

# Introduction to Postabortion Care (PAC)

## Postabortion Care (PAC)

- Postabortion care is the management of a medical emergency
- It is care for women with complications of abortion
- You are already providing PAC services
- Our aim is to improve the quality and expand the services available

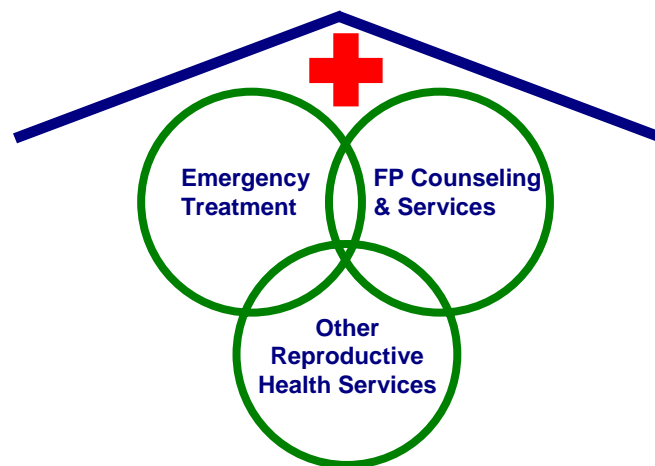
## Objectives

By the end of this session, we will be able to:

- Explain the importance of PAC
- List the key elements of quality PAC services
- Defend the rationale for this program

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## Elements of Postabortion Care



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## Importance of PAC Services

- PAC is a life-saving service
- Death from abortion complications is preventable
- We have the technology to make quality PAC services much more accessible
- Most unwanted pregnancies, and therefore abortions, are preventable

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## Importance of PAC Programs

- Many hospitals manage patients with complications of abortions, but . . .
- Quality, accessible PAC services are currently only available in a few hospitals

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## The Scope of the Problem

- 70 million unwanted pregnancies yearly
- 40-60 million abortions performed every year
- 20 abortions occur in unsafe conditions
- 99 % of these occur in developing countries
- 25-50 % of them Among Teenagers

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## The Scope of the Problem (cont.)

- 600,000 women die annually in the world from pregnancy related causes
- 70,000 women die annually from abortion
- 13-50% of MMR is due to complications of abortion
- 15-60 % gynaecological beds in hospitals occupied by postabortion cases

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## The Scope of the Problem (cont.)

Plus . . .

- 15% of all pregnancies result in spontaneous abortions – many clients seeking PAC services have had a miscarriage

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## In Zambia

- 649/100,000 live births (1996 DHS)
- 1,000-2,000/100,000 reported in some districts
- PAC caseload doubled in <10 years
  - 16,000 PAC Admissions in UTH, 1993
  - 16,000+ in first half of 2002

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## Why is the risk so high in Africa?

- Emergency services are not accessible
- Few paramedical staff are trained in PAC
- Patients arrive in late and in poor condition
- Services are not available on an emergency, immediate basis
- D&C is the primary clinical management
  - added delays waiting for OT time and staff
  - added risk of complications
- Community understanding is poor and cultural barriers are a reality

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## Postabortion Care: Rationale for Using Manual Vacuum Aspiration (MVA)

MVA is the preferred treatment of incomplete abortion because:

- Risk of complications is reduced
- Access to services is increased
- Cost of postabortion services & consumption/ use of resources is reduced
- Immediate access to emergency care is much more likely

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## Comparison of Complication Rates

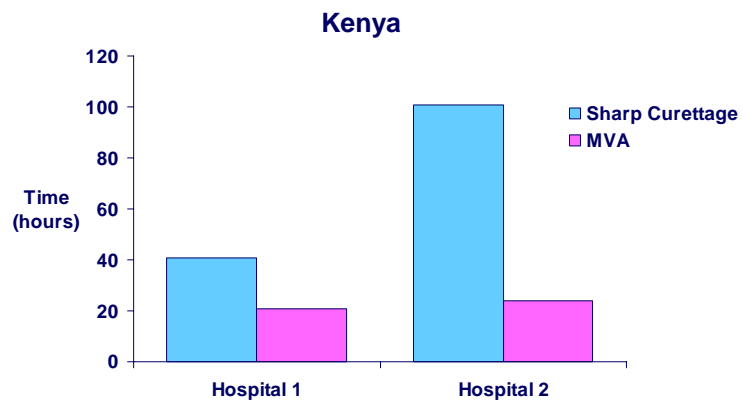
### Summary of 13 Studies

Complications (major only)	Vacuum Asp. (Range %)	D&C (Range %)	Summary (Rate < D&C)
Excessive blood loss	0-15.7	0.5-28	10/13 (78%)
Pelvic infection	0.2-5.4	0.7-6	7/9 (78%)
Cervical injury	0-3.1	0.3-6.4	6/7 (86%)
Uterine perforation	0-0.5	0-3.3	10/12 (83%)

Source: Greenslade et al 1993.

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## Average Total Patient Stay for Vacuum Aspiration vs. D&C



Source: Johnson et al 1992.

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## Average Patient Stay for Vacuum Aspiration vs. D&C

### Zambia

Average hospitalization duration:

UTH (full-time MVA service)	0.6 days
Ndola (sporadic MVA service)	1.2 days
Livingstone (no MVA service)	3.5 days
Mongu (no MVA service)	4.4 days

Source: PAC Needs Assessment, 1998

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## Cost of inpatient stay for D&C

### Chipata General Hospital

**Average hospitalization duration: 5 days**

Food	2,500 (breakfast, lunch, dinner)
Stationery	1,400 (folder, paper)
Cleaning mat's	1,500 (detergents)
<u>Drugs/Supplies</u>	<u>188,500</u> (gentamycine, pethadine, flagyl, catheter, IV fluids, etc.)

**Total 193,900 ZMK per patient**

**Plus . . . Over utilization of beds, sheets, water, facilities, laundry, staff time, etc.**

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## Factors Contributing to the Risk of Repeat Unsafe Abortion

- Lack of recognition of problem of unsafe abortion and patient FP / RH needs
- Lack of FP services for some groups of women (e.g., adolescents, single women)
- Separation of emergency services from preventive services (FP)
- Misinformation about which FP methods are appropriate postabortion

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## Summary

- PAC is a life saving service
- Quality PAC Services require:
  - Prompt and safe emergency treatment
    - with MVA, for most cases
  - Positive, non-judgmental staff attitudes
  - Psychosocial support and counseling
  - Proper pain management
  - Preventive services (i.e. family planning counseling & services)
  - Linkages to other RH services

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The Situation of  
**Postabortion Care in  
Zambia**

## Objectives

By the end of this session, we will be able to:

- Describe the health system and policy environment affecting PAC services in Zambia
- Explain the weaknesses in caring for women with complications of pregnancy in Zambia

## Assessment team

- Dr. Christine Kaseba-Sata, UTH
- Mrs. Dorcas Phiri, General Nursing Council
- Ms. Carol Camlin, POLICY Project
- Dr. Harshad Saghvi, JHPIEGO
- Ms. Tamara Smith, JHPIEGO
- Dr. Peggy Chibuye, USAID/Zambia
- Ms. Michelle Folsom, USAID/REDSO/ESA

