FEDERAL MINISTRY OF HEALTH

DEPARTMENT OF FAMILY HEALTH

On-the-Job Training Manual on Post Abortion Care (PAC) for Healthcare Providers in Nigeria

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Ipas Partners for Reproductive Justice

NIGERIA HEALTH FOUNDATION

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Contents

FOREWARD

Re-training Medical professionals can be challenging for governments and partners alike, especially in resource constrained settings or non-mainstream subjects. The formal classroom training is costly and disrupts routine activities which further compounds access to quality health services. These reasons make it imperative to seek cheaper and more sustainable ways to advance the knowledge of health care workers for better service delivery. It is for that reason that the on-the-job (OJT) training manual was developed.

The purpose of the manual is therefore to make it easier for health professionals to acquire needed skills in a practical and flexible setting. With the OJT approach, more professionals can be reached at their own places of work for the training with little or no cost attached. By this, more patients can have access to quality health care services especially in rural areas where there is poor health seeking behavior despite the high burden of disease.

The manual was structured to be user friendly with five modules as follows: Overview of Maternal Mortality, Reproductive Health and Education, Postabortion Care, Indicated Medical abortion and Contraceptive services. The OJT training process using this manual is intended to take not less than four weeks to complete. Supervisory visits and evaluation by senior Federal and State officials are embedded in the OJT, to ensure that optimum quality of the training is achieved.

It is my hope that this document will be embraced by health care organizations, to enhance the capacities of various cadres of health professionals, especially those who have to deal with post abortion complications, now that the National task shifting and task sharing policy (TSTS) is in place. This should in turn accelerate the journey to achievement of the Sustainable Development Goals and improve the poor maternal health indices in Nigeria.

Dr. E. Osagie Ehanire, MD, FWACS
Honorable Minister of Health, Federal Republic of Nigeria
November, 2022

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Also we appreciate the technical input of all the contributors from the Federal Ministry of Health, National Primary Healthcare Development Agency (NPHCDA), State Ministry of Health (SMOH), Society of Obstetrics and Gynaecologists of Nigeria (SOGON), Medical and Dental Council of Nigeria (MDCN), Nursing and Midwifery Council of Nigeria (NMCN), Academia, Ipas Nigeria, World Health Organization (WHO), Clinton Health Access Initiatives (CHAI), Marie Stopes Nigeria (MSION), and Planned Parenthood Federation of Nigeria (PPFN).

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Finally, we extend our profound gratitude to the Honourable Minister of Health, Dr Osagie Ehanire for his leadership role and providing an enabling environment to the development of this manual.

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November, 2022

ACRONYMS

OJT	On the Job Training
FMoH	Federal Ministry of Health
SToP	Safe Termination of Pregnancy
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CAC	Comprehensive Abortion Care
FP	Family Planning
IPCC	Interpersonal Communication Counselling
PAC	Post Abortion Care
MEC	Medical Eligibility Criteria
RH	Reproductive Health
PAFP	Post Abortion Family Planning
PHC	Primary Health care
MCH	Maternal and Child Health
LGA	Local Government Area
VCAT	Value Clarification and Attitude Transformation
UE	Uterine Evacuation
MVA	Manual Vacuum Aspiration
MA	Medication Abortion
IUD	Intra Uterine Device
WHO	World Health Organisation
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome

INTRODUCTION

On-the-Job Training (OJT) for service providers is designed basically to address the gaps in service provision and also ensure uninterrupted services at the health facilities.
This document will address quality improvement issues relating to abortion care, following supportive supervisory visits to service providers. In addition, an on-site intervention will ensure the provision of knowledge, hands-on practice and demonstration of techniques and skills, thereby improving providers' confidence.
OJT can only succeed, if key stakeholders buy into the system and participate actively in the decision-making process. It must be embedded within Government structures and driven by their functionaries.
Therefore, trained supervisors will conduct the OJT with oversight from and/or the Federal Ministry of Health (FMoH) as well as the primary health care development agencies/boards and partners They will use a simplified OJT document/checklist and OJT Manual, as the core tools during visits to facilities. This will help to streamline their work and promote sustainability of OJT activities.

Broad Objectives/Aim

To ensure that providers are mentored, and the practice of new skills reinforced with feedback to ensure competence in post abortion care provision.

Specific Objectives

- To Provide immediate on-site technical support/coaching/mentoring tools
- To improve performance standard for abortion care services as provided for in the FMoH documents for safe termination of pregnancies for legal indications (SToP guidelines), OJT Manuals and Checklists as adopted/modified by the states in Nigeria

Methodology

- Duration: The duration of the OJT per person/cluster will be based on their scope of work and identified gaps, usually for 3-4 days per week for 4-6 weeks, with each session lasting between 2 and 3 hours per day.
- Conduct structured OJT for the specific cadres (Doctors, Nurses, Midwives, Community Health Officers (CHOs), Community Health Extension Workers (CHEWs)

Plan and conduct the OJT in batches (of not more than three trainees per batch), such that providers with similar gaps in knowledge or skills will be clustered into small groups of participants.
Reports should summarize key findings during the OJT, highlighting strengths, improvements made (based on previous observations), areas that need further improvement and recommendations for improving performances.
The report is important to help in identifying and following-up actions required for improving performance of trainees at various facilities.

Process of OJT

- Identify OJT needs of the service provider(s)
- Develop agenda together with the trainee(s) and supervisor, share topics and determine number of training days and hours
- Determine a suitable venue for both didactic and practical sessions
- Inform facility ahead of time for the conduct of OJT
- Outline major achievement(s) in the reports and other gaps identified

Training – This will involve training to address the knowledge and skill gaps identified. The training will cover Comprehensive Abortion Care (CAC), Post abortion care, FP, IPCC and referral.

Provision of tools and job aids – This may include printing and distribution of the existing PAC Manual. The tools and job aids should include the MEC wheel and the RH wheel.

Period of mentorship with the facility providers– This is necessary to create the opportunity for direct observation and learning from the supervisor or trainer.

Objectives:

- To equip the provider with knowledge and skills on Abortion Care.
- To equip the provider with knowledge and skills for Post-Abortion Care (PAC), including Post-Abortion Family Planning (PAFP).

Scope of Training:

- Knowledge and skills on comprehensive abortion care
- RH policy and adolescent friendly services
- Post abortion family planning, referral and linkages

Methodology:

- Demonstrations and return demonstrations.
- Presentations.
- Role Plays.
- Practical Sessions.
- Simulation

Expected Outcome:

I. Increased number of service providers that can offer comprehensive abortion care services which include Postabortion care, safe termination of pregnancies for legal indications (SToP) as provided for in the FMoH SToP guidelines (as amended by the states) and Postabortion family planning.
II. Increased pool of competent facility health workers.

Monitoring and maintenance of standards.

1. Use of OJT checklists to assess the availability and quality of equipment at each health facility.
2. A score of ≥85 % would be the pass mark for the competence score for all trainees.
3. A doctor will be declared competent after successfully performing five fully supervised procedures.
4. A nurse/midwife will be declared competent after successfully performing seven fully supervised procedures.
5. A community health extension worker (CHEW) or Community Health Officer (CHO) will be declared competent after successfully performing 10 fully supervised procedures.

Operationalization of the OJT process in the states.

Successful conduct of OJT requires the leadership and coordination of relevant officials of the FMoH , NPHCDA,SMOH and SPHDA. The OJT process should typically begin with planning to determine the need and scope. At the PHC level, the RH/MCH coordinator under the guidance of the Director Primary Health will provide the necessary coordination and oversight for implementation while at the secondary & tertiary facility level, the head of clinical services under the leadership guidance of the Director, Medical/Hospital Services provides necessary implementation coordination.

Regular supervision and coordination meetings should be held at the facility, LGA, state and federal level with relevant personnel.

The facility heads at least should hold check-in meetings weekly with the trainer and trainees while the RH coordinator or head of clinical services is expected to hold monthly check-in meetings with the facilities and trainees. For standardization and proper documentation of the supervisory process, a suggested supervisory checklist is included as an appendix to the guideline (see appendix below).

The OJT process should be seen as a continuum. Therefore, trainees that have achieved competency, should be supported to cascade training (using the OJT approach) to other providers that meet the criteria, wherever they find themselves. This will help address the issue of attrition of trained providers and move towards universal coverage in the state.

Eligibility Criteria

The categories of health care providers who should be trained on the provision of abortion care services through the OJT document should be according to the FMoH national PAC Manual and the Task Shifting Task Sharing Policies of the FMoH or as adopted by the state.

Facilities are to ensure the training includes passing knowledge of correct and complete documentation of abortion care provision in the facility PAC registers if applicable and the NHMIS delivery register.

Pretest, review of pre and post tests should be incorporated in the training.

The OJT training should last for a minimum period of 4 weeks and maximum of 6 weeks.
An OJT Trainer will have a maximum of three trainees at a time.
Below is the structure and supervision protocols for implementation of the CAC OJT approach.

Supervision of the OJT (PHC)

- Identification of supervisors
    - Facility In-Charge
    - LGA PHC Managers/Coordinators
    - LGA RH/MCH Coordinator
    - State RH/MCH Coordinator
    - Director PHC

Supervision of the OJT (Secondary & Tertiary facilities)

- Director Medical/Hospital Services
- Director Nursing Services
- Heads of O&G Department/Medical Officers in-charge
- In-Charges of Maternity/Gynae Ward
- Head of Nursing Services
- Head of Clinical Services

Supervision of the OJT by the FMoH

OJT EVALUATION

- Knowledge Pre and Post-test
- Competence checklist for competence assessment
- Logbook Documentation
- Supervision Checklists

It is recommended that FMoH and states should keep a routinely updated record and digital database of trained providers in all states both for those who had formal (classroom) PAC trainings and those who are trained and assessed as competent through the PAC OJT process.

