenda/schedule to participants' needs. Below is a suggested three-day training schedule that includes a clinical practicum. The didactic part of this workshop could be completed in two days if no clinical practicum is completed at that time. Alternatively, the training may be delivered one unit at a time over several weeks, or trainers may select from the units they determine are most relevant to participants' needs. Lastly, trainers could combine online learning with Ipas University (www.ipasu.org) with a short face-to-face workshop and clinical practicum.

An agenda template is included on the CD-ROM to allow trainers to personalize a schedule. Suggested times are approximate and may change based on clinical regimens to be taught as well as any additional activities.

For more assistance with designing an MA workshop to meet your needs, feel free to contact *training@ipas.org***.**

DAY ONE	
Unit Title	***Time***
1. Overview on Medical Abortion	2 hours
2. Medical Abortion Regimens	1 hour, 15 minutes
3. Clinical Care	3 hours

DAY TWO	
Unit Title	***Time***
4. Informed Consent, Information and Counseling	3 hours
5. Follow-up Care	1 hour, 30 minutes
6. Problems, Complications and Emergencies	1 hour, 15 minutes
7. Service Delivery	1 hour, 30 minutes

DAY THREE	
Unit Title	***Time***
8. Clinical Practicum	4-6 hours
9. Final Assessment, Closing, & Evaluation	1 hour, 30 minutes

Appendices

B. Four Corners Activity

Time

45 minutes

Advance Preparations

- ☐ Prepare four signs for Four Corners activity and post one sign in each corner of the room.
- ☐ Review and, if necessary, adapt the handout Four Corners Statements to make them more relevant to the participants or workshop content.

Instructions and Materials

Materials:

- Pre-prepared signs:
  - ▸ Strongly Agree
  - ▸ Agree
  - ▸ Disagree
  - ▸ Strongly Disagree
- Handout: *Four Corners Statements*

1. Introduce the Four Corners activity.
   *(**Note:** This activity is an excellent opportunity to recognize and respect various opinions and values, but only if you have experience in leading values clarification should you undergo this activity)*
   - Explain that the activity asks participants to think honestly about their beliefs about MA, and defend other people's views about MA.
   - Give each participant a Four Corners Statements handout.
   - Ask participants to complete the handout and turn the sheet over when they are done; instruct participants not to write their names on the handout.
   - When everyone is done, request that participants crumple their handout into a ball.
   - Ask participants to stand in a circle, throw their ball into the circle, pick up a different ball, and toss it to another participant.
   - Instruct participants to represent the responses on the handout they picked up for the remainder of the activity, even if the responses conflict with their personal beliefs.
     *(**Note:** If participants get their own handout back, they should act as though someone else completed it)*

Appendices

- Point out the four signs placed around the room (*Strongly Agree, Agree, Disagree, Strongly Disagree*).
- Make sure that the groups understand the difference between "*agree*" and "***strongly** agree*," and between "*disagree*" and "***strongly** disagree*."

2. Begin the Four Corners discussion.
   - Tell participants they will discuss the statements one at a time.
   - Read the first statement aloud and ask participants to move to the sign that matches the response circled on their handout.
   - Invite participants to look around the room and notice the range of opinions held. There may be different-sized groups in each corner, or one or more unoccupied corners.
     *(**Note**: If there are corners with no one in them or just one person, one of the trainers can join or represent that corner)*
   - Give the groups two minutes to discuss (within their group) the strongest reasons why people might hold that opinion. Ask each group to appoint a spokesperson.
   - After two minutes, ask the spokesperson from each group to convincingly represent the belief (for example, "I strongly agree with this statement because…"). Tell them to act as if they were an actor, even if they disagree with how the statement was marked, and to always represent the viewpoint with respect because it was someone's opinion.
   - Start with "*Strongly Agree*" and proceed, in order, to "*Strongly Disagree.*"
   - Read the next statement and continue with the activity until you have discussed several statements.
     *(**Note:** it is not necessary to discuss <u>all</u> the statements – which may be too time-consuming – just discuss the ones most relevant to the participants' circumstances)*

3. Ask participants to return to their seats and reflect on the activity and the specific statements made. Key questions include:
   - *What was it like to represent beliefs about MA that were different from your own?*
   - *What was it like to hear your beliefs represented by others?*
   - *How might a provider's beliefs influence their provision of MA services?*

4. Lead a discussion about the types and origins of abortion method biases and how they affect the care and treatment women receive. Key issues to discuss include:
   - *Who controls the abortion procedure – women or providers?* This relates to issues of power and control. MA can help some women feel more in charge of their bodies and retain more control over the abortion experience. Some providers, however, may feel uncomfortable about giving up the control they have when they perform a vacuum aspiration procedure on a woman. They may not see women as being capable of managing an abortion without their intervention. Other providers may feel more comfortable with women controlling the experience because of their own discomfort initiating

Appendices

the abortion process. These providers may feel that when women take the pills themselves they are not the ones initiating/causing the abortion. Other providers, however, may just trust women to maintain control of the abortion process.