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## Background to the Study

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## Postabortion Care

- Emergency treatment services for complications of abortion
- Postabortion family planning counselling and services
- Links between emergency treatment and other RH services

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## Legal environment for abortion

- Zambia's Termination of Pregnancy Act of 1972:
  - abortion is permitted if continuation of pregnancy involves risk to the life, or injury to the physical or mental health of the woman, unborn child or the woman's existing children
- Legal abortion requires:
  - consent of three physicians, one of whom is a specialist
  - performance by a licensed physician
- Illegal abortion is subject to imprisonment

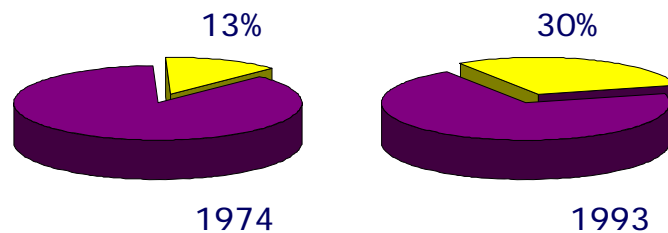
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## Limited access to legal abortion services

- Hospitals lack physicians and specialists
- Health care providers and administrators often are opposed to abortion for religious and personal reasons
- Many Zambians are misinformed about the Act and its guidelines
- Self-induced and other illegal abortions are unsafe and frequent

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## Maternal deaths due to abortion



16,000 hospital admissions for emergency cases of illegally induced abortions

UNICEF, 1994

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## Abortion complications

- Complications result from miscarriage and legal abortions as well as from illegally induced abortions
- Urban and rural women of all ages seek care for complications
  - young, unmarried women make up the highest proportion
- Emergency services are available only at hospitals
  - demand for services at hospitals is high-- 42% of all emergency gynaecology admissions at UTH are due to cases of incomplete abortion

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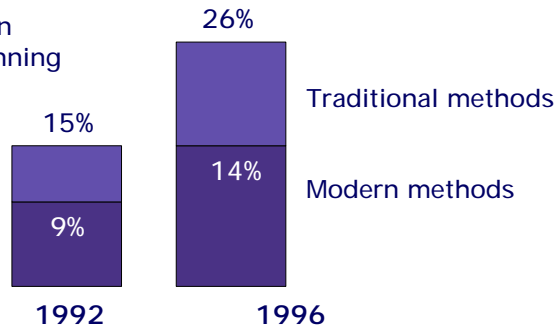
## Unmet need for family planning

More than one in four married women who want to space or limit childbearing are not using family planning

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## Family planning use

% of married women  
who use family planning



ZDHS, 1996

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## Women at greatest risk

- Rural women are 3 times less likely than urban women to use family planning
- 91% of married women ages 15-19 are not using a modern family planning method
- Adolescents are often excluded from reproductive health services
- Limited access to quality family planning services contributes to high abortion rates

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## Policy Environment for PAC

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### Health sector reform

- Decentralisation
- “Essential Package” of health services

### Issues relevant to strengthening PAC

- Deployment of health personnel
- Retraining of medical and paramedical personnel in the “Essential Package”

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## Nurses and Midwives Act of 1997

- Guides the education, training, monitoring and scope of work of nurses and midwives
- Removes legal barriers to their expanded role in primary health care services and allows them to become private, independent practitioners
- Allows them to play a greater role in provision of PAC services

## Postabortion Care Services

## Limited capacity for emergency care

- Lower-level facilities cannot provide emergency care
- Delays in emergency PAC:
  - staff and supply shortages
  - scheduling conflicts and pressure from other emergencies
  - insufficient providers skills in emergency treatment
  - facilities are unprepared to deal with acute emergencies

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## MVA is not widely used or available

- Many physicians are unaware of the procedure, equipment is not widely available, and sharp curettage is most often used
- Average hospitalization duration:
 

UTH (full-time MVA service)	0.6 days
Ndola (sporadic MVA service)	1.2 days
Livingstone (no MVA service)	3.5 days
Mongu (no MVA service)	4.4 days

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## Infection prevention procedures vary

- Most sites visited have difficulty applying infection prevention principles
- Decontamination is not always available
- Hospitals rely on central sterilization services which are overworked and inefficient

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## No links to FP and other RH services

- In all sites visited, PAC is not provided as a complete package
- FP counselling, service provision and linkages to other reproductive health services are virtually nonexistent
- There is little pre-procedure counselling and no counselling of patient at discharge

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## Standards of care are not in place

- Specific service delivery standards and guidelines have not been incorporated into CBOH technical guidelines
- There are no written standards and protocols guiding the care of PAC patients
- Hospitalization is prolonged due to lack of protocols for seeing clients as soon as they are admitted

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## Support systems & supervision are weak

- Service delivery infrastructure
- Logistics and distribution of supplies and commodities
- IEC materials and strategies
- Information systems for monitoring & evaluation
- DHMTs supervise only health centres and outposts
- Central/referral hospitals have no mechanism to supervise district hospitals

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## Training in Postabortion Care

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### Overview

- Training in PAC to date has focused on doctors' use of MVA
- No linkage between emergency treatment for abortion complications with the provision of FP or other RH services
- No links between training and supervision

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## Medical training

- Interns taught MVA at UTH; no FP counselling or links to other services included
- When interns are deployed outside of UTH, they learn D&C as no MVA kits are available

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## Nurse training

- PAC not incorporated into preservice nursing education
- No formal training currently conducted in PAC counselling, FP service or links to other RH service
- UTH conducts unstructured on-the-job training for nurses working in acute gynae ward

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## Training recommendations

- Strengthen training programmes for doctors and clinical officers
- Develop UTH as a national demonstration site
- Develop innovative approaches to institutionalise PAC training

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## Conclusions

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## Positive beginnings were not sustained

- Although all interns are trained in MVA, services still are not available outside Lusaka
- Focus is still on emergency care, not abortion prevention

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## Weak healthcare system

- Inadequate staff, supplies and equipment for expansion of PAC activities
- Lack of training in IP, FP and emergency care
- Weak supervision of clinical care areas
- Inadequate referral system

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## Fragmented approach to expansion

- Existing services aimed at emergency care only
- Little effort made to prevent future abortions through IEC or advocacy
- No systems (in training, supplies and commodities procurement, supervision and service delivery) to ensure sustainable services

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## Discriminatory attitudes and behaviors

- Abortion cases are often ill-treated as patients
- Many providers feel that abortion is morally wrong and withhold quality care

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## Lack of public awareness

- Patients often unaware of symptoms of abortion complications, therefore they seek care late
- Late care means increased risk of serious complications or death

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## Limited roles of nurses and midwives

- Lack adequate knowledge and training in PAC and FP counselling
- Inadequate numbers of nursing staff means nurses don't have enough time to offer additional attention to PAC clients
- Since nurses are not yet authorised to perform MVA, emergency PAC services are restricted to facilities with doctors

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# National PAC Taskforce Action Plan