This training manual is harmonized from the following documents on abortion care:

1. FMOH Training Manual for post-abortion care
2. FMoH SToP for legal indications as adopted by the states
3. Ipas Woman-Centred Comprehensive Abortion Care Training Manual and Reference Manual
4. Ipas Woman-Centred Postabortion Care Training Manual and Reference Manual
5. Ipas Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences
6. Training Guide for House Officers on Select Interventions in Maternal and Reproductive Health Care

7. Nigerian Urban Reproductive Health Initiative 2 (NURHI)
8. Reproductive Health in Emergencies toolkit, Save the Children's Resource Centre, 2017
9. Clinical Updates in Reproductive Health 2021
10. Abortion Care Guideline. Geneva. World Health Organization.2022

Content

This manual consists of five modules that should be presented in the following order.

Module 1: Overview of Maternal Mortality
Module 2: Reproductive Health and Education
Module 3: Post-Abortion Care
Module 4: Medical Abortion
Module 5: Contraceptive Services

The OJT should last about 32 hours. However, it is not realistic to run a training continuously for 32 hours. For an effective training, the OJT should last for 4-6 weeks.

Materials

Each module in this manual provides instructions for teaching the module content and includes the materials needed, identifies the training methods, recommends the duration of training and provides a list of academic resources.
The modules can be converted to PowerPoint presentations, where needed, which can be loaded onto a computer that is connected to a digital projector.
Where a digital projector is not available, the slides can be printed into handouts. In some circumstances, flip charts, writing boards or a combination of the other methods may be used.
Other materials and powerpoint referenced in the material can be found on the Federal Ministry of Health website on www.health.gov.ng or using the links below:

http://bit.ly/3VS6EbJ or

https://drive.google.com/drive/folders/1zvurjGJt-fIGtl1JR8Fru3gy3HpFJ3aS?usp=sharing

Materials can also be accessed using the QR code below:

Using the On-The-Job (OJT) Manual

This manual was designed to produce a single document that can be used to train various cadres of service providers to acquire the requisite knowledge and skills to be able to offer safe abortion care services.

It is targeted at practically relevant skills and techniques on clinical service provision for abortion care services.

Where applicable, the OJT manual will refer to the FMoH training guide for PAC, FMoH (or state) Guidelines for Safe Termination of Pregnancy for Legal indications documents or other relevant resources for basic information, especially for those categories of staff that have not benefited from an initial PAC training but have learnt from step-down trainings.

How to conduct OJT

Before conducting an OJT

OJT should be carried out when gaps in knowledge or skills or both are identified by the supervisor, the individual provider or his/her colleague(s). These are gaps that cannot be adequately addressed through direct mentoring during a supportive supervision.

Once these gaps are identified, the following steps are taken in planning for the OJT together with the trainee(s).

1) Collate findings on the gaps (for example from supportive supervision, annual reports etc)
2) Determine the scope of the OJT
3) Determine coverage, whether as individual or in cluster(s)
4) Determine date, location, time and duration, which should be flexible, depending on the identified gaps. It could be done for 2-3 hours per day, over several days, weeks or months.
5) Prepare a budget
6) Develop an agenda
7) Put together required training materials
8) Inform the providers to be trained ahead of time

During the OJT

Before addressing the gaps identified, a brief overview of anatomy and physiology of female reproductive tract, using models, manikins and charts, should be used to update the provider's knowledge as well as reinforce modern methods of abortion care.

After the OJT

A post-OJT competence assessment is necessary to evaluate how much the providers have gained and attest to their new level of competence. This will help to determine the intensity and coverage of the follow-up supportive supervision.

MODULE 1: OVERVIEW OF MATERNAL MORTALITY

Purpose

The purpose of this module is to help providers understand relevant terms and their definitions, the major causes of maternal morbidity and mortality globally and in Nigeria. This is to enable them to understand the concept of the three delays and how they contribute to maternal morbidity and mortality.

Specific objectives

By the end of this module, providers should be able to:

I. Define maternal morbidity, mortality and unsafe abortion
II. Discuss maternal mortality rates, ratios and the prevalence of the major causes of maternal deaths
III. Describe the three delays contributing to maternal mortality and the role service providers can play in addressing the delays

Module Plan

[a]Recommended Duration (90mins; 1 day)

Module outline	Training methods	Materials	Resources	Session time
Introduction 1.1 Definitions: maternal morbidity and mortality, unsafe abortion	Lecture PPT, Interactive, Participatory.	Computer, multimedia projector, Flip chart, Cardboard paper, Marker.	Content below	15 min
1.2 Maternal mortality statistics: Leading causes of maternal mortality globally and in Nigeria	Lecture PPT, Interactive, Participatory	Computer, Multimedia projector, Flip chart, Cardboard paper, Marker.		15 min
1.3 Contribution of unsafe abortion to maternal morbidity and mortality in Nigeria	Lecture PPT, Interactive, Participatory.	Computer, Multimedia projector, Flip chart, Cardboard paper, Marker.		30 min
1.4 The three delays contributing to maternal mortality	Role play or didactic lecture	Role play		30 min

[a]The actual duration per session should be determined in consultation with the facility, the trainee and trainer. Module duration is 90 mins =1 hour 30 mins. This module should be taken on the first day.

Instructions to facilitators:

The facilitator should ascertain the perceived knowledge and understanding of maternal mortality, unsafe abortion, causes of maternal mortality and the three-delay model.
With the result of providers' answers, the facilitator should note areas to emphasize, based on gaps in knowledge of the providers. Facilitator may use the language understood by the participants during the training in order to ensure good understanding of the subject matter.

Session 1: Definitions of maternal mortality, maternal morbidity and unsafe abortion

Facilitator:
Define and explain to providers what maternal mortality, maternal morbidity and unsafe abortion are.

Discussion guide:

Maternal mortality is defined as death of a woman during pregnancy or within 42 days of its termination, irrespective of the duration or site of the pregnancy, from any cause(s) related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
Maternal morbidity includes physical and psychological conditions that result from or are aggravated by pregnancy and have an adverse effect on a woman's health.
Unsafe abortion refers to any procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal standards, or both.

Session 2: Maternal Mortality Statistics

Facilitator: The facilitator should provide the formula for the statistics to providers, explain the formulae and if possible, provide figures for the providers to calculate theoretical mortality rates and ratios to demonstrate understanding of the formulae. Also, the direct and indirect causes of maternal mortality should be provided at this point. The facilitator should refer to the current NDHS for the updated data.

Discussion guide:
Maternal mortality ratio: $\frac{\text{Number of maternal deaths}}{\text{Number of live births}} \times 100{,}000$
Maternal mortality ratio depicts the risk of maternal death relative to the frequency of childbearing.

Maternal mortality rate: $\frac{\text{Number of maternal deaths X 100,000}}{\text{Number of women of reproductive age (15 – 49) years}}$

The maternal mortality rate not only reflects the risk of maternal death during pregnancy or per birth, but also the level of care in a population.

However, Maternal Mortality Ratio is the indicator used globally among countries because it is easier to calculate and more reliable. The maternal mortality ratio for Nigeria is 512 (NDHS 2018)

Lifetime risk of maternal death: The risk of a woman dying from pregnancy-related complications during her reproductive age. The lifetime risk of maternal death varies according to country. For example: Nigeria: 1 in 31, Ethiopia: 1 in 52, Ghana: 1 in 66, Canada: 1 in 5,200, Singapore: 1 in 13,900.

The facilitator should explain further about the significance of this data to the understanding of the participants.

Causes of maternal mortality can be divided into two categories: direct causes and indirect causes.

Direct causes include Haemorrhage, Infection, Hypertensive disorders, Obstructed labor, Abortion and others

Indirect causes include Diabetes Mellitus, Sickle Cell disease, Malaria, HIV/AIDS and recently COVID-19, among others.

Session 3: The three delays contributing to maternal mortality

Facilitators: Facilitators should provide and explain the concept of the three delays to providers. The facilitator should ask providers to repeat what the three delays are and their understanding of the concept. Providers should be able to identify specific ways these delays play out in their communities, contributing to morbidity and mortality.

Discussion guide:

Type I Delay: Delay in seeking appropriate medical care. It may take some time to recognize that there is a problem that needs medical attention. Once this is determined, there may be an additional delay in making the decision to seek care. This delay can be caused by cultural and financial factors, the perceived quality of care, woman's status and level of education.

Type II Delay: Delay in reaching an appropriate facility. Time can be lost going to facilities or providers, who are unable to provide the care or manage the emergency. This delay can depend on the type and conditions of the road, weather and seasons, availability of transport and distance to appropriate facilities.

Type III Delay: Delay in receiving adequate (or timely) care when the facility is reached. Poorly equipped health facilities, inadequate human resources and technical capacity of staff, shortages of necessary supplies and equipment and provider attitudes among others can all contribute to the delay in receiving appropriate and timely care.

MODULE 2: REPRODUCTIVE HEALTH AND EDUCATION

Purpose

The purpose of this module is to help providers understand and advocate for a woman's right to receive high quality and comprehensive sexual and reproductive health care.

