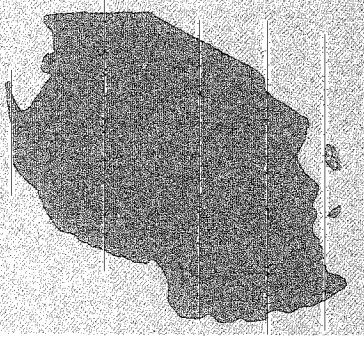
Post-abortion Care Clinical Skills Curriculum

Volume 2
Trainee's Handbook



July 2002

Publisher's Notes:
Text was prepared in MS Word 6.0

ISBN 9966-897-14-3

Designed and formatted by:
Mercie Gachie
PRIME II/Intrah Regional Office, Nairobi
Norfolk Towers, Block G
P.O. Box 44958, 00100
Nairobi, Kenya

This document has been produced by the Ministry of Health, Tanzania (Reproductive and Child Health Section) with technical assistance from PRIME II, Regional Office in Nairobi. The views expressed in this document are the responsibility of the authors and do not represent the policy of the USAID.

Table of Contents

Foreword

Comprehensive Postabortion Care (PAC) is a strategy aimed at reducing maternal mortality and morbidity. The overall objective is to reduce maternal deaths. Maternal mortality devastates thousands of families and is considered a world-wide crisis. About 600,000 women die every year from complications of pregnancy and child birth. Ninety-nine percent of these deaths occur in the developing world. In 1995, the World Health Organisation (WHO) estimated that up to 15% of pregnancy related mortality world-wide is due to abortion. The maternal mortality rate (MMR) in Tanzania is estimated as 529 per 100,000 live births. The 1996 Tanzania Demographic and Health Survey (TDHS) indicates that abortion contributed 16% of the maternal deaths (TDHS 1996). Several strategies have been tried in Tanzania to reduce the problem of maternal mortality, including adoption of the Safe Motherhood Initiative. However, these efforts seem to have yielded minimal impact on maternal mortality.

In light of the above, the MOH is committed to scaling up comprehensive PAC so as to reduce abortion related maternal mortality and morbidity through training of middle level health service providers such as clinical officers, nurse-midwives in addition to the medical doctors. The aim is to ensure that comprehensive PAC services are available at lower level health facilities. Comprehensive PAC entails community involvement and participation, comprehensive PAC counselling, emergency treatment of complications from spontaneous or induced abortions, family planning counselling and services, and linkages with social, general medical and other reproductive health services to cover comprehensive reproductive health.

It is my hope that this curriculum will enhance quality comprehensive PAC, increase community awareness of abortion complications and maximise utilisation of comprehensive PAC services within the health sector reform policies, strategies and guidelines. I urge all users of this curriculum to make it a living document in government's efforts to improve women's health taking into account emerging community needs and scientific developments.

Dr. G. L. Upunda

Dr. Gabriel L. Upunda
Chief Medical Officer
Ministry of Health

Acknowledgements

This document "Comprehensive ***Postabortion Care Clinical Skills Curriculum for Service Providers*** was developed in order to improve the quality of Comprehensive PAC and break the cycle of repeat abortions in Tanzania. The development of this curriculum has gone through several stages. The Reproductive and Child Health Section (RCHS) of the Ministry of Health (MOH) provided the leadership in this process with support from local and international organisations.

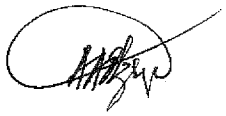
The MOH wishes to acknowledge the following individuals and organisations that contributed to the development of this curriculum: Dr. Catherine Sanga, Head, RCHS and UMATI for the leadership and technical support to the curriculum development process and USAID/Tanzania for the financial and material support. The MOH is indebted to EngenderHealth, Intrah and JHPIEGO regional offices in Nairobi for their commitment and technical assistance provided in developing this curriculum.