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## Clinical Training Network & Expansion of PAC Services

### Objectives

By the end of this session, we will be able to:

- Discuss the national action plan for expanding PAC services
- Explain how this activity, and our own institutions, fit into this overall program

## Three Phase Expansion

- I. Establish quality clinical training sites at 3 referral hospitals
- II. Establish quality clinical training sites at 9 Provincial Hospitals
- III. Establish quality PAC services at district hospitals

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## I. Establish quality clinical training sites at 3 referral hospitals

- Advocate and develop support at national level **(completed)**
- Identify national training sites **(completed)**
- Orient hospital management and staff **(completed)**
- Prepare hospital (PAC organization within the facility, supply of necessary drugs, supplies, equipment, etc.) **(completed)**
- Strengthen underlying skills and services (infection prevention, FP counseling & method provision, etc.) **(completed)**

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## I. (continued)

- Provide follow-up Support **(completed)**
- PAC Standardization **(completed)**
- Provide follow-up support to help establish model PAC services **(completed)**
- Train trainers in Clinical Training Skills **(completed)**
- Co-teach first PAC courses (See Below – training of provincial hospital teams)

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## II. Establish quality clinical training sites at 9 Provincial Hospitals

- Orient and secure support of PMO and DHMT
- Orient hospital management and staff and identify key staff
- Prepare hospital (PAC organization within the facility, supply of necessary drugs, supplies, equipment, etc.)

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## II. (continued)

- Strengthen underlying skills and services (infection prevention, FP counseling & method provision, etc.)
- Train PAC teams at one of the three established training sites
- Follow-up support to help establish model PAC services
- Train PAC teams in clinical training skills  
Co-teach first PAC courses (See Below – training of district hospital teams)

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## III. Establish quality PAC services at district hospitals

- Orient and secure support of DHMT and hospital management teams
- Identify appropriate and interested hospitals  
Orient hospital management and staff and identify key staff
- Prepare hospital (PAC organization within the facility, supply of necessary drugs, supplies, equipment, etc.)

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### III. (continued)

- Strengthen underlying skills and services (infection prevention, FP counseling & method provision, etc.)
- Train PAC teams at one of the 12 established training sites
- Follow-up support to help establish quality PAC services

### II. Establish quality clinical training sites at 9 Provincial Hospitals

## Activity 2.01

- Orient and secure support of PMO, DHMT, hospital management
- Conduct a one-week orientation and skills building workshops for PMO, DHMT and hospital management team members

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## 2.01 Outputs:

- 9 PMOs, DHMTs, and hospital management teams oriented to PAC
- Strengthened capacity developed to support the PAC expansion
- Support and coordination mechanisms established

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## Activity 2.02

- Visit provincial hospitals to orient the management and staff
- Outputs:
  - 9 Provincial Hospitals supportive of providing quality PAC services
  - Plans developed for preliminary strengthening prior to PAC training
  - Hospital staff to implement PAC services and training identified

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## Activity 2.03

- Ensure that the necessary steps are taken to prepare the hospital
- Outputs:
  - 9 Provincial Hospitals with adequate equipment, commitment to provide necessary medicines and supplies, and organized to provide quality PAC services

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## Activity 2.04

- Strengthen underlying skills and services at the selected hospitals
- Outputs:
  - 9 Provincial Hospitals prepared to initiate quality PAC services, using quality infection prevention practices, able to provide PAC, FP counseling and services, and integrated RH counseling with linkages to other RH services on the ward as part of PAC service provision

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## Activity 2.05

- Train PAC teams in PAC services at one of the three established training sites
- Outputs:
  - PAC teams from 9 provincial hospitals trained in PAC services

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## Activity 2.06

- Provide follow-up support to help establish model PAC services
- Outputs:
  - 9 provincial hospitals providing quality PAC services

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## Activity 2.07

- Train PAC teams in clinical training skills
- Outputs:
  - Training teams from 9 sites prepared to offer quality clinical training
  - 27 candidate PAC clinical trainers

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## Activity 2.08

- Co-teach first PAC courses at Provincial Hospitals
- Outputs:
  - Training teams from 9 provincial hospitals competent in PAC clinical training
  - 27 qualified PAC clinical trainers

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## III. Establish quality PAC services at district hospitals

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## Summary

- Expansion to the provincial level:
  - Establish quality PAC services
  - Develop training capacity
- Thorough preparation, orientation, and collaboration with local management is a significant investment of the program

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## **Roles and Responsibilities at National, Provincial, & District Levels in PAC Expansion**

## Objectives

By the end of this session, we will be able to:

- Describe the role of National, Provincial and District level partners and their interaction
- List the key responsibilities for each of our own institutions

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## National Level

- Guidelines and protocols for PAC
- Development of training system (materials, training sites, trainers)
- Coordinate expansion programs
- Advocate among stakeholders at the National level for funding and support
- Support Provincial and District level
- Overall monitoring / supervision / evaluation
- Feedback

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## Provincial Level

- Prepare expansion plans on Provincial level (coordinating among Districts)
- Ensure logistics – equipment & supplies (ensure districts are planning & budgeting appropriately)
- Collaborate with stakeholders for funds and logistic support at the Provincial level
- Ensure Quality of Care – incorporate PAC into quality assessment visits to all districts
- Monitoring, supervision & evaluation at the Provincial level (coordinating among districts)

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## District Level

- Plan for introduction of PAC within the District
- Site assessment and preparation
- Support for site strengthening
- Ensure appropriate, adequate manpower
- Provision of quality, emergency PAC services on demand
- Outreach and linkages throughout the district to improve access and referrals

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### District Level (cont.)

- Assure preventive services (immediate FP counseling and services on-site)
- Integration of other RH services with PAC (HIV/AIDS, STI, cervical cancer screening, infertility, etc.)
- Ensure sustainability: budget for equipment and supplies, manpower
- Monitoring, supervision & evaluation within the District
- Reporting to the Provincial level and the National Task Force

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### Conclusion

- National, Provincial & District levels each have responsibilities
- These areas overlap, so there is need for coordination and communication
- Through teamwork we can develop and sustain good quality PAC services

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# PAC Training & Supervision

## Orientation to the Individualized Training Approach and Materials

### Objectives

By the end of this session, we will be able to:

- Explain the training & supervision approach
- Describe the training and supervision materials
- Discuss the realities from the field

## Individualized Training

- On-The-Job-Training (OJT)
- Training small groups
- Competency-based & Performance-oriented

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## Why an Individualized Approach?

- Case load constraints
- Flexible, efficient, effective
- Practical

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## Learning Package Development

- Initiated in Nairobi in November 1999
- Regional
  - Zambia, Kenya, South Africa, and Uganda
- Representative Cooperating Partners
  - JHPIEGO, INTRAH, IPAS, AVSC, REDSO/ESA, and USAID/Kenya

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## Learning Package Materials

- PAC Supervisor's Guide
- PAC Trainer's Guide
- PAC Trainee's Guide
- PAC Reference Manual
- Videos
- Anatomical models

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## Key Players

- Trainees
- Trainers
- Supervisors
- Central level (PAC Task Force)
- Training site management
- PAC service site management

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## Approach to Expansion

- Decentralize
  - Establish provincial training sites and capacity
- Emphasize quality of care
  - IP, Counselling, Prompt & Comprehensive Care
- Progressive Expansion
- Teamwork

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## Supervisor's Role

- Establish, support & monitor training sites
- Identify potential PAC service sites
  - Orient administration and staff
  - Ensure basic quality services
  - Organize / coordinate training

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## Supervisor's Role (cont.)