Specific objectives

By the end of this module, providers should be able to:

I. Define and describe components of reproductive health, reproductive rights and the sexual rights of patients.
II. Articulate barriers to care and possible actions for improving women's reproductive rights.
III. Enumerate components of post-abortion care and proffer solutions to barriers and restrictions to accessing post-abortion care
IV. Understand the current legal indications for abortion in Nigeria and demonstrate an understanding of the abortion laws as detailed in the FMoH (or as amended by the states) guidelines for Safe Termination of Pregnancy (SToP) for legal indications.
V. Distinguish and appropriately separate personal beliefs [religious, cultural, traditional] from professional responsibilities.
VI. Clarify values and demonstrate empathy toward women and their families, who need and experience abortion or have other reproductive health needs.
VII. Define advocacy and providers' unique advocacy role.
VIII. Learn to eliminate abusive and disrespectful care in reproductive health.

Module Plan

Recommended Duration- (260min:4 hrs.; 1-2 days) [a]

Module Outline	Training methods	Materials	Resources	Session time
2.1 Introduction Definition of reproductive health components of sexual and reproductive rights. Global and National commitments and statements supporting women's reproductive rights	Lecture/ Instructor-led facilitation and, Group-discussion	Multimedia projector Participant's manual and job aids Flip chart, marker, tape Discussion guide	Ipas Woman-Centered Post-abortion Care Reference Manual, second edition, pages 13-28. WHO Guide for Prevention and Elimination of Abusive and Disrespectful Care When a Health Professional Refuses (Legal and Regulatory Limits to Conscientious Objection on Abortion Care), Ipas 2012 Penal Code, Art. 232 and Criminal Code Act, Art. 297. National guideline for safe termination of pregnancy for legal indications	80min.
2.2 Client's Rights, Areas of infringement, Actions to Improve Sexual and Reproductive Rights, The abortion law in Nigeria	Lecture Instructor-led facilitation, Group-discussion	Multimedia projector Participant's manual and job aids Flip chart, markers tape Discussion guide		45min.
2.3 Barriers to Delivery and Access to Post-Abortion Care. Restrictions that affect access, narrow interpretation of the law Provider shortages, Technological and supply limitations, Conscientious refusal of care, Provider attitudes: refusal of care, Prevention and elimination of abuse and disrespect in reproductive health care	Lecture Instructor-led facilitation, Group-Discussion /Role play	Multimedia projector Participant's manual and job aids Flip chart, marker, tape Discussion guide		60min.
2.4 Overcoming	Lecture	Multimedia		20 min.

Barriers to Delivery and Access to PAC	Group Discussion and role play	projector Participant's manual and job aids Discussion guide flip charts, Pen makers, Tape		
Providers as advocates	Group discussion	Flip charts, makers, tape		30 min.
Values Clarification for Abortion Attitude Transformation (VCAT)	Group discussion	Flip charts, makers, tape and role play	Abortion Attitude Transformation: A Global Values Clarification Toolkit (pdf and ppt files)	30 min.

[a]*The actual duration per session should be determined in consultation with the facility, the trainee and trainer. This module lasts 260 minutes (approx. 4 hours). This module should be done in 1-2 days*

Instruction to facilitators:

The approach to this module will include both providing information and asking questions of providers. The questions and discussions ensuing should be guided by the facilitator, using answers provided in the discussion guide. The facilitator may have to refer to the FMoH PAC guidelines to be able to succinctly explain the different points in the discussion guide.

Session 1: Definition of reproductive health and components of sexual and reproductive rights

Facilitator:

- Define and explain reproductive health
- Define and explain reproductive rights
- Define and explain sexual rights
- Enumerate and explain the components of reproductive health
- Enumerate and explain the components of sexual and reproductive rights

Discussion guide:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or disorder in all matters related to the reproductive system, its functions and processes.

Sexual rights: The right of individuals to decide freely and responsibly on all aspects of their sexuality; to be free from discrimination, coercion and violence in their sexual life and sexual decisions; to expect and demand full consent, mutual respect and shared responsibility in their sexual decisions

Reproductive rights: The rights of couples to decide freely and responsibly on the number, timing and spacing of their children and have the information, education and means to do so;

to attain the highest standard of their reproductive health; and to make decisions about their reproduction free from discrimination, coercion and violence.

Components of sexual and reproductive rights include the rights of all persons to:

- Access the highest attainable standard of sexual health, including sexual and reproductive health services
- Seek, receive and impart information related to sexuality
- Education about sexuality
- Respect for bodily integrity
- Choose their partner
- Consensual marriage
- Decide whether, and when, to have children
- Be free from abusive and disrespectful care

Multiple international, regional and local commitments and statements that support women's reproductive rights.

Session 2: Areas of infringement of client's rights

Facilitator:
Ask questions to ascertain if providers can identify areas of client's right infringements. Guide answers and discussions, using the discussion guide provided.

Question to providers: What are the different areas of client's rights infringements you have noted in your communities?

Discussion guide:
Social, financial and physical barriers to maternal health services, including safe abortion and contraceptive services.
Harmful traditional practices such as:

- early marriage
- female genital mutilation
- widowhood rites
- widow's rights infringement
- female disinheritance
- violence against women
- domestic violence
- intimate partner violence
- human trafficking and prostitution
- gender inequity and inequality

Question to providers: What actions can be taken to improve sexual and reproductive rights and address infringements to women's sexual and reproductive rights?

Discussion guide:
Develop reproductive rights-based policies, e.g., free antenatal care, family planning and delivery services
Legislate in favour of reproductive health and rights issues, e.g., favourable legislation on abortion care
Empower women and economically and educationally
Engage in advocacy: Public enlightenment on reproductive health issues.
Domestication of provisions of international conventions, such as CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women).
Develop a rights-based code of ethics and inclusion in the curriculum of medical education.

Session 3: Post-Abortion Care - Barriers to delivery and access

Facilitator:
Ask trainees about the indications for safe termination of pregnancy for legal indications as provided for in the FMoH guidelines, or as adopted by the states.
Ask questions to ascertain if providers can enumerate the components of post-abortion care.
Guide answers and discussions, using the discussion guide provided.
Explain and ensure that providers understand what each component of post-abortion care entails.

Question to providers: What are the components of Post-Abortion Care?

Discussion guide:

- Treatment of pregnancy termination for legal indications, inevitable, incomplete, missed or unsafe abortion
- Compassionate counselling
- Contraceptive services
- Sexual and reproductive health services (on-site or via referral)
- . Community-service provider partnerships

Question to providers: What are the barriers and restrictions that affect access to abortion care?

Discussion guide:

I. Lack of access to information on safe abortion services even when indicated
II. Third-party consent requirements (e.g., parental, guardian, spousal or judicial consent).
III. Mandatory waiting periods.
IV. Regulatory barriers to access medicines.
V. Conscientious refusal by providers to deliver abortion care
VI. Cost of care
VII. Ignorance of the availability of services.

VIII. Sex and age of the provider

Question to providers: How can health care providers eliminate barriers and restrictions to access of abortion care?
Discussion guide:

- Providers as advocates of abortion care
- Request their professional associations to organize seminars that review abortion laws and discuss how those laws are interpreted and implemented
- Partner with other advocates, such as lawyers' associations and women's rights organizations, to plan advocacy strategies
- Write, publish and encourage colleagues, organizations to publish statements recognizing reproductive rights as human rights or stating their support for safe, legally permitted abortion
- Work with policymakers to take active role in defining current laws and policies
- Educate policymakers and others by disseminating statistics on abortion-related maternal mortality and morbidity
- Connect with community-based advocacy efforts that demand safe abortion services, improved access to contraception and/or sexual and reproductive health education for women, particularly young women
- Partner with religious leaders/groups who understand abortion care
- Values clarification for abortion attitude transformation
- Identify their personal beliefs and values about abortion
- Separate their beliefs and values from those of their clients' and focus on their clients' needs.
- Show respect to all women, regardless of their age, marital status, sexual and reproductive behaviours and decisions.
- Treat women with empathy - understand their feelings and perspectives and communicating this understanding.

Session 4: Abortion laws in Nigeria

Facilitator: Provide information about abortion laws in Nigeria

Discussion guide:
Abortion laws in Nigeria are restrictive
Penal code in the Northern states and criminal codes in the southern states
Legal provisions of the abortion law in Nigeria make it generally acceptable to perform an abortion to save the woman's life
A person performing an abortion outside the provisions of the law may be sentenced to up to fourteen years in prison and/or a fine
A pregnant woman who performs an abortion on herself may be sentenced to imprisonment for up to seven years
Inform and introduce participants to the guidelines for safe termination of pregnancy for legal indications as adopted from the FMoH for their state

MODULE 3: POST-ABORTION CARE

Purpose

The purpose of this module is to ensure that providers have the skill to provide high-quality care for women presenting after spontaneous or induced abortion (with or without complications), using recommended technologies.