- *How do perceptions of MA as more natural, simulating a miscarriage, less like a human intervention influence behaviors towards women seeking abortion?* This can be influenced by women and providers' discomfort with induced abortion.
- *How do biases of abortion procedures influence the counseling process and informed consent?* If counselors prefer one method over the other, they may not help a woman decide what is best for her based on her individual needs.

5. Conclude the activity by summarizing the key points and encouraging participants to consider these issues further throughout the workshop and clinical practicum.

Appendices

Handout: Four Corners Statements*

Instructions: Read the following statements and circle the answers that best reflect your personal beliefs. Please be honest and do **not** write your name on this paper. Turn the paper over when you are done.

SA = Strongly Agree **A = Agree** **D = Disagree** **SD = Strongly Disagree**

1. Medical abortion (MA) is preferable to vacuum aspiration (VA) because women are able to have more control over the abortion experience.	**SA**	**A**	**D**	**SD**
2. MA is better than VA because it is more like a natural process.	**SA**	**A**	**D**	**SD**
3. MA is less acceptable than VA because of the longer bleeding time with MA**.**	**SA**	**A**	**D**	**SD**
4. MA gives women too much burden for managing the expelled pregnancy**.**	**SA**	**A**	**D**	**SD**
5. Providers should always assess whether the MA worked because women cannot determine this themselves.	**SA**	**A**	**D**	**SD**
6. Adolescents are good candidates for MA and should have the same right to information and care as older women do.	**SA**	**A**	**D**	**SD**
7. MA should be made easily available to women even if a few women end up using improper dosages.	**SA**	**A**	**D**	**SD**
8. A woman who took MA pills but has an ongoing pregnancy should be able to continue the pregnancy if she chooses to.	**SA**	**A**	**D**	**SD**
9. The misoprostol-only protocol for first-trimester MA should be used where mifepristone isn't available, even though the failure rate is higher.	**SA**	**A**	**D**	**SD**
10. Community health workers should be allowed to provide MA if they are properly trained.	**SA**	**A**	**D**	**SD**

**Adapted from: Turner, Katherine L. and Kimberly Chapman Page. 2008. Abortion attitude transformation: A values clarification toolkit for global audiences. Chapel Hill, NC, Ipas.*

Appendices

C. Guidance for choosing a practicum site

Excerpted from: Wegs, Christina, Katherine Turner and Betsy Randall-David. 2003. *Effective training in reproductive health: Course design and delivery. Reference Manual.* Chapel Hill, NC: Ipas.

Selecting a clinical training site: Special considerations

Is there an adequate caseload?

Determine the caseload available at the site for the clinical procedure being taught. There should be sufficient clients to provide all participants with adequate opportunities to practice what they have learned. If no single site has adequate clients to accommodate all the participants, an alternative must be provided in the training plan. Learners may need to return to the site at another time, or trainers may need to divide participants into smaller groups that can go to other sites. A clinical trainer skilled in the clinical procedure being taught must be present at each clinical site every time a clinic practice session takes place.

Will a clinical training hinder the provision of services at the site?

Learners should be able to take part in clinical training without sacrificing the quality of services at the training site. Trainers and participants should not interfere with client flow and provider service provision. The training plan should accommodate this aspect of clinical learning at the site.

Are all essential supplies and equipment available at the site?

A clinical site must have enough supplies readily available to allow the clinical training to take place while continuing to provide regular services to clients. Trainers may need to provide part or all of the supplies needed for the clinical training. The trainer should determine the need for supplemental supplies in advance so that supplies can be procured prior to the training.

Is the site already providing appropriate services?

Clinical staff at the site should model correct service provision to participants and assist them as they practice.

Is the site similar to those in which the participants work?

If the clinical training site is similar to participants' work places, learners are able to practice applying new skills using the resources that they will have in their real work environments, increasing the chances they will be able to put their new skills into practice in their own work sites.

(McInerney et al. 2001; JHPIEGO, 2001)