- Facilitate and Supervise Training
  - Supervise training & ensure competency
- Provide supportive supervision
  - To establish PAC Services
  - Continual support and monitoring of quality

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## Summary

- The decentralized, individualized approach depends on:
  - Teamwork
  - Individual commitment to quality
    - **Supplies & equipment**
    - **Manpower: skilled, consistent**
    - **Basics: IP, interpersonal communication, etc.**
    - **Comprehensive services: emergency care, counselling, FP, linkages to other RH**

## Integrating Family Planning & Reproductive Health Services into PAC

## What is integration?

**Integration** is the provision of two or more types of services, which were previously provided separately, as a single, coordinated and combined service

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## Objectives

By the end of this session, we will be able to:

- Justify the need for providing FP services on the ward
- Explain the value of integrating and linking other RH services to PAC services

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## Why integrate?

- Ability to prevent future health problems (e.g., FP for PAC patients)
- Improvement of quality of service
- More efficient and cost-effective service
- No missed opportunity to meet clients' RH needs
- Convenient for the client
- Components of RH are interrelated

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## Importance of Starting Postabortion FP Immediately

FP is a preventive service for PAC clients

Increased risk of repeat pregnancy:

- Ovulation may occur by day 11 postabortion
- 75% of women will have ovulated within 6 weeks postabortion

Source: Lahteenmaki 1993; Lahteenmaki et al 1980.

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## Which FP Methods to Use Postabortion

All modern methods are acceptable if:

- Thorough counseling is given to ensure voluntary acceptance and choice
- Clients are screened for precautions

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## FP Methods for PAC

- |                                    |       |
|------------------------------------|-------|
| • Oral Contraceptive Pills         | (+++) |
| • Injectables                      | (+++) |
| • Condoms                          | (+++) |
| • Intrauterine Devices             | (++)  |
| • Implants                         | (++)  |
| • Female Sterilization / Vasectomy | (+)   |
| • Periodic Abstinence              | (--)  |

+++ can be provided immediately at any PAC service site

++ can be provided immediately, but require trained staff

+ appropriate only if the woman / couple is sure of their choice, but may not be available immediately

-- not appropriate until menstrual cycle regularizes

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## Integration of FP with PAC – what does it take?

- Training ward staff in FP counselling and method provision
- Ensuring that FP counselling and methods are always available, in the emergency care setting (i.e., on the ward)
- Establishing clear protocols for FP follow-up after initial supply (e.g., an effective referral system to a FP clinic)

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## To ensure correct and continued use:

Systematic follow-up and information, education and communication are necessary whenever a family planning method is supplied.

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## Examples of Other Linked RH Services

- HIV counseling, referral for VCT
- Treatment of sexually transmitted diseases (STDs)
- Cervical cancer screening for women over age 30B35
- Infertility services
- Pre-pregnancy advice (e.g., nutrition, immunization, management of existing medical conditions)

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## Summary

- Quality services are comprehensive
- FP is a preventive service for many PAC clients to prevent repeat abortions
- Some PAC clients want to get pregnant, and have suffered a miscarriage and may need help or guidance
- Some patients may only come in contact with the health care system during an emergency, so it is a rare opportunity for them and the health provider

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# Infection Prevention (IP)

## Objectives

By the end of this session, we will be able to:

- Explain proper IP practices and procedures
- Justify and support the need to improve IP practices to protect staff and clients

## Objectives of Infection Prevention:

- To prevent major postoperative infections when providing surgical contraceptive methods
- To minimize the risk of transmitting serious infections (e.g., HBV, HCV, HIV/AIDS) from or to:
  - clients
  - service providers
  - other staff, including cleaning and housekeeping personnel

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## IP Principles

### Standard Precautions:

- Consider every person (client or staff) infectious
- Wash hands **C** the most practical procedure for preventing person to person transmission
- Wear gloves before touching anything wet **C** broken skin, mucous membranes, blood, body fluids, secretions or excretions **C** or soiled instruments and other items
- Use other physical barriers including personal protective equipment (PPE) – such as protective goggles, face masks and aprons – if splashes and spills of blood, body fluids, secretions or excretions are anticipated

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## IP Principles (cont.)

- Use safe work practices:
  - Not recapping or bending needles
  - Safely passing sharp instruments
  - Properly disposing of medical waste
- Process instruments and other items (decontaminate, clean, high-level disinfect or sterilize) using recommended infection prevention (IP) practices

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## IP Principles (cont.)

- In addition to the standard precautions, use transmission based precautions only for patients known or suspected to be infected with highly transmissible disease spread by:
  - Airborne transmission (e.g., tuberculosis, measles, varicella)
  - Droplet transmission (e.g., influenza, mumps, rubella)
  - Contact transmission (e.g., hepatitis A, Staphylococcal furunculosis, herpes simplex)

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## Risk of Disease Transmission

Source of exposure	HBV (%)	HIV (%)
Skin puncture (broken skin)	27-37	0.3-0.4
Mucocutaneous	S	< 0.1

As little as  $10^{-8}$  ml (.00000001 ml) of HBV-infected blood can transmit HBV to a susceptible host

Source: Gerberding 1995; Seelf 1978; Bond et al 1982.

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## Reducing the Risks of Disease Transmission

Between clients and staff:

- Hand hygiene
- Personal Protective Equipment (PPE) such as gloves and clothing (worn by service providers and cleaning staff)
- Proper handling and disposal of sharps

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## Reducing Risks (cont.)

### From contaminated objects:

- Processing instruments and other items
  - Decontamination (staff)
  - Cleaning (clients and staff)
  - Sterilization (clients and staff)
  - High-level disinfection (clients and staff)
- Proper waste disposal (staff and community)
- Encouraging appropriate IP practices in the community (not reusing cutting implements or needles, properly disposing of wastes, etc.)

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## Hand Hygiene Techniques

- Handwashing
- Hand antiseptics
- Waterless handrub
- Surgical scrub

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## Handwashing

**Purpose:** Mechanically remove soil and debris from the skin and reduce number of transient microorganisms

**Handwashing may be the single most important procedure in preventing infection**

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## Handwashing

### Steps:

- Thoroughly wet hands
- Apply a handwashing agent
- Vigorously rub all areas of hands and fingers for 10B15 seconds, paying close attention to fingernails and between fingers
- Rinse hands thoroughly with clean running water from a tap or bucket
- Dry hands with a dry clean towel or air dry them
- Use a paper towel when turning off water if there is no foot control or automatic shut off

Source: Larson 1999.