Specific Objectives

By the end of this module, providers should be able to:

- Enumerate the five essential elements of post-abortion care
- Demonstrate competence in the procedure of Manual Vacuum Aspiration
- Demonstrate knowledge in the use of mifepristone and/or misoprostol for medical management of postabortion care
- Demonstrate effective counselling technique in PAC
- Demonstrate significance of Infection Prevention and Control (IPC) and its methods
- Acquire community-health service provider partnership skills
- Acquire referral/linkages skills

Module Plan

Recommended duration: (870min, 14.5hrs; 4 days)[a]

Module Outline	Training methods	Materials	Resources	Session time
3.1 • Introduction • Overview and Guiding Principles • Key elements of woman-centred PAC	Lecture	Multimedia projector Flip Chart	FMoH Post Abortion Care Manual	60min
3.2 Upholding a woman's sexual and reproductive rights in a postabortion care setting	Lecture and Discussion	Projector Flip chart	FMOH Post Abortion Care Manual	30min
3.3 Uterine Evacuation Methods	Didactic lectures, practical	PowerPoints, use of pelvic model, use of	Ipas Clinical	90min

• Definition of Overview of • methods: MVA, MA, expectant management Factors that may promote or hinder UE method availability and acceptability • Indications, advantages and disadvantages	demonstration, bedside teaching	MVA kits, misoprostol, video viewing	Updates in Reproductive Health,2021	
3.4 Counselling and Informed Consent.	Lecture, demonstration and role play	Multimedia projector, Counselling materials		75 min
3.5 Infection Prevention and Control	Lecture Discussion Demonstration	Multimedia projector, flipchart, infection prevention materials.		90min
3.6 Clinical Assessment	Lecture and clinical demonstration	Power Point, mannequin, patient		165 min
3.7 Ipas MVA instrument	Lecture and practical demonstration	Multimedia projector, MVA kit, pelvic model, bi-valve speculum, tenaculum/stopes forceps, videos on MVA		90 min
3.8 Uterine evacuation procedure with Ipas MVA Plus including paracervical block	Lecture and practical demonstration.	Ipas MVA Plus kit, pelvic model, video, speculum, tenaculum/Stopes forceps, gloves, kidney dish, antiseptic solution, sponge holding forceps, gauze/cotton wool, needle, syringe		180 min
3.9 Clinical practicum on live client	Coaching	Ipas MVA Plus kit, speculum, tenaculum/Stopes		30 min

		forceps, gloves, kidney dish, antiseptic solution, sponge holding forceps, gauze/cotton wool, needle, syringes, pain-relieving drugs, consent form		
3.10 Uterine evacuation with medical methods	Lecture	IEC Materials, misoprostol and mifepristone		45 min
3.11 Complications	Brainstorming, lecture, clinical case scenarios	Multimedia projector flipcharts, writing board, and marker		60 min
3.12 Community Linkages	Lectures, brainstorming	Multimedia projector flipcharts		60 min

[a]*The actual duration per session should be determined in consultation with the facility, the trainee, and the trainer. 9.75=16.25 hours. For OJT, this session is critical, so should last at least 4 days to ensure that trainees have a firm grip of the module*

Instruction to facilitators:

The approach to this module will include providing information, asking questions of providers and demonstrating procedures. The facilitator should be led by the discussion guide provided. The training should be tailored to individual provider's need.

Session 1: The five essential elements of Post-Abortion Care

Facilitator:

1. Ask questions to ascertain if providers can enumerate the elements of post-abortion care
2. Guide answers and discussions, using the discussion guide provided.
3. Explain and ensure that providers understand what each element of post-abortion entails.

Question to providers: What are the five essential elements of Post-Abortion Care?

Discussion guide:

1. Treatment of inevitable, incomplete, missed, or unsafe abortion
2. Compassionate counselling
3. Contraceptive services
4. Sexual and reproductive health services (on-site or via referral)
5. Community-service provider partnerships

Question to providers: How do you manage pregnancy complicated by inevitable, incomplete, missed or unsafe abortion?

Discussion guide:

Surgically - using the Manual Vacuum Aspiration (MVA)
Medically - using misoprostol and mifepristone

Session 2: The Manual Vacuum Aspiration

Facilitator: Using the discussion guide and available instruments, materials and mannequins, demonstrate the procedure for the manual vacuum aspiration. Allow providers to carry out procedures after watching your demonstration and make corrections as they go along. For practice on clients, ensure providers take turns to replicate the process.

Discussion guide:
Obtain written informed consent before the MVA procedure

The MVA procedure is outlined below:

1. Prepare the room, equipment and supplies for MVA and other reproductive health services (Pap's smear, IUD, etc.).
2. Give misoprostol two or three hours prior to MVA (if cervical os is closed as in blighted ovum and missed abortion.
3. Administer prophylactic antibiotics and analgesics
4. Ask the client to empty her bladder or empty bladder with catheter.
5. Place client in lithotomy position, clean with antiseptic and drape.
6. Perform a bimanual pelvic examination to re-confirm the size and position of the uterus.
7. Prepare the MVA aspirator and select which cannula to use.
8. Insert a speculum gently into the vagina and inspect the cervix for products of conception, which can be removed with a sponge holding forceps.
9. Clean the cervix and vagina gently.
10. Hold the cervix with a tenaculum or Stope's forceps, where available.
11. Perform paracervical block, if planned.
12. If the cervical canal does not allow the selected cannula, it can be dilated with cannulae of progressively increasing sizes until the desired cannula size is achieved
13. With gentle traction on the tenaculum/Stope's forceps, and using a non-touch technique, insert the cannula through the cervical canal into the uterine cavity just past the internal os or until the cannula touches the fundus of the uterus, after which it should be slightly withdrawn.
14. Attach the pre-charged aspirator to the cannula.
15. Release the valve buttons on the aspirator to commence suctioning of uterine contents.
16. Evacuate products of conception by gently and slowly rotating the cannula 180 degrees in each direction, using an in-and-out motion Detach aspirator if three quarter full before the end of the procedure and empty it.
17. Remove the cannula if blocked and clear the aperture.
18. Check for signs of completion, which should include:
    i. Red or pink foam with no more tissue in the cannula.

ii. Gritty sensation is felt as the cannula passes over the surface of the empty uterus. The uterus contracts and the cervix close on the cannula making the in-and-out movements of the cannula more difficult. The woman may feel more pain at this point.

19. Withdraw the aspirator and the cannula from the cervix, detach the aspirator and place cannula in a tray/kidney dish. Empty the contents of the aspirator into a strainer.
20. Remove tenaculum/Stope's forceps and check for vaginal bleeding. Apply pressure on the site of bleeding on the cervix or repeat evacuation if bleeding is from the uterine cavity.
21. Repeat bimanual examination after removing the speculum to check that the uterus is well contracted and confirm that the uterine size has reduced as expected.
22. Put speculum and other used instruments into a container with clean water or spray with enzymatic solution (Point of use preparation).
23. Evacuated tissue must be inspected under a bright light for completeness and molar pregnancy.

Post-procedure care

- Help the client out of bed to a comfortable and relaxed position for at least two hours.
- Check the client's vital signs every half hour for two hours.
- Check for vaginal bleeding every half hour for two hours.
- Administer antibiotics, when indicated.
- Give uterotonics, where indicated.
- Provide contraception based on informed consent.

Session 3: Medical Management

Facilitator: Provide information on the use of misoprostol in the medical management of abortion. Also, highlight that mifepristone combined with misoprostol can be used for missed abortion.

Discussion guide:
Preparation, prior to medical management, includes counselling and obtaining informed consent, performing examination, including general, abdominal, bimanual and speculum examination. Confirm that the woman knows what to do in an emergency and discuss her contraceptive needs.
Counsel the patient on the basic information on misoprostol and mifepristone, risks and benefits, expected effects, possible side effects, the warning signs for potential complications, and when and where to seek medical help.

Guidelines on taking misoprostol
Women should be offered a choice of taking the misoprostol at home or in the healthcare facility, since different women have different needs and desires. For some women, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy.

It is of great importance that only those women who are able to return to the health facility in case of emergency (such as heavy bleeding) are given misoprostol to use at home. The distance from the health facility, support at home and transport, should all be carefully evaluated.

Health-care providers should provide the following to all women taking misoprostol at home:

- Misoprostol pills or a prescription for them.
- Detailed information on number of tablets to be taken.
- Details on the route of taking misoprostol.
- Pain medication, such as ibuprofen and/or mild narcotics, with instructions on how to take it.
- Written and pictorial information on the uterine evacuation with misoprostol, side effects and warning signs, what signs indicate that the evacuation is complete, and information for follow-up contact, if desired.
- Information on whom to contact, including a telephone number where possible, in case of questions, problems or complications, or the possibility of an unsuccessful evacuation, and where to go, in the case of an emergency.
- Contraceptive information and supplies.
- Antibiotics are essential, where sepsis is suspected or confirmed.

MODULE 4: MEDICAL ABORTION FOR LEGAL INDICATION

Purpose

The purpose of this module is to make providers aware that medically indicated abortions could be offered to women who meet the indications. Providers are to familiarize themselves with the laws governing abortion in Nigeria and the FMoH guidelines (or state adopted) for Safe Termination of Pregnancy for legal indications. Providers are to have the skills to provide high-quality care for women presenting with medical indications for termination of pregnancy, using WHO-recommended technologies.

Specific Objectives

By the end of this module, providers should be able to:

- Know the in-country abortion laws as specific to their states.
- Understand the indications for medical termination of pregnancy
- Know the methods used for medical abortion.

Instruction to facilitators:

The approach to this module will include providing information, asking questions of providers and demonstrating procedures. The questions and discussions ensuing from asking questions should be guided by the facilitator, using answers provided in the discussion guide. Also, demonstration of procedures should be guided by the facilitator, using the discussion guide provided.

Session 1: The abortion laws of Nigeria.

Facilitator:

- Ask questions to ascertain if providers know the in-country abortion laws.
- Ask providers if they know the FMoH (or state adopted) guidelines for SToP
- Guide answers and discussions, using the discussion guide provided.
- Explain and ensure that providers understand what the abortion laws cover

Question to providers: Are there laws governing the provision of induced abortions in Nigeria?