The MOH would like to thank the following individuals for their contributions to this curriculum:

Dr. Zahida Qureshi	Consultant – JHPIEGO
Ms. Grace Mtawali	Consultant – PRIME/Intrah
Dr. David Kihwele	Director of Programmes – UMATI
Dr. Isaac Achwal	Medical Associate and PAC Advisor – EngenderHealth
Ms. Rose Wasira	Service Delivery Programme Officer – RCHS
Ms. Gaudensia Tibaijuka	Former Asst. Training Coordinator – RCHS
Mr. John Simbamwaka	Research and Evaluation Officer – UMATI
Dr. Nsima Mshumba	Marie-Stopes, Tanzania
Dr. K. Mohammed	Medical Officer – Njombe District Hospital
Ms. Leonia Rutahiwa	Reproductive Health Trainer – Njombe District Hospital
Ms. Colleta Obunga	Former Ipas Regional Director
Dr. Joseph Kanama	National Service Delivery Coordinator – UMATI
Dr. Dawson Mrosso	Obstetrician/Gynaecologist – Mbeya Consultant Hospital
Dr. Regina Kutaga	Safe Motherhood Initiative Officer – RCHS
Dr. H.S.S Shemhilu	Head of Information and Documentation – PHC Iringa

Dr. David E. Martin	Vice Principal – CEDHA, Arusha
Dr. Andrew Kilonzo	Obstetrician/Gynaecologist – Bugando Medical Centre, Mwanza
Ms. E Mwanshinga	Zonal MCH Coordinator – Southern Highlands Zone
Mr. P.P. Sanga	Principal, Operating Theatre Management School – Mbeya
Ms. Evelyn Mutio	Private Nurse Midwife – Kenya
Ms. Illuminata Ndile	Family Planning trainer – UMATI
Dr. Peggy Chibuye	PRIME Manager – Intrah

Last, but not least, thanks go to Mr. Jared Ndiege Finance Officer and other Administrative Officers at the RCHS. Ms. Gertrude M. Limbe, Ms. Rose Ntanga and Ms. Concepsia Kabuteni for secretarial services.



Dr. A. A. Mzige
Director, Preventive Services, MOH

Abbreviatons

AIDS	-	Acquired Immunodeficiency Syndrome
AMO	-	Assistant Medical Officer
ANC	-	Ante-natal Care
Bp	-	Blood Pressure
BUN	-	Blood Urea Nitrogen
CEDHA	-	Center for Educational Development in Health, Arusha.
cm	-	Centimetre
CO	-	Clinical Officer
COC	-	Combined Oral Contraceptives
COPE	-	Client Oriented Provider Efficiency
CPAC	-	Community-level Post Abortion Care
CVS	-	Central Vascular System
D&C	-	Dilatation and Curettage
DIC	-	Disseminated Intravascular Coagulopathy
DMPA	-	Depot– Medroxy Progesterone Acetate
EC	-	Emergency Contraception
ELC	-	Experiential Learning Cycle
EPI	-	Expanded Program of Immunization
FP	-	Family Planning
GATHER	-	Greet, Ask, Tell, Help, Explain, Refer/Return (as used in counselling technique)
gm/dl	-	grammes/decilitre
Hb	-	Haemoglobin
HBV	-	Hepatitis B Virus
Hct	-	Haematocrit
HIV	-	Human Immunodeficiency Virus
HLD	-	High-level Disinfection
IEC	-	Information, Education and Communication
IM	-	Intramuscular
IP	-	Infection Prevention
Ipas	-	International Project Assistance Services

IUCD	-	Intrauterine Contraceptive Device
IV	-	Intravenous
JHPIEGO	-	Johns Hopkins Programme for International Education in Reproductive Health
LMP	-	Last Menstrual Period
LNMP	-	Last Normal Menstrual Period
MCH	-	Maternal Child Health
mm	-	millimetre
MMR	-	Maternal Mortality Ratio
MO	-	Medical Officer
MOH	-	Ministry of Health
MSD	-	Medical Stores Department
MTUHA	-	Mfuno wa Taarifa za Uendeshaji wa Huduma za Afya (The National Health Information System)
MVA	-	Manual Vacuum Aspiration
N/M	-	Nurse/Midwife
NSAID	-	Non-Steroidal Anti–inflammatory Drugs
Ob/Gyn	-	Obstetrician/Gynaecologist
OJT	-	On the Job Training
OPD	-	Out–patients Department
OR	-	Operation Room
OT	-	Operating Theatre
PAC	-	Comprehensive postabortion Care
PCV	-	Packed Cell Volume
PHC	-	Public Health Care
PMH	-	Past Medical History
POCs	-	Products of Conception
POP	-	Progestin Only Pill
PR	-	Pulse rate
RCHS	-	Reproductive and Child Health Section
RH	-	Reproductive Health
RS	-	Respiratory System

STD	-	Sexually Transmitted Diseases
TT	-	Tetanus Toxoid
TDHS	-	Tanzania Demographic and Health Survey
UMATI	-	Uzazi na Malezi Bora Tanzania (FP Association of Tanzania)
USAID	-	United States Agency for International Development
VCT	-	Voluntary Counselling and Testing for HIV
WHO	-	World Health Organisation
WST	-	Whole Site Training (orientation of all personnel including management, cleaners and security staff on the subject/issues skills on-job-training of service providers)

Basis of the Curriculum

This is a competency-based curriculum based on five elements of comprehensive PAC, national policy guidelines and Program Components and Service Standards for Family Planning and Safe Motherhood.