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## Handwashing

### When:

- Before and after examining any client (direct contact)
- After removing gloves, because gloves may have holes in them
- After exposure to blood, body fluids, secretions and excretions – even if gloves were worn

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## Hand Antisepsis

**Purpose:** Remove soil and debris and reduce both transient and resident flora on the hands

### Steps:

- Similar to plain handwashing except that it involves use of an antimicrobial agent instead of plain soap or detergent

### When:

- Before performance of invasive procedures (e.g., placement of an intravascular catheter)

Source: Larson 1999.

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## Waterless Handrub

**Purpose:** Inhibit or kill transient & resident flora

If hands are not visibly dirty, use an alcohol-based waterless preparation

### Steps:

- Apply enough alcohol-based rinse or foam to cover the entire surface of hands and fingers
- Rub the preparation vigorously into hands until dry (approximately 30 seconds)

### When:

- Same as handwashing
- Following surgical scrub

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## Surgical Handscrub

**Purpose:** Mechanically remove soil, debris, & transient organisms & to reduce resident flora during surgical procedure

### Steps:

- Remove rings, watches and bracelets
- Thoroughly cleanse hands and forearms to the elbows
- Clean nails with a nail cleaner
- Rinse thoroughly
- Apply 3 to 5 ml of antimicrobial agent
- Vigorously scrub all surfaces of hands, fingers & forearms for at least 2 minutes
- If a sponge or a soft brush is used it should be discarded after use or processed before reuse
- Rinse hands and arms thoroughly, holding hands higher than the elbows
- Keep hands up and away from the body, do not touch any contaminated surface or article, and dry with a sterile towel

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## Surgical Handscrub with Waterless Alcohol-Based Preparation

### Steps:

- Wash hands and arms with soap/detergent and water
- Clean fingernails thoroughly
- Dry hands thoroughly
- Follow manufacturers' instructions regarding application of alcohol preparation
- Use enough alcohol for fingers, hands, and forearms, and rub for at least 20 seconds

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## Alcohol-Based Waterless Preparation for Handrub and Surgical Handscrub

- Add 2 ml glycerine to 100 ml 60-90% alcohol solution
- Apply 3 to 5 ml and continue rubbing the solution over the hands, covering all surfaces, until dry
- Repeat the application a second time

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## Skin Preparation Prior to Surgical Procedures

Purpose – To minimize the number of microorganisms on the skin or mucous membranes by:

- Washing with soap and water
- Applying an antiseptic

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## Skin and Mucous Membrane Preparation

- Do not shave hair at the operative site (if necessary, trim hair close to skin surface immediately before surgery)
- Ask the client about allergic reactions before selecting an antiseptic solution
- Wash first with soap and water if visibly soiled
- Apply antiseptic starting from the operative site and working outward in a circular motion for several inches

122

## Cervical and Vaginal Preparations

- Apply antiseptic solution liberally to the cervix (2 or 3 times) and then to vagina
  - It is not necessary to prep the external genital area if it appears clean.
  - If heavily soiled, it is better to have the client wash her genital area thoroughly with soap and water before starting the procedure

123

## Personal Protective Equipment (PPE)

### **Wear gloves:**

- When performing a procedure in the clinic or operating room
- When handling or cleaning soiled instruments, gloves and other items
- When disposing of contaminated waste items (cotton, gauze or dressings)

### **Wear protective goggles, face masks, aprons and enclosed shoes:**

- If splashes and spills of any body fluids are likely

124

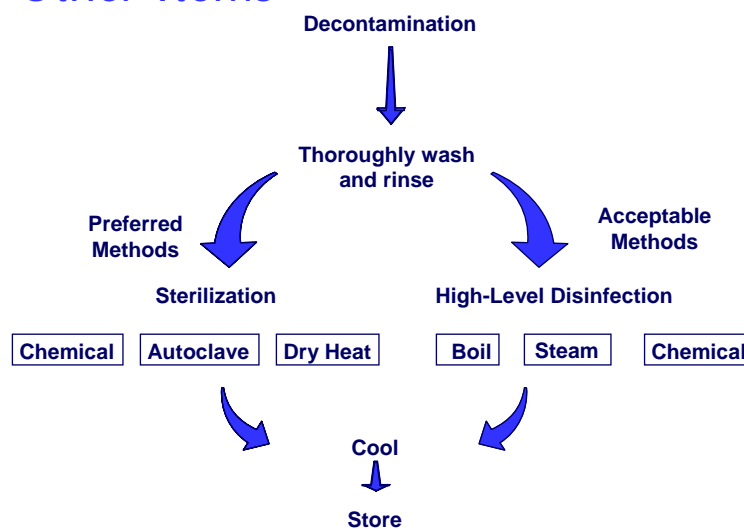
## Effectiveness of Methods for Processing Instruments

	Effectiveness (removal or inactivation of microbes)	End point
Decontamination	Kills HBV and HIV	10 minute soak
Cleaning (water only)	Up to 50%	Until visibly clean
Cleaning (detergent with rinsing water)	Up to 80%	Until visibly clean
Sterilization <sup>1</sup>	100%	Autoclave, dry heat or chemical for recommended time
High-level disinfection <sup>1</sup>	95% (does not inactivate some endospores)	Boiling, steaming or chemical for 20 minutes

<sup>1</sup> Prior decontamination and thorough cleaning required.

125

## Processing Soiled Instruments and Other Items



126

## Decontamination

### Principles:

- Inactivates HBV, HCV and HIV
- Makes items safer to handle
- Must be done before cleaning

### Practices:

- Place instruments and reusable gloves in 0.5% chlorine solution after use
- Soak for 10 minutes and rinse immediately
- Wipe surfaces (exam tables) with chlorine solution

127

## Instructions for Preparing Dilute Chlorine Solutions

$$\text{Total parts (H}_2\text{O)} = \left[ \frac{\% \text{ Concentrate}}{\% \text{ Dilute}} \right] - 1$$

128



## Instructions for Preparing Dilute Chlorine Solutions (cont.)

**Example:** To make 0.5% decontamination solution from Jik 3.5% concentrated chlorine solution

$$\text{Total parts (H}_2\text{O)} = \left[ \frac{3.5\% \text{ Concentrate}}{0.5\% \text{ Dilute}} \right] - 1 = 6$$

To make 0.5% decontamination solution, mix 6 parts water to 1 part Jik

129

## Instructions for Preparing a Chlorine Solution from a Powder

$$\text{Gram/Liter} = \left[ \frac{\% \text{ Dilute}}{\% \text{ Concentrate}} \right] \times 1000$$

130

## Instructions for Preparing a Chlorine Solution from a Powder (cont.)

**Example:** To make 0.5% decontamination solution from a 35% concentrate chlorine powder

$$\text{Gram/Liter} = \left[ \frac{.5\% \text{ Dilute}}{35\% \text{ Concentrate}} \right] \times 1000 = 14.2 \text{ g/l}$$

To make a 0.5% decontamination solution from a 35% chlorine powder, mix 14.2 grams of powder to 1 liter of water

131

## Cleaning

### Principles:

- Removes organic material that:
  - protects microorganisms against sterilization and HLD
  - can inactivate disinfectants
- Must be done for sterilization and HLD to be effective
- Method of mechanically reducing the number of endospores