Discussion guide:

- Abortion in Nigeria is a controversial topic
- Abortion in Nigeria is governed by two laws that differ depending on geographical location. Northern Nigeria is governed by The Penal Code and Southern Nigeria is governed by The Criminal Code. The only legal way to have an abortion in Nigeria is if having the pregnancy is going to put the mother's life in danger.
- The Criminal Code is currently enforced in southern states. The abortion laws of the Criminal Code are expressed within sections 228,229 and 230. Section 228 states that any person providing a miscarriage to a woman is guilty of a felony and risks up to 14 years of imprisonment. Section 229 states that any woman obtaining a miscarriage is guilty of a felony and risks up to imprisonment for 7 years. Section 230 states that

anyone supplying anything intended for a woman's miscarriage is also guilty of a felony and risks up to 3 years of imprisonment.

- Section 297 states" A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life, if the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case". This section provides the legal framework for legal indications for termination of pregnancy in Nigeria.
- The Penal Code operates in northern states, with abortion laws contained in sections 232, 233, and 234. The sections of the Penal Code parallel the Criminal Code, besides the exception for abortion with the purpose of saving the life of the mother. The Penal Code's punishments include imprisonment, fine, or both.
- The FMoH Guidelines (and state adopted) for Safe Termination of Pregnancy for Legal indications has provided a comprehensive list of maternal and foetal conditions/indications for which termination of a pregnancy is permissible under the law towards saving the life of the mother

Session 2: Indications for Medical Abortion

Facilitator:

- Ask questions to ascertain if providers know why abortions may be obtained for medical reasons.
- Guide answers and discussions, using the discussion guide provided.
- Explain and ensure that providers understand the various indications.

Question to providers: What reasons are sufficient to provide a medically indicated induced abortion in Nigeria?

Discussion guide:

- The reasons may be maternal, or foetal, as summarized in the tables below:

Table 1: *Maternal indications for termination of pregnancy

Category	Examples
Cardiovascular disease	Pulmonary hypertension
	Eisenmenger's syndrome
	History of myocardial infarction
	History of pregnancy cardiomyopathy
	Severe hypertensive disease
Genetic disease	Marfan's syndrome
Hematologic disease	Thrombotic thrombocytopenic purpura

Category	Examples
Neurologic disease	Untreated cerebrovascular malformation, such as aneurysm or arteriovenous malformation
Renal disease	Deterioration of renal function in early pregnancy
Neoplastic disease	Invasive carcinoma of the cervix
	Any neoplastic disease in which maternal survival depends on prompt treatment with chemotherapy or radiation in teratogenic doses
Metabolic disease	Proliferative diabetic retinopathy
Terminal maternal disease	End-stage cancer, end-stage AIDS
Disorders of the current pregnancy	Intrauterine infection
	Rupture of the fetal membranes before fetal viability
	Severe pre-eclampsia or eclampsia
Pregnancies that present a high risk of uterine injury	Conjoined twins
	Placenta accrete
	Prior catastrophic uterine rupture
Neoplastic pregnancy	Gestational Trophoblastic Disease
Nonviable pregnancy	Fetal death in utero
	Anembryonic pregnancy (“empty sac” or “blighted ovum”)
	Inevitable abortion

Table 2: Fetal indications for termination of a desired pregnancy

Category	Examples
Known major fetal malformation	Anencephaly
	Myelomeningocele
	Severe hydrocephaly
	Severe cardiac anomaly
	Renal agenesis
Chromosomal abnormality	Down's syndrome and other trisomies
	Fragile X
	X-linked recessive disease such as hemophilia
Inherited metabolic defect	Duchenne muscular dystrophy
	Tay-Sachs disease
Fetal exposure to known teratogen	Warfarin
	Thalidomide
	Isotretoin

	Cancer chemotherapy
Radiation exposure	15 rad or more total
	Radioactive iodine in ablative doses
Maternal infection	Rubella
	Cytomegalovirus
	Toxoplasmosis

**See other indications in the Standard & Guidelines for Safe Termination of Pregnancy for Legal Indications (FMoH 2018) or as adopted by the state.*

Session 3: Methods of Medical abortion for legal indication

Facilitator: Provide information on the use of mifepristone and/or misoprostol in the medical management of abortion.

Discussion guide:

- Provider should re-establish legal termination of pregnancy.
- Preparation, prior to medication abortion, includes counselling and obtaining informed consent; performing a client assessment, including physical, bimanual and speculum examination.
- Confirm that the woman knows what to do in an emergency and discussing her contraceptive needs.
- Counsel the patient on the basic information on mifepristone and/or misoprostol, risks and benefits, expected effects, possible side effects, the warning signs for potential complications, and when and where to seek medical help.

Guidelines on taking misoprostol

- Whenever possible, women should be offered a choice of taking the misoprostol at home (up to 11 weeks) or in the healthcare facility, since different women have different needs and desires.
- For some women, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy.
- It is of great importance that only those women who are able to return to the health facility in case of emergency (such as heavy bleeding) are given misoprostol to use at home.
- The distance from the health facility, support at home, and transport, should all be carefully evaluated.

Table 2: Summary of Recommended Medical Abortion Regimen

Indication	Drug	Dosage	Route of Administration
For incomplete abortion at < 14 weeks	Misoprostol	600 µg start OR 400 µg	Orally Sublingually
For incomplete abortion at ≥ 14 weeks	Misoprostol	400 µg	Misoprostol: administered sublingually, vaginally or buccally every 3 hours until expulsion
For missed abortion at < 14 weeks	Mifepristone + Misoprostol OR Alternative regimen: misoprostol	200mg 800 µg* 800 µg	200 mg mifepristone administered orally, followed by 800 µg misoprostol administered by any route (buccal, vaginal or sublingual). The minimum recommended interval between use of mifepristone and misoprostol is 24 hours Buccal, vaginal, or sublingual route. it should be noted that at gestational ages ≥ 9 weeks, evidence shows that repeat dosing of misoprostol (every three hours until expulsion of products of conception) is more efficacious to achieve success of the abortion process.
For missed abortion at ≥ 14 weeks	Mifepristone Misoprostol OR Misoprostol alone	200 mg 400 µg	200 mg mifepristone administered orally, followed 1–2 days later by 400 µg misoprostol administered sublingually or vaginally every 4–6 hours until expulsion. 400 µg misoprostol administered sublingually or vaginally every 4–6 hours until expulsion.

For medically indicated abortion at < 12 weeks	Mifepristone + Misoprostol OR Misoprostol alone	200 mg 800 µg 800 µg	200 mg mifepristone administered orally, followed 1–2 days later by 800 µg misoprostol administered vaginally, sublingually or buccally. 800 µg misoprostol administered vaginally, sublingually or buccally. Repeat doses of misoprostol can be given every 3 hours until expulsion.
For medically indicated abortion at ≥ 12 weeks:	Mifepristone + Misoprostol OR Misoprostol alone	200 mg 400 µg	200 mg mifepristone administered orally, followed 1–2 days later by repeat doses of 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours 400 µg misoprostol administered vaginally, sublingually or buccally every 3 hours until expulsion

Misoprostol is administered 1-2 days (24-48 hours) after initial Mifepristone dose

Notes:

- After 7 weeks of gestation, oral administration of misoprostol should **not** be used.
- Home use of misoprostol following mifepristone or in a misoprostol-only regimen may be offered up to 11weeks gestation.
- • After 11weeks gestation, misoprostol should be used in a facility

Health-care providers should provide the following to all women taking misoprostol at home.

- Misoprostol pills or a prescription for them
- Detailed information on number of tablets to be taken
- Details on the route of taking misoprostol
- Pain medication, such as ibuprofen and/or mild narcotics with instructions about how to take it.
- Written and pictorial information on the uterine evacuation with misoprostol, side effects and warning signs, what signs indicate that the evacuation is complete, and information for follow-up contact, if desired; side-effects include vomiting, diarrhoea, fever, and chills.
- Information on whom to contact, including a telephone number where possible, in case of questions, problems or complications, or the possibility of an unsuccessful evacuation, and where to go in the case of an emergency, e.g., if bleeding soaks two or more pads per hour for at least 2 hours, the woman should contact her provider to determine whether she needs to be seen
- Contraceptive information and supplies.

When the administration of the drugs results in an incomplete abortion,

- A manual vacuum aspiration may be used to follow up.
- Antibiotics are essential, where indicated, to prevent sepsis following an induced abortion.
- Other components of the post-abortion care should also be instituted.
- At the follow-up appointment, routine sonographic examination is typically unnecessary. Instead, clinical evaluation, including history and a bimanual examination, should be done.

MODULE 5: POSTABORTION CONTRACEPTIVE SERVICES

Purpose

The purpose of this module is to ensure that providers have the necessary skills of counselling and providing contraceptive services to patients.

Specific Objectives

By the end of this module, providers should be able to:

- Recall the modern contraceptive methods available to patients
- Discuss how modern contraceptive methods promote women's health and rights
- Understand the models of service delivery of contraceptives
- Adequately counsel patients and guide them in making informed choice of contraceptive method before they leave the facility.