In 1991, the initial concept of comprehensive PAC had 3 elements however after many years experience, other important aspects that make it holistic and all inclusive were added and the elements were globally revised in 2002 to five. These are:

1. ***Community involvement and participation*** (for prevention of unwanted pregnancies and unsafe abortion), mobilisation of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs;

2. ***Comprehensive postabortion counselling*** (to identify and respond to women's emotional and physical health needs and other concerns);

3. ***Emergency treatment of complications from spontaneous or induced abortion*** (that are potentially life-threatening);

4. ***Family planning counselling and services*** (to help women prevent an unwanted pregnancy or practice birth spacing);

5. ***Linkages to access comprehensive reproductive health*** (CRH) care (provided on-site or via referrals to other accessible facilities in providers' networks.

Contribution to Providing Positive attitudes to Comprehensive PAC

- The curriculum contributes to expanding the knowledge, improving skills and changing attitudes of health workers who will be trained using this curriculum, in order for them to:

  - Display non-judgmental and caring attitude to women who have suffered complications of abortion.

  - Be proactive in assisting Comprehensive postabortion women to prevent repeated abortion and the health consequences associated with it.

Contribution to geographic and human resources decentralisation

- Programmatically, the implementation of the curriculum will help the Ministry of Health and Local Government Health Management Teams to decentralise Comprehensive postabortion care from central referral hospitals to health centres – district hospitals and from few physician service providers to many middle level service providers.

Pool of Comprehensive PAC graduates and integrating Comprehensive PAC with other health services

- The graduates of the curriculum will form a pool of comprehensive postabortion care (PAC) service providers from which to draw comprehensive PAC trainers and health facility level comprehensive PAC supervisors. However, given the integrated approach, comprehensive PAC services will be part of other life saving skills, reproductive health, medical and other social care. Hence the inclusion of skills related to client/provider interaction, STD/HIV/AIDS etc.

Training Approaches

- The curriculum will be adaptable for a variety of structured training approaches depending on training needs, setting of the training and availability of resources. Examples of these approaches are:

  - Short centralised or group training (which is the main approach in this curriculum).
  - Individualised and self-directed learning.
  - On-the-job training.
  - Whole site training.

- For each training approach participants will be assisted to link or transfer learning to work situation through:

  - Applying the seven step experiential learning cycle during all sessions.
  - Developing and using individual skills application plans (each participant or team of participants).
  - Supportive/facilitative trainee follow-up, which is ultimately phased into supportive supervision.
  - Applying self assessment tools, including COPE (Client-Oriented Provider Efficiency) checklist or procedural steps; and
  - Use of relevant job aids.

Link with clients and Community rights

- In all the above training approaches, upholding the clients' and community's rights will be a key quality for comprehensive PAC service. Community rights include the clients' right of participating in the design, implementation and evaluation of the health service. The comprehensive PAC curriculum reflects an aspect of this community right.

- Trained comprehensive PAC service providers should apply other Ministry of Health guidelines and use data from MTUHA, in maximising community involvement in comprehensive PAC service delivery, access and quality.

Link with existing national health information system (MTUHA)

- Existing Comprehensive PAC providers will use Comprehensive PAC records developed for a transitional period until this information is incorporated in the MTUHA.

- Trainers will assist trainees to use Comprehensive PAC data during practice and after the training, while ensuring that this data stays accessible for continuing client care when needed.

How to use Volume 2 of the Comprehensive PAC Clinical Skills Curriculum

Relationship Betweem Volume 1 and Volume 2

- Volume 2 of the Comprehensive PAC Clinical Skills Training Curriculum is a companion to Volume 1: Trainers Guide. It contains all materials, which are required to promote Comprehensive PAC knowledge, attitude and skills acquisition by the learner.

- The trainee will note that the schedule introduces Clinical Practice and MVA earlier than in the traditional approaches. This new approach allows more time for clinical practice.

Primary users of Volume 2

- The Primary users of Volume 2 of the Curriculum are Comprehensive PAC TRAINEES. Since a detailed outline of how the trainer uses the Comprehensive PAC Curriculum is in Volume 1, the information provided below is directed at the Comprehensive PAC trainee.