132

## Cleaning (cont.)

### Practices:

- Wash with detergent and water
- Scrub instruments under the water until visibly clean
- Use a brush where necessary
- Thoroughly rinse with clean water

133

## Sterilization

### Principles:

- Destroys all microorganisms, including endospores
- Used for instruments, gloves, and other items that come in direct contact with blood stream or tissue under the skin

134

## Sterilization (cont.)

### Practices:

- Steam sterilization (autoclave):
  - 121°C (250°F); 106 kPa (15 lbs/in<sup>2</sup>) pressure: 20 minutes for unwrapped items, 30 minutes for wrapped items
  - Allow all items to dry before removing
- Dry-heat (oven):
  - 170°C (340°F) for 1 hour, or 160°C (320°F) for 2 hours
- Chemical sterilization:
  - Soak items in glutaraldehyde (2%) for 10 hours or formaldehyde (8%) for 24 hours
  - Rinse with sterile water
  - Handle only with a sterile instrument to remove & rinse
- Store sterilized equipment in a sterile container

135

## High-Level Disinfection

### Principles:

- Destroys all microorganisms including HBV, HCV and HIV; does not reliably kill all bacterial endospores
- Only acceptable alternative when sterilization equipment is not available

Source: Favero 1985; McIntosh et al 1994.

136

## High-Level Disinfection by Boiling

### Practices:

- Boil instruments and other items for 20 minutes (sufficient up to 5,500 meters or 18,000 ft. altitude)
- Always boil for 20 minutes in pot with lid
- Start timing when water begins to boil
- Do not add anything to pot after timing begins
- Handle only with an HLD or sterile instrument
- Air dry before use or storage
- Store high-level disinfected instruments in HLD or sterile container

137

## Chemical High-Level Disinfection

### Practices:

- Cover all items completely with disinfectant
- Soak for 20 minutes
- Rinse with boiled water
- Handle only with an HLD or sterilized instrument to remove & rinse instruments
- Air dry before use and storage
- Store high-level disinfected instruments in HLD or sterile container

138

## Preparing a HLD Container

- Boil (if small), or
- Fill a clean container with 0.5% chlorine solution.
  - Soak for 20 minutes.
  - Pour out solution. (The chlorine solution can then be transferred to a plastic container and reused.)
  - Rinse thoroughly with boiled water.
- Air dry and use for storage of HLD items.

139

## Waste Disposal

### Objectives:

- Prevent spread of infection to clinic personnel who handle waste
- Prevent spread of infection to local community
- Protect those who handle wastes from accidental injury

### Practices:

- Wearing utility gloves, place contaminated items (gauze or cotton) in leak-proof container (with a lid) or plastic bag
- Dispose by incineration or burial

140

## Traffic Flow and Activity Patterns

### Goal:

- To decrease level of microbial contamination in areas where “clean activities” take place:
  - procedure rooms
  - surgical areas
  - areas for final processing and instrument storage
- Number of microorganisms in area is related to number of people present and their activity

141

## Summary

- Simple, low cost IP measures will protect staff, clients, and the community
- Handwashing is the single most important procedure in IP
- Decontamination with 0.5% chlorine solution inactivates HIV and Hepatitis B and C
- Proper instrument processing requires precision and attention to details
- Proper sharps handling and waste disposal protects staff and communities

142

# PAC Guidelines

## Objectives

By the end of this session, we will be able to:

- List the major elements of the guidelines for providing quality PAC services



## EMERGENCY CARE

Any presence of life threatening complications such as:

- Shock
- Severe vaginal bleeding
- Infection/sepsis
- Intra-abdominal injury, should be addressed without delay

145

## COUNSELING

Which includes:

- Pre-MVA counseling
- Verbal anesthesia during the procedure
- Post MVA counseling on warning signs and FP services and issuing of supplies on the unit.

146

## LINKAGES TO OTHER SERVICES

In the presence of other RH needs such as:

- STIs and STDs including HIV/AIDS counseling
- Cancer screening
- Infertility counseling and other services.

147

## MANAGEMENT

- Measures to control equipment and maintenance must be in place
- Maintain an inventory or record book for good monitoring and evaluation
- Patient documentation and follow up of any PAC clients must be in place.

148

## Summary: PAC Guidelines

- Immediate access to emergency treatment, 24 hours/day
- Quality psychosocial support and counselling provided throughout
- Appropriate pain management
- FP counselling and services for every PAC client
- Linkages to other RH services
- Management systems to ensure availability of necessary equipment and supplies, manpower, and information

149

National PAC Task Force

## Quality PAC Services

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## Clinical Care & Supervision

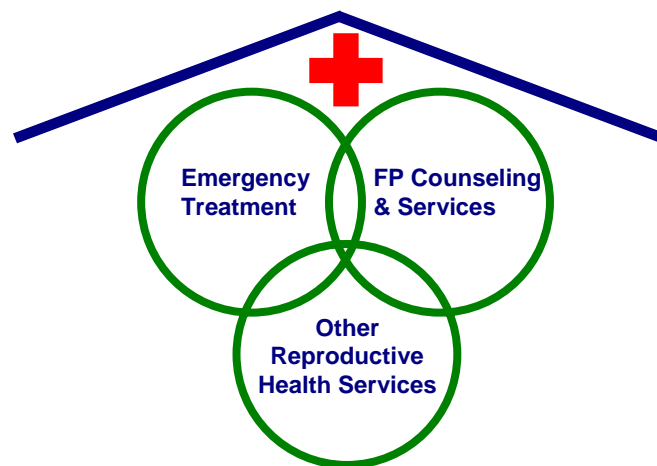
## Objectives

By the end of this session, we will be able to:

- Describe the essentials of PAC services
- Identify key aspects of the service for supervisors to review
- Be familiar with the PAC clinical tools (checklists)

151

## Elements of Postabortion Care



152

## Postabortion Care: Emergency Treatment

- Initial screening (triage) for emergency conditions
- Talking to the client regarding her condition
- Medical assessment
- Referral or transfer for extensive treatment (e.g., major surgery)
- Stabilization (IVs, antibiotics) prior to Manual Vacuum Aspiration (MVA)\*
- Uterine evacuation by MVA

\* MVA is the preferred method for removal of retained products of conception. More information is provided later in this transparency set.

153

## Treatment of Incomplete Abortion

- PAC patients should be treated without delay
- Remove any POC from the uterus
- Method depends on uterine size, patient's condition, and the availability of equipment, supplies and skilled staff
- Manual Vacuum Aspiration (MVA)
  - Effective and safe, Removes POC by suction
- Sharp Curettage
  - Effective, slightly higher risk of perforation
  - Added risk of complications from general anaesthesia
  - Increased delays due to OT schedules, unavailability of necessary staff (anaesthetist, scrub nurse, etc.)