Module Plan

Recommended duration: (615min: 10hrs; 3days)[a]

Module Outline	Training methods	Materials	Resources	Session time
5.0 Introduction	Didactic Lecture	Multimedia projector, flip charts, photocopy of the power points, presentations, training slides		30 min
5.1Contraception counselling and method provision after postabortion care	Didactic Lectures, practical demonstration &return demonstration	PowerPoint slides, counseling materials (job aids and relevant IEC materials)		120 min
5.2 women's contraceptive needs following postabortion care	Didactic Lectures	PowerPoint slides, role play		30 min
5.3 Contraceptive failure	Lectures	PowerPoint slides, role play		30 min
5.4 Rights to Privacy,	Lectures	PowerPoint slides,		30 min

confidentiality, and informed choice		demonstratio n		
5.5 Involvement of partners	Lectures	PowerPoint slides		15 min
5.6 Essential steps for contraceptive counselling	Lecture and clinical demonstratio n	PowerPoint slides		60min
5.7 Medical eligibility for contraceptive use after uterine evacuation	Lecture	PowerPoint slides, MEC Wheel (medical eligibility criteria tool)		30min
5.8 Uncomplicated vacuum aspiration	Lecture	PowerPoint slides, audio-video clips		30min
5.9 Vacuum aspiration with complications	Lecture	PowerPoint slides, audio-video clips		30min
5.10 Emergency contraception	Lecture	PowerPoint slides, demonstratio n with the commodities		90min
5.11 Special contraceptive counselling considerations e.g., people living with disabilities, adolescent, mental illness, etc.	Lecture, small group work scenarios	PowerPoint slides, job aids		60min
5.12 Summary	Lecture	PowerPoint slides		60min

Instructions to facilitator:

The approach to this module will include providing information, asking questions of providers and role play in order to practice counselling sessions. The questions and discussions ensuing from asking questions should be guided by the facilitator, using answers provided in the discussion guide.

Session 1: Overview of Modern contraceptive methods

Question to providers: List the different categories of modern contraceptive methods and their examples.

Discussion guide:

***Hormonal contraceptives* -**

- Oral contraceptive pills (e.g., COCs, Progestin only pills, emergency contraceptive pills, like postinor 2, dermal patches)
- Injectables (e.g., Depo-Provera, Noristerat, Sayana press),
- Implants (Jadelle, Implanon)

***Intra-Uterine Devices* -**

- Copper bearing intra-uterine contraceptive device,
- Levonorgestrel containing intra-uterine system (LNG-IUS)

***Barrier methods* -**

- Male condom,
- Female condom,
- Cervical caps

***Surgical contraception* –**

- Bilateral Tubal ligation
- Vasectomy

Natural methods e.g., cycle beads, lactational amenorrhea, etc.

Question to providers: How can contraceptive use promote women's health and rights?

Discussion guide:

- Allowing mothers to achieve adequate spacing between births, which improves infant health and saves infant lives.
- Helping women avoid unwanted pregnancies, which prevents unnecessary exposure to potential risks during pregnancy and delivery.

Session 2: Models of service delivery

Facilitator: Explain the different models of service delivery to providers

Discussion guide:
Contraceptive counselling and method provision can take place at various points and in different ways during abortion services. Service-delivery models include:

- On-site provision of services.
- Referral to another facility that can counsel and provide services.
- Community-based contraceptive counselling and method provision can be offered by trained individuals, such as CHEWs/trained CHIPs agents or staff of community-based organizations e.g., CSOs, NGOs.

Providing contraceptive services at the same time and in the same location as the abortion care can help ensure that a woman receives a contraceptive method before leaving the facility.
If a woman is eligible and has consented to a method, any method of contraception, including IUDs and female sterilization, may be started at the same time as a vacuum aspiration.
If a woman chooses misoprostol, most methods of contraception can be provided with the medication.
After misoprostol, an IUD may be inserted, when it is reasonably certain that a woman is no longer pregnant.

Session 3: Essential steps for contraceptive counselling

Facilitator:
Provide information and explanation on the essential steps for contraceptive counselling, using the **GATHER** technique
Ask providers to pair themselves, role play and provide contraceptive counselling to each other, while the facilitator observes and fills in the gaps that are missing.

Discussion guide:
The following steps have been adapted from the **GATHER** technique, a widely used approach in contraceptive services.
Greet and establish rapport: Secure a private space to talk, greet the woman in a friendly way, speak directly to her and demonstrate interest and concern.
Ask if it is an appropriate time to discuss contraception, assure her that the conversation will be kept confidential and ask if she wants her partner present.
Ask the woman about her needs. Using open-ended questions, discuss the factors that led to the abortion and determine if the pregnancy was planned or not.
If she was using contraception, ask her to explain how failure occurred. Explain human reproduction, if necessary. Some women who seek an abortion may not fully understand basic information on how they became pregnant or how contraception prevents pregnancy. This may be particularly true for young women.
Find out if she desires to delay or prevent future pregnancy.
Consider the woman's clinical condition and her personal situation.
Tell the woman about characteristics of available methods
Determine which contraceptive methods are available and accessible.

Explain characteristics, side effects and effectiveness of the methods available and direct her to accessible places to obtain them.
Help the woman choose her method
Support the woman in selecting the contraceptive method that best suits her and her partner.
Solicit follow-up questions, explaining the characteristics of different methods and exploring resupply issues, including where contraceptives may be available in her community.
Discuss potential barriers to successful use of contraception and explore ways to overcome them.
Explain how the method works
Ensure she understands how the method works.
Help her develop a plan for continued use.
Return for follow-up care and refer to other resources
Encourage her to return if she has concerns or problems with her method, the method becomes unacceptable, if she wants to change methods, if she needs resupply or if she wishes to stop using contraception.
Discussions about contraception may reveal other factors affecting a woman's sexual and reproductive health, such as violence or commercial sex work.
Providers should have resource lists available.

Session 4: Medical Eligibility for Contraceptive Use after a Uterine Evacuation.

Facilitator:
Provide information on various methods of contraception available and highlight possible side effects.
Assess provider's knowledge about medical eligibility criteria for contraceptive advise.

Discussion guide:
The following guidelines should be discussed:
There are no severe complications requiring further treatment.
The woman receives adequate counselling and gives informed consent.
The provider screens for any precautions for using a particular contraceptive method.
Women who desire contraception should be provided the preferred method as soon as possible as shown in table below.

Table: When to start contraception after Mifepristone or Misoprostol

Contraceptive method	**Initiating time**
Oral contraceptive pills, contraceptive ring, and patch	Immediately after the first pill of the medical abortion regimen (mifepristone or misoprostol)
Implant	Immediately after the first pill of the medical abortion regimen (mifepristone or misoprostol)
Injection	Immediately after the first pill of the medical abortion regimen (mifepristone or misoprostol)
IUD	After successful uterine evacuation
Sterilization	After successful uterine evacuation and the client not willing to have more children

Fertility awareness-based Methods (Rhythm, Basal body temperature, Cervical mucus etc)	Should only be started after the resumption of regular periods

When To Start Contraception after Manual Vacuum Aspiration (MVA)

Contraceptive method	**Initiating time**
Oral contraceptive pills, contraceptive ring, and patch	Immediately after procedure
Implant	Immediately after procedure
Injection	Immediately after procedure
IUD	Immediately after procedure
Sterilization	Immediately after procedure
Fertility awareness-based Methods (Rhythm, Basal body temperature, Cervical mucus etc)	Immediately after procedure

- Women should not have unprotected sexual intercourse until any medical complications are resolved and their chosen contraceptive method becomes effective.
- Fertility-awareness based methods should only be started after the resumption of regular menstrual cycle.
- Some medical conditions require a delay in the use of certain methods. Another contraceptive method should be offered to the woman for use in the interim.

Special Contraceptive Counselling Considerations.

For the following women and issues, there are certain specialized considerations providers should keep in mind. Special contraceptive counselling considerations, which cover how providers can meet the specific contraceptive needs for women in these circumstances:

- Young women.
- Women who have had multiple abortions.
- Women who are experiencing violence.
- Women who are living with HIV.
- Women engaged in sex work.
- Women with cognitive and developmental disabilities and mental illness
- Refugees and displaced persons.

Women who have experienced female genital cutting.

APPENDIX

A. POST ABORTION CARE KNOWLEDGE QUESTIONNAIRE

Instructions: This is a pre-assessment checklist for the CAC-OJT trainees to complete before and after the On-The-Job training completion. In the space provided, print a capital T if the statement is TRUE or a capital F if the statement is FALSE.

STATE	
FACILITY NAME	
SUPERVISOR'S NAME	
TRAINER'S NAME & ID	
TRAINEE'S NAME	
DATE	

1. The rights of women to choose when, if and with whom to engage in sexual activity and whether or when to have children is a basic human right.	
2. Unsafe abortion is a procedure performed either by persons lacking in necessary skills or in an environment lacking in medical standards.	
3. Taking herbs, poison, or traditional medicine to induce an abortion may lead to cramping nausea and vomiting.	
4. Manual vacuum aspiration is the most widely used recommended method of uterine evacuation.	
5. If a client is suffering from shock, they should rest in a quiet room away from other clients.	
6. High blood pressure is a sign of shock.	
7. The MVA procedure can begin before the size of the uterus has been determined.	
8. The uterine size can be determined using bimanual examination.	
9. During an abdominal examination you should check for masses, suprapubic or pelvic tenderness and distended abdomen with decreased bowel sounds.	
10. Spontaneous abortion occurs in one in five (20%) of clinically recognized pregnancies.	
11. MVA instruments are made up of a semi rigid cannula and a vacuum forming syringe.	
12. Any size of cannula is used for the MVA procedure.	
13. The risks associated with MVA procedures are lower than those with sharp curettage procedures and full term delivery.	
14. After a PAC procedure a normal menstrual period should begin within 2 weeks.	