Users of Volume 2

- These are listed below.

a) The Trainee

- During training, the trainee will use the handouts as reference and help in mastering all the attitudes, knowledge and skills taught. He/She will also use other materials as guides for self-learning.

- After training, the materials will be used for consolidating all knowledge skills and attitudes obtained from the training.

- When appropriate the materials will be used for conducting on the-job-training of others.

b) The Trainer

- Will use the materials as visual aids for the trainee or to further elaborate on training/learning experiences addressed in the theoretical and practice session. The observation checklists will be used when the trainer conducts monitoring and evaluation of learning as well as for providing supportive trainee follow-up.

- The trainer will also use relevant materials selected for on-the-job orientation and training of other providers and during Comprehensive PAC educational sessions in the community.

c) *On-site or distance-based reproductive health supervisor*

He/She will use:

- The checklists and appropriate FP/PAC/RCH service standards to identify technical assistance needed in order to strengthen the Comprehensive PAC provider's skills/ practices. He/She will ensure this assistance in provided in a timely manner.
- The list of equipment, supplies and materials needed for providing quality comprehensive PAC service; to ensure that a sustainable system for avoiding stock out is in place.
- The Comprehensive PAC provider guidance in record keeping, to ensure that in the long term, Comprehensive PAC data will be integrated with other RH data in MTUHA.

d) *Hospital and Council Health Management Teams*

- To ensure that the post training tasks of the Comprehensive PAC service provider will be recognised officially and explicitly reflected in the job description of the Comprehensive PAC provider.
- To ensure that support to the supervisors and in turn the Comprehensive PAC provider leads to "training that has impact/results on service".

Using the Materials during training

- Read the materials relevant for the sessions, before and after the session, alone or with a group of your peers. Clarify any difficult points with the trainer(s).
- Monitor your own knowledge and skills acquisition using the various evaluation checklists.
- Trainers and trainees through simulation and/or on models demonstrate all Comprehensive PAC procedures before practicing on actual patients. Perform simulations with a peer on selected procedures to strengthen the skills and attitudes as guided by the trainer.
- During training, if your skill acquisition pace does not match the process and time covered in the sessions, ask for the trainer's help. Ensure that you use the set general and specific objectives as one main way of checking your learning progress and achievement. Also co-operate with the trainers if they suggest putting in extra curricular time for conducting training /learning activities that cannot be covered during the regular time.
- Ensure that you understand the guidelines and time frames for the project on Facility Organisation. Complete the project on the set deadline.

- During the centralised training practicum, the trainer will provide one-on-one guidance to trainees. She/he will ensure that each trainee provides emergency care, including at least 10* MVA procedures for incomplete abortion, practicing new skills such as using chemicals for high level disinfection; history taking for Comprehensive PAC service, recording client care provided, counselling for emotional support of Comprehensive postabortion clients, holding a meeting for community involvement in Comprehensive PAC service delivery etc.

> Note: *This number provides several opportunities for the trainee to practice and refine these skills.

- Document the changes/applications learnt that you intend to make at your work site. Compile those that you feel are a priority at the end of the training, for application.

Monitoring the Training

- Outcomes of monitoring the training contribute to end of training recommendations for certifying participant.

- Use the Comprehensive PAC Performance Standards, FP Procedure Manual, STD Syndromic Management Flow Charts, Checklists and steps of providing Comprehensive PAC, including Infection Prevention procedures, to monitor your skills acquisition. Participate in process reviews after each practicum session and classroom day. Seek immediate guidance and support from the trainer during training on clients' rights and quality of service.

- Remember that you will monitor your own skills acquisition at your work sites using the Comprehensive PAC Performance Standards, FP Procedure Manual, STD Syndromic Management Charts and the Skills application (Action) Plans.

Evaluating Training

Evaluation of training to be conducted jointly by the trainer and yourself.

- Some approaches, tools and methods of evaluation which will be used in Comprehensive PAC training are:

  - Completing the Pre-Post Training Questionnaire, Results Completing the Pre-Post Training Questionnaire, Results will be shared with individual trainees during the first week of training.

Using the checklists/skills assessment tools, the Comprehensive PAC Standards Performance and STD Syndromic Management Flow Charts:

- Completing Participant Course Evaluation Form to evaluate the whole training.
- Participating in a grand (end-of-training) process review.
- Participating in documenting the status of your competence through daily and weekly trainers' and trainee's process reviews.