154

## MVA Technique

- Create vacuum in the syringe
- Insert cannula into uterus
- Then attach the syringe and release the vacuum
- Rotate the cannula gently (10:00 – 2:00) and slowly move it back and forth
  - Do not use it like a curette!
- The suction created by the syringe pulls the contents of the uterus into the syringe
- Disconnect & empty syringe in a strainer if necessary
- When complete, check POC for completeness

155

## Pain Management

- MVA can be performed without GA – no OT / OR
- Providers must be attentive to pain management throughout the procedure
- Supportive treatment (“verbacaine”) must always be provided
  - Reassure and talk to the patient throughout the procedure
  - Often this is the only anesthesia required
- Low doses of analgesics and sedatives, or local anaesthesia (paracervical block), may be required
- Providers must assess the patient’s needs in order to decide on appropriate pain management

156

## Psychosocial Support

- Most PAC patients are traumatized, whether they've undergone a miscarriage or provoked abortion
- They often have little or no support from family or friends
- Their fear increases the likelihood of pain and of difficulty during the procedure, if they are not made to feel comfortable and safe
- Counselling and providing FP is one of the only sure methods of preventing future unwanted pregnancies and repeat abortions

157

## Psychosocial Support (cont.)

- Psychosocial support should be provided from the moment the patient enters the facility
- Client-centered care requires that providers leave their own beliefs outside and are not judgmental
- Good psychosocial support will enable the client to tell you her problems, so you can truly help her and avoid repeat abortions or miscarriages

158

## Summary

Supervisors should ensure:

- Proper MVA technique is being used according to the checklists
- Appropriate pain management is used
- Infection Prevention guidelines are being followed
- FP counselling and methods are available and being provided
- RH linkages are in place
- Staff are non-judgmental and supportive
- Psychosocial support is adequate

159

National PAC Task Force

## Organization, Equipment & Supplies for Quality PAC Services



## OBJECTIVES

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

- Describe the physical facilities required,
- Discuss the type of systems to be put in place, and
- List the equipment and supplies needed for the provision of quality PAC services

161

## Background

- Emergency post abortion care services must be widely accessible through the existing health system to all women on a 24 hour basis.
- In order to improve the accessibility of post abortion care, health services should include:
  - Provision of care at the lowest level
  - Adequate transport between levels of care
  - Coordination between the units within larger referral facilities

162

## Background (cont.)

- Reducing client waiting time removes major obstacles many women face in obtaining care
- Facilities and equipment should not become barriers to provision of the safest possible post abortion care

163

## Facilities for Emergency PAC

- MVA can be carried out by trained staff in a simple treatment room and the woman released after a short recovery period
- For uncomplicated incomplete abortions, care can be provided at the primary or first referral level
- Clinical care and counseling should be provided in a private environment

164

## Referral Systems

- Most severe complications require ready access to pre-arranged referral sites
- The most important elements of any referral system include:
  - Timely communication
  - Prompt decision-making and transfer
  - Transfer of patient information between the units

165

## Referral Systems (cont.)

- Indications for referral should be clearly stated in written service protocols
- The staff at each level should be aware of referral arrangements for each level of care
- Immediate availability of transport can save many women's lives

166

## Outpatient and Emergency Care

- Emergency PAC services can be provided in an out-patient setting or simple procedure room with minimal use of anaesthesia
- Advantages:
  - Increased access and more timely treatment
  - Increased availability of OR facilities and staff for other procedures
  - Decreased number of cases that must be referred to the secondary and tertiary levels
  - Decreased hospital stay, and less consumption of resources

167

## Client Flow

- Current case records can be determined by reviewing hospital and clinic records
- Effective management of client flow ensures that women receive care in a logical form without unnecessary delay
- This can be achieved by organizing existing resources more efficiently

168

## Client Flow (cont.)

- Improvement of client flow can be achieved by:
  - Outline activities that must be carried out in a particular area or sequence
  - Eliminate duplication of tasks
  - Examine where and why crowding occurs.
  - Outline how the use of space and personnel could be modified to increase the efficiency of activities and serve clients better.

169

## Client Flow (cont.)

- For example, client flow can often be improved by:
  - Performing MVA in the emergency room rather than referring to gynae service
  - Making use of patient treatment rooms rather than operating rooms

170

## Coordination Within Facilities

- Facility managers ensure that linkages between units providing all elements of PAC are made and functioning smoothly
- All staff need to be oriented to how the facility is functioning
  - How to provide quality FP counselling and services on the ward, and to link with outpatient or health centers for re-supply of contraceptives
  - Where to refer clients for other RH services such as VCT, infertility, etc.

171

## Coordination (cont.)

- Units which need to be coordinated may include:
  - Reception and screening areas
  - Emergency room
  - Obs/Gynae and nursing departments
  - Operating room or theatre
  - Outpatient FP, STI, and HIV/AIDS or VCT services
  - Social work or community outreach unit

172

## Coordination (cont.)

- Units which need to be coordinated (cont.):
  - Central equipment sterilization services
  - Pharmacy & equipment supply units
  - Medical records unit
  - Central laboratory
- Inadequate communication and linkages can restrict access to high quality services

173

## Equipment and Supplies

- Quality PAC services do not require much specialized equipment or drugs
- Important considerations regarding the purchase, supply and maintenance of equipment are as follows:
  - What is the current status of emergency PAC services?
  - What material resources exist?
  - What type of equipment & supplies will be needed?

174

## Equipment and Supplies (cont.)

- Important considerations (cont.):
  - What type of equipment & supplies will be needed?
  - What are the inventory control issues?
  - What policies and procedures are needed to manage the logistics of obtaining & maintaining equipment?

175

## Basic Furniture, Instruments, and Consumable Supplies

- Examination table with stirrups
- Strong light (e.g. gooseneck lamp)
- Seat or stool for clinician (optional)
- Bivalve speculum (small, medium or large)
- Uterine tenaculum or vulselum forceps
- Sponge or ring forceps (2)

176



## Basic Instruments and Supplies (cont.)

- MVA instruments which include:
  - MVA vacuum double valve syringe
  - Flexible cannulae of different sizes
  - Adapters
  - Silicone for lubricating MVA syringe o-ring
- Small hand-held light source (to see cervix & inspect tissue)
- Swabs/gauze
- Antiseptic solution

177

## Basic Instruments and Supplies (cont.)

- Strainer and clear container or (for tissue inspection)
- Disinfectants for decontamination and chemical sterilization

178

## Basic Instruments and Supplies (cont.)

- Items that should on hand, but are not required for all MVA procedures:
  - Local anesthetic (e.g. 1% lidocaine without epinephrine)
  - 10-20ml syringe & 22G needle (for paracervical block)
  - Currettes, sharp
  - Tapered mechanical dilators
    - Pratt (metal) or Denniston (plastic)

179

## Basic Instruments and Supplies (cont.)

- Infection Prevention:
  - Gloves:
    - Sterile or high level disinfected surgical gloves or new examination gloves
    - Utility gloves for cleaning and waste disposal
  - Plastic buckets for decontamination solution
  - Puncture proof container for disposal of sharps (needles)
  - Leak-proof container for disposal of infectious waste