15. The goal of pain management is to ensure that the procedure can be done as quickly as possible so that many patients can be seen in one day.	
16. Fear and anxiety can increase the amount of pain experienced.	
17. The MVA procedure causes no pain at all to the client.	
18. Vocal Local is a pain management method that is drug free and is based on reducing anxiety, involving the client and demedicalising the procedure.	
19. Misoprostol, a drug effective in post abortion care, is administered in 4 doses.	
20. Bleeding is considered a side effect, after administering misoprostol.	
21. Staff attitude towards the client can be helpful but is not that important.	
22. Women will return to fertility 4 weeks after an abortion.	
23. Family planning methods should be available at the site where the PAC procedure is offered.	
24. One designated individual in each health facility should be responsible for infection prevention.	
25. Careful handling of sharps is essential to protect staff members from exposure to TB.	
26. To decontaminate instruments a solution of 50% chlorine should be used.	
27. Point of use preparation should replace decontamination soak Ten minutes is enough time for instruments to be soaked in a chlorine solution.	
28. Instruments do not need to be cleaned and decontaminated before sterilizing by autoclave.	
29. The maximum storage time for wrapped sterile items is 14 days.	
30. Sharps can be destroyed by burning.	

SCORING: Give 1 point for each **correct** answer.

$$\frac{\text{---------}}{30} \text{ X } 100 = \text{……..…\%}$$

REMINDER	**EXCELLENT** **GOOD** **FAIR**	test score >= 85% 85% > test score >= 65% test score < 65%

POST-ABORTION CARE KNOWLEDGE QUESTIONNAIRE – ANSWERS

1. The rights of women to choose when, if and with whom to engage in sexual activity and whether or when to have children, is a basic human right.	TRUE
2. Unsafe abortion is a procedure performed either by persons lacking in necessary skill or in an environment lacking in medical standards.	TRUE
3. Taking herbs, poison or traditional medicine to induce an abortion may lead to cramping nausea and vomiting.	TRUE
4. Manual vacuum aspiration is the most widely used recommended method of uterus evacuation.	TRUE
5. If a client is suffering from shock, they should rest in a quiet room away from other clients. Shock requires immediate and intensive treatment to save the patient's life. The client's condition can worsen quickly and so they must be closely monitored.	FALSE
6. High blood pressure is a sign of shock. When a client is in shock, she will have low blood pressure.	FALSE
7. The MVA procedure can begin before the size of the uterus has been determined.	FALSE
8. The uterine size can be determined using bimanual examination. You can also use the MVA cannula or uterine sound.	TRUE
9. During an abdominal examination, you should check for masses, suprapubic or pelvic tenderness and distended abdomen with decreased bowel sounds.	TRUE
10. Spontaneous abortion occurs in one in five (20%) of clinically recognized pregnancies.	TRUE
11. MVA instruments are made up of a semi rigid cannula and a vacuum forming syringe.	TRUE
12. Any size of cannula is used for the MVA procedure. You should have several sizes available. A cannula that is too small will result in retained tissue or loss of suction.	FALSE

13. The risks associated with MVA procedures are lower than those with sharp curettage procedures and full-term delivery.	TRUE
14. After a PAC procedure a normal menstrual period should begin within 2 weeks.	FALSE
15. The goal of pain management is to ensure that the procedure can be done as quickly as possible so that many patients can be seen in one day. The goal is to ensure that the patient experiences minimal worry and discomfort with the lowest possible health risks.	FALSE
16. Fear and anxiety can increase the amount of pain experienced.	TRUE
17. The MVA procedure causes no pain at all to the client. The MVA procedure will cause additional pain and cramping.	FALSE
18. Vocal Local is a pain management method that is drug free and is based on reducing anxiety, involving the client and de-medicalizing the procedure.	TRUE
19. Misoprostol, a drug effective in post abortion care, is administered in 4 doses. Misoprostol is administered in 1 dose of 600mg (3x200mg tablets). Repetitive doses are given as needed, depending on clinical presentation.	FALSE
20. Bleeding is considered a side effect, after administering misoprostol. Bleeding is a desired effect and may be heavy for 3 to 4 days before becoming moderate. Side effects are nausea, vomiting, diarrhoea, skin rash and cramping.	FALSE
21. Staff attitude towards the client can be helpful but is not that important. Staff attitude is very important. Staff should be non-judgmental, show empathy and offer emotional support. They should also have good communication and counselling skills.	FALSE
22. Women will return to fertility 4 weeks after an abortion. Women can be fertile again 10 days after an abortion. It is important that this is explained clearly to her, and FP methods discussed and offered.	FALSE

23. Family planning methods should be available at the site where the PAC procedure is offered. Studies have shown that women, who were offered a method of family planning at the time of PAC, were more likely to use a method of FP and less likely to present for another abortion within 2 years.	TRUE
24. One designated individual in each health facility should be responsible for infection prevention. IP is the responsibility of everybody in a health facility as it is necessary to follow procedures in all areas of the facility and at every point of the client 'journey'.	FALSE
25. Careful handling of sharps is essential to protect staff members from exposure to TB.	FALSE
26. To decontaminate instruments, a solution of 50% chlorine should be used. A solution of 0.5 % chlorine should be used.	FALSE
27. Point of use preparation should replace decontamination soak	TRUE
28. Instruments do not need to be cleaned and decontaminated before sterilizing by autoclave. Instruments should be cleaned and decontaminated before sterilizing with autoclave, chemical or dry heat. Clots of blood can still harbour harmful micro-organisms even after autoclaving.	FALSE
29. The maximum storage time for wrapped sterile items is 14 days. It is 7 days maximum, after which the instruments should be sterilized again.	FALSE
30. Sharps can be destroyed by burning. Sharps will only be destroyed by industrial incinerators. Sharps boxes should be dealt with when full, pour in fuel and set fire, the plastic of the syringes will melt and encapsulate the sharps which can then be buried safely.	FALSE

REMINDER	**EXCELLENT** **GOOD** **FAIR**	test score >= 85% 85% > test score >= 65% test score < 65%

B. CHECKLIST FOR POST-ABORTION CARE BY MANUAL VACUUM ASPIRATION (MVA)

- To be used by the service provider as a learning guide for practice
- To be used by the trainer at the end of the course for skill competence assessment
- To be used by the supervisor during supportive supervision in the health facilities

Place a "✓" in case box, if step/task is performed satisfactorily, an "✗", if it is not performed satisfactorily or if not observed, "N/A" if the step is not required.
Satisfactory: Performs the step or task according to the standard procedure or guidelines.
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines.

Trainee Service provider's name:

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	MODELS OR CLIENTS					COMMENT
Enter M for Model and C for Client (if assessment is done on Model, do not enter score in the training database)						
Enter the date						
INITIAL ASSESSMENT						
Greets woman respectfully and kindly.						
1. Assesses client for pelvic inflammation, shock or complications.						
2. If complications are identified, stabilizes the client and transfers, if necessary.						
MEDICAL EVALUATION						
3. Documents a full medical history.						
4. Performs limited physical (heart, lungs, abdomen) and pelvic examination to confirm the incomplete abortion status.						
5. Ensures an open cervical os and a uterine size less than 12 weeks of gestation.						
6. When available, uses ultrasound as an additional diagnostic tool, if provider cannot confirm incomplete abortion status by history and clinical examination.						
7. Gives the woman information about her condition and what to expect.						
GETTING READY						
8. Explains the process to the woman (and her support person), listens to he and responds attentively to questions and concerns.						
9. Provides continual emotional support and reassurance, as feasible.						
10. Provides pain management, depending on each client:						

premedication PO 1 hour before procedure, depending on the status of the client.						
11. Ensures that the required sterile or high-level disinfected instruments are present.						
12. Ensures the appropriate size of cannulaa is available. Checks MVA syringe and charges it (establishes vacuum).						
13. Checks that client has emptied her bladder and washed her perineal area.						
14. Puts on personal protective equipment.						
15. Uses antiseptic hand sanitizer or washes hands thoroughly and puts on high-level disinfected/sterile surgical gloves.						
16. Arranges sterile/high-level disinfected instruments on sterile tray or in high-level disinfected container.						
PRE-PROCEDURE TASKS						
17. Explains each step of the procedure before performing it.						
18. Performs bi-manual examination.						
19. Inserts speculum.						
20. Applies antiseptic to cervix and vagina three times.						
21. Gently applies a sterile non-traumatic tenaculum or forceps on the anterior labia of the OS to ensure stability of the uterus and avoid perforation throughout the MVA procedure.						
22. Removes any POC and checks for cervical tears.						
SELECT CANNULA AND SYRINGE						
23. Assesses uterine size.						
24. Selects cannula appropriate to the uterine size and cervical dilations.						
25. Inspects cannula for cracks or signs of weakness. Discards, if any are present.						
26. Selects syringe.						
27. Inspects syringe for cracks or signs of weakness. Discards, if any are present.						
ASSEMBLE CANNULA AND SYRINGE						
28. Attaches cannula to syringe.						
29. Checks that the plunger is positioned fully within the barrel of the syringe, with the pinch valve open and the valve button out.						
30. Grasps the barrel of the syringe and pulls back on the plunger until the arms of the plunger snap outward.						
31. Checks that the plunger cannot move forward without being released.						

32. Checks the syringe for vacuum tightness by leaving the syringe for a couple of minutes once the vacuum is established then opens the pinch valve and listens for a rush of air into the syringe.						
33. Places the prepared equipment on sterile cloth and covers until procedure begins.						
MVA PROCEDURE						
34. Puts single-toothed tenaculum or vulsellum forceps on lower lip of cervix.						
35. Administers paracervical block.						
36. Applies traction to cervix.						
37. Dilates the cervix (if needed)						
38. Inserts the cannula gently through the cervix into the uterine cavity.						
39. Attaches the prepared syringe to the cannula and once ready, open the vacuum.						
40. Evaluates contents of the uterus.						
41. When signs of completion are present, withdraws cannula and MVA syringe. Empties contents of MVA syringe into a strainer.						
42. Removes tenaculum or forceps and speculum.						
43. Performs bi-manual examination.						
44. Inspects tissue removed from uterus to ensure complete evacuation.						
45. Inserts speculum and checks for bleeding.						
46. If uterus is still soft or bleeding persists, repeats steps 39-44.						
POST-PROCEDURE TASKS						
47. Before removing gloves, disposes of waste materials in a leak-proof container or plastic bag.						
48. Flushes MVA syringe and cannula with 0.5% chlorine solution and submerges in solution for decontamination.						
49. Removes gloves and discards them in a leak-proof container or plastic bag.						
50. Uses antiseptic hand rub or washes hands thoroughly.						
51. Checks for bleeding and ensures cramping has decreased before discharge (after 2 hours).						
52. Instructs client regarding PAC precautions.						
53. Discusses reproductive goals, counsels on contraception and provides FP as appropriate.						
54. Encourages the client to return any time, if they have a question or problem.						
55. Records the findings in client's file and daily activity register before saying goodbye.						

Enter the total of "✓"						
Enter the total of steps (remove the "N/A", if any)						

SCORE - Calculate the percentage: Score = Total of "✓" / Total of steps X 100 = ...% If the assessment is done on Model, do not enter the score in the training database						

Ask the service provider his/her level of confidence to perform the procedure safely and efficiently on a scale from 1 to 10:

COMMENTS:

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REMINDER	EXCELLENT	checklist score >= 90%	GOOD	90% > checklist score >= 80%	FAIR	checklist score < 80%

C. CHECKLIST FOR POST-ABORTION CARE WITH MISOPROSTOL/MIFEPRISTONE

- To be used by the service provider as a learning guide for practice
- To be used by the trainer at the end of the course for skill assessment
- To be used by the supervisor during supportive supervision in the health facilities

Place a "✓" in case box if step/task is performed satisfactorily, an "✗" if it is not performed satisfactorily or if not observed, "N/A" if the step in not required.
Satisfactory: Performs the step or task according to the standard procedure or guidelines.
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines.

Service provider name:

(Many of the following steps/tasks should be performed simultaneously)

STEP/TASK	CLIENTS (C)					COMMENT
	C 1	C 2	C 3	C 4	C 5	
Enter the date						
INITIAL ASSESSMENT						
1. Greets client respectfully and kindly.						
2. Assesses client for allergy to misoprostol or other prostaglandins, shock, ectopic pregnancy, and signs of pelvic infections and/or sepsis.						
3. If any of above complications are identified, does not administer misoprostol.						
MEDICAL EVALUATION						
4. Takes a full medical history.						
5. Performs limited physical (heart, lungs, and abdomen) and pelvic examination to confirm the incomplete abortion status.						
6. Ensures an open cervical OS and a uterine size less than 12 weeks of gestation.						
7. Where available, uses ultrasound as an additional diagnostic tool if provider cannot confirm incomplete abortion status by history and clinical exam.						
8. Gives the woman information about her condition and what to expect.						
9. If she has an IUCD in place, IUCD is removed before drug administration.						
10. Makes sure she has no coagulation disorders or is currently taking						

anticoagulants.						
GETTING READY						
11. Explains to the woman (and support person) how the procedure will work, listens to her and responds attentively to her questions and concerns.						
12. Provides continual emotional support and reassurance, as feasible.						
13. Explains that she may have some side effects.						
14. Informs the client of the course of treatment which involves a follow-up visit.						
REGIMEN						
15. Checks expiry date. Correctly administers a single dose of Misoprostol 600-800mcg, and or Mifepristone 200mg as a single done						
COURSE OF TREATMENT						
16. Explains the use of Mifepristone/or misoprostol as well as possible side effects and success rate. Explains that surgical intervention may be needed to empty the uterus for some women.						
17. Explains to client that the expulsion can occur over several hours to several days and bleeding is likely to be heavy for 3-4 days, followed by light bleeding or spotting for several days.						
18. Explains to client that she can take the Mifepristone/or misoprostol at the clinic or at home. Encourages her to ask any questions or voice any concerns.						
19. Does not provide antibiotic automatically without assessing need for it. *Routine antibiotic coverage is not necessary and local norms regarding antibiotic use should be followed if the woman requires antibiotics, based on history or clinical exam.*						
20. Asks client about her reproductive health goals and advice client to receive FP counselling before discharge or during the follow-up visit.						
21. Discusses return visits and follows up with the client within 7 to 14 days.						
EFFECTS AND SIDE EFFECTS						

22. Bleeding: tells client to seek medical attention if she soaks more than 2 extra-large sanitary pads or equivalent per hour, for 2 consecutive hours.							
23. Cramping: give analgesia (e.g., NSAID).							
24. Fever and/or chills: advises client to seek medical attention if fever persists more than 24 hours after taking misoprostol.							
25. Advises client that nausea and vomiting may occur 2-6 hours after taking misoprostol and will typically resolve within 6 hours.							
26. Advises client that she may experience diarrhoea, but that it should resolve within a day.							
27. Advises client that she may experience a skin rash, but it should resolve within several hours.							
✓ *Enter the total of "✓"*							
*Enter the total of steps (remove the "**N/A**", if any)*							
✓ **SCORE** - *Calculate the percentage:* % Score= Total of "✓" / Total no. of steps x 100							

COMMENTS:

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REMINDER	EXCELLENT	checklist score >= 90%	GOOD	90% > checklist score >= 80%	FAIR	checklist score < 80%

FAIR performance on client - the trainee can perform the procedure at the facility on client only with a supervisor

To be qualified, the SP must have performed the procedure MVA with at least 5, 7 or 10 clients under observation (with either a trainer or a supervisor) and obtains a score above 90%, at least once for a medical doctor, nurse/midwife and CHEW/CHO respectively.

D. CHECKLIST FOR POST-ABORTION FAMILY PLANNING COUNSELLING

- To be used by the service provider as a learning guide for practice
- To be used by the trainer at the end of the course for skill assessment
- To be used by the supervisor during supportive supervision in the health facilities

Place a "✓" in case box, if step/task is performed satisfactorily, an "✗", if it is not performed satisfactorily or if not observed, "N/A", if the step is not required.
Satisfactory: Performs the step or task according to the standard procedure or guidelines.

Trainee Service provider's name:

STEP/TASK	CLIENTS (C)					COMMENT
	C 1	C 2	C 3	C 4	C 5	
Enter the date						
INITIAL INTERVIEW						
1. Greets woman respectfully and kindly.						
2. Assesses whether counselling is appropriate at this time (if not, arrange for counselling at another time).						
3. Assures necessary privacy.						
4. Discusses fertility preferences and desire to get pregnant soon or delay/limit future pregnancy.						
5. Informs client on the return of fertility and a consecutive pregnancy within six months.						
6. Asks about her previous experience with contraception. Provides general information about family planning.						
7. Gives her information about FP choices available and the benefits and limitations of each.						
8. Discusses woman's needs, concerns and fears. Helps her begin to choose an appropriate method.						
9. Performs physical examination, if indicated.						
10. Discusses what to do, if client experiences any side effects or problems.						
11. Provides follow-up visit instructions and assures client that she can return to the same clinic at any time.						
12. Asks the woman to repeat instructions and answer any questions.						
Enter the total of "✓"						
Enter the total of steps (remove the "N/A", if any)						

SCORE - Calculate the percentage: % Score= Total of "✓" / Total no. of steps x 100						

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

(Many of the following steps/tasks should be performed simultaneously)

COMMENTS:

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REMINDER	EXCELLENT	checklist score >= 90%	GOOD	90% > checklist score >= 80%	FAIR	checklist score < 80%

E. Postabortion Care On-The Job-Training Logbook

STATE	
Facility name	

Trainee Service Provider
Name- _____ Cadre- _____

Trainer's Name- _____ Cadre- _____

Date	Activity (Modules/learnings Covered)	Trainer Comments (Sign & date)

- **This logbook should be filled and signed each day an activity is done.**
- **Challenges faced, and actions taken, or suggestions on how to overcome the challenges can also be included where necessary.**

F. SUPERVISION CHECKLIST FOR POSTABORTION CARE ON THE JOB TRAINING

Instructions: This tool is meant to aid supervisors in CAC OJT Supportive Supervision visits to facilities. Use the questions as a starting point for discussions with providers on areas which are going well and areas that need improvement. At the end of each section, score the section, using the directions provided. Enter the findings into the training database after each visit.

Health Center: _____ Date of Supervision: ____/____/____

LGA: _____

Time Supervision Started: _____ Time Supervision Ended: _____

Person(s) conducting Supervision:

s/no	Name	Designation	Phone

Trainer Providers' details

s/no	Trainer (s) (Name of trained/skilled provider)	Cadre

Trainee Providers' details

s/no	Trainee (s) (Name of providers being trained on CAC on the Job)	Cadre

Is the trainer an experienced CAC provider?	
Is the CAC OJT guideline available in the facility?	
Are other guidelines and tools recommended as references in the guideline available in the facility?	
Is the CAC OJT guideline used for the OJT training in the facility?	
Are the modules recommendations for knowledge and competence followed	

for the training?	
Is there a documented schedule followed to conduct the training?	
Is the training schedule adhered to?	
Is the facility management aware and support the training?	
Are the right training materials and equipment available?	
Are training uterine models available for practice?	
Are training sessions documented in the training log recommended in the guideline?	
Are MVA equipment and commodities available in the facility during the period of the training?	
Are Medical abortion drugs and commodities available in the facility during the period of the training?	
Are live clients available for practice and learning during the period of the training?	

Issues identified	Action plan	Responsible person	Timeline


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