Sharing relevant outcomes of evaluation with the trainer and making alternate plans if appropriate.

Expectations of trainee competence at the end training

By the end of the training participants are expected to have achieved the following:

- Developed positive attitudes towards comprehensive postabortion clients and Comprehensive PAC generally.
- Acquired/updated their FP, STD/HIV/AIDS and counselling skills, including empathetic interaction counselling, treatment, MVA and other procedures.
- Updated their skills in infection prevention.
- Updated their skills in documenting findings of client assessment and management of abortion complications.
- Updated their skills in community mobilisation and involvement.
- Identified how to advocate for comprehensive PAC and source of comprehensive PAC messages.
- Committed themselves to each train at least one colleague on-the-job in comprehensive PAC.
- Developed comprehensive PAC Action Plans that would include establishing and strengthening the involvement of the community in their catchment areas for comprehensive PAC services.

Supportive on-site trainee follow-up and other guidance

The two weeks training enables the graduate to achieve acceptable exit level competence. Proficiency is expected to occur once you as a newly trained person is deployed as a Comprehensive PAC provider. As a newly qualified Comprehensive PAC service provider, it is anticipated that the trainer will give you initial support and guidance your work-site to help you consolidate your Comprehensive PAC skills. It is also hoped that the Hospital Management Teams or the CHMT will support you in the provision of comprehensive PAC services.

- Ask for guidance of your trainer, other Comprehensive PAC trained providers, other RH service delivery experts and supervisors when needed.

  - Continue with learning through using job aids provided during the training and various procedures FP/PAC/STD/ HIV/AIDS. The source of these job aids includes the FP Procedure Manual, and STD/HIV/AIDS manual leaflets and posters.

  - Do your best to tactfully, encourage the on-site supervisor to provide you an atmosphere for self-directed learning e.g. during the periods of low client load.

Certification

- If you complete the 2 weeks training and in that time you have demonstrated acquisition of all Comprehensive PAC skills according to set standards, then the trainer will either issue a certificate of competency or recommend you for certification.

- Trainees who do not meet certification requirements will be recommended for:

  a) Certification and issuing of a a Certificate of Competence at a later date, if you're their continuous skills assessment during training reveals limitation in critical skills for offering comprehensive PAC services. Critical skills include those which:

  - Make comprehensive PAC service complete.

  - Influence Comprehensive PAC client.

  b) On-the-job guidance or self-directed learning that is needed to help you reach certification level. In this case a person to guide you at the practice-site will be recommended.

Trainee's Note

Section 1

Foundational Information for Enhancing Effective Comprehensive Postabortion Care Training

Selection Criteria for Trainers, Trainees and Practicum Site for the Training Reflected in this Curriculum

The Comprehensive PAC Trainer

- CO, AMO, MO, Ob/Gyn Specialist, N/M PHC.
- Currently practicing and deployed in Comprehensive PAC service.
- Having training skills including OJT, coaching/preceptor-ship. Is recognised by RCHS as Comprehensive PAC trainer.
- Having participated in contraceptive technology update, interpersonal communication/counselling course, infection prevention update and Comprehensive PAC Standards.

The Comprehensive PAC Trainee

- Health workers i.e. MO, AMO, Ob/Gyn Specialist, CO, N/M AND PHN and N/M "B".
- Should be working in a health care facility that provides women health services.
- Should have interest in Comprehensive PAC services.
- Have a positive attitude towards clients.
- Will be deployed for Comprehensive PAC services and will train another staff member for the continuity of Comprehensive PAC service.

The Comprehensive PAC Practicum Site

- In order to provide effective OJT, the site where practice training will occur must meet the following criteria:
  - Be a facility that provides quality Comprehensive PAC services according to national standards.
  - The management of the facility must show an interest in hosting Comprehensive PAC training and indicate acceptance to host the same upon request.
  - Should have a client caseload that will enable trainee reach acceptable exit level of competence
  - The facility must have adequate water supply to maintain IP standards.
  - The facility should be one that has good support services (i.e. those needed to complement Comprehensive PAC service provisions such as a laboratory and pharmacy).
  - Should be a facility that provides family-planning services according to expected national service polices and standards.
  - The facility should ideally have a range of or has access to other RH services to which Comprehensive PAC patients are routinely referred.

Equipment, Supplies and Drugs for Quality Comprehensive PAC Service Delivery

The Comprehensive PAC Trainer

- Bivalve speculum (small, medium or large).
- Uterine