180

## Basic Instruments and Supplies (cont.)

- Infection Prevention (cont.):
  - Detergent and clean water for cleaning instruments
  - Nonmetal (plastic) containers for chemical sterilization
  - Steamer for steaming surgical gloves, cannulae and surgical instruments
  - Autoclave (steam) or convection oven (dry heat) for sterilizing metal instruments

181

## Basic Instruments and Supplies (cont.)

- Infection Prevention (cont.):
  - Disinfectants
    - Decontamination of instruments
      - 0.5% chlorine solution
    - Chemical sterilization of cannula & syringes
      - Glutaraldehyde 2% (Cidex) - preferred
      - Formaldehyde 8% (Formalin)

182

## Essential Drugs for Quality PAC Services

- Local Anesthetics (should be available at all secondary and referral facilities)
  - Atropine
  - Diazepam
  - Lignocaine, 1% without epinephrine
- Analgesics
  - Asetysalicylic acid
  - Ibuprofen
  - Pethidine (or suitable substitute)

183

## Essential Drugs (cont.)

- Broad Specrum Antibiotics such as:
  - Ampicillin, Benzylpenicillin, Crystalline penicillin, Chloramphenicol, Metronidazole, Sulphamethoxazole, Sulphamethoxazole-trimethoprim, Tetracycline
- Antiseptics
  - Chlorhexidine, 4% (Hibitane, hibiscrub)
  - Iodine preparations 1-3%
  - Iodophors (Betadine)

184

## Essential Drugs (cont.)

- Blood Products
  - Dried human plasma
- Tetanus Toxoid
- Oxytocics
  - Ergometrine injection
  - Ergometrine tablets
  - Oxytocin injection
- Contraceptives

185

## Essential Drugs (cont.)

- Intravenous Solutions
  - Water for injections
  - Sodium lactate (ringer's)
  - Glucose 5% and 50%
  - Glucose with isotonic saline
  - Potassium chloride
  - Sodium chloride

186

## Emergency Resuscitation

- These items are seldom required in uterine evacuation cases, but must be on hand for emergencies:
  - Spirit of ammonia
  - Atropine
  - IV infusion equipment and fluid
  - Ambu bag with oxygen
  - Oral airways

187

## Summary

- Emergency PAC services can be provided in an out-patient setting or simple procedure room with minimal use of anaesthesia
- Equipment, supply and drug needs are minimal, especially compared to performing D&C under general anaesthesia

188

## Summary (cont.)

- Benefits include:
  - Emergency PAC services can be provided at lower levels in the health system, making them more accessible
  - Delays and hospital stays are reduced
  - Costs to clients and the facility can be reduced
  - Psychosocial support and counselling can be more easily integrated

## Overview of Postabortion Care at Different Levels

## PAC Program Goal

- Health care services at all levels must be available 24hrs a day to provide emergency care for complications of abortions

191

## Objectives

By the end of this session, we will be able to:

- Describe the essentials PAC services that should be available at different levels of the health system
- Discuss issues in providing quality PAC services throughout the continuum of care

192



## Why are there many maternal deaths due to abortion?

The three-delay model:

- Delay in seeking care
- Delay in reaching medical facility
- Delay in receiving adequate treatment

193

## Ways to improve the accessibility of abortion care

- Provision of care at the lowest level that has trained staff and appropriate equipment
- Effective referral networks and practices
- Adequate transport between levels of care
- Coordination between units within larger referral facilities

194

## The Basic Health Care Package

Level	Possible Staff
Community	CBA (TBAs, traditional healers, NHC members, etc.) Community members
Health post	Nurses, Midwives, COs, EHTs
Health Centres	Nurses, Midwives, COs, EHTs
First referral	Nurses, Midwives, GMOs
Second referral	Nurses, Midwives, GMOs, Obs & Gynae specialists

195

## Activities at Community Level

- Recognition of signs and symptoms of abortion complications
- Timely referral to formal health sector
- Health education regarding unsafe abortion
- Family planning information, education and services

196

## Activities at Health Post

All of the above activities plus:

- Simple physical and pelvic exams
- Diagnosis of stage of abortion
- Resuscitation and preparation for treatment or transfer

197

## Activities at Health Centre

All of the above plus:

- Initiation of essential treatment including antibiotic therapy
- IV fluid replacement and oxytocics, uterine evacuation and basic analgesia
- Linkage to other RH services

198

## Activities at First Referral

All the above activities plus:

- Emergency uterine evacuation in the 2<sup>nd</sup> trimester
- Treatment of most complications of abortion & blood x-match and transfusion
- Local, general anesthesia & laparotomy
- Referral of severe complications
- Linkage to other RH services

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## Activities at 2<sup>nd</sup> and 3<sup>rd</sup> Referral

All the above activities plus:

- Uterine evacuation as indicated
- Treatment of severe complications
- Treatment of coagulopathy
- Linkage to other RH services

200

## Questions for discussion

- What is the information required by various community groups & the best way of transmitting it?
- What referral mechanisms are in place?
- What transport systems are in place?
- How can we involve private clinics/practitioners in providing PAC services?

## Organization & Preparation for a PAC Clinical Training Site

## Objectives

By the end of this session, we will be able to :

- Discuss the requirements for becoming a clinical training site
- Describe the preparations and logistics required for conducting training
  - within the site (on-the-job training)
  - for staff from other sites

203

## PAC Training Site Requirements

- Model, high quality PAC Services
- Qualified PAC clinical trainers
- Self-study training area, secure but accessible, equipped with:
  - TV & VCR
  - Anatomic model for practice
  - Equipment, instruments & supplies for demonstrations and practice
  - Reference materials

204

## Individualized Training

Remember, this package can be used in two ways:

- On-The-Job-Training (OJT)
- Remote Site Training
  - Periodic, for staff from nearby sites who can commute
  - Residential, for staff from distant sites

205

## Logistics for On-the-Job-Training (OJT)

- As a training site, site strengthening is not needed – you should already have appropriate IP and FP practices in place
- Identify all staff who need training
- Develop a training program
- Set time limits
- Ensure the supervision system is in place

206

## Supervisor's Preparation for a Remote Site – Before Training!

- Identify sites
- Ensure sites are adequately prepared
  - Site administration & staff are oriented
  - PAC services are well planned and staff involved are clearly identified
  - Equipment and supplies in place
  - IP practices are up to standard
  - FP counselling and method provision skills and systems are in place

207

## Training Staff from a Remote Site

- If nearby and commuting, develop a firm training schedule with deadlines
- If residential training from a far-away site, agree on the training period
- Ensure availability and accessibility of trainers and training resources
- Plan for support to initiated PAC services at trainee's site after training

208



## Links with National PAC Task Force

- Notify Task Force of training plans, and request any support needed, well in advance
- Keep Task Force apprised of progress
  - Task Force keeps a register of competent PAC providers (and trainers)
- Notify Task Force of any problems
- Task force should be conducting regular periodic reviews and supervision visits

209

## Summary

- Training requires teamwork:
  - Supervisors, training site (trainers and administrators), new PAC service site (clinical staff and administrators)
- Time is money . . . set deadlines and stick to them
- Support while initiating a new service is critical
- Supportive supervision should be built-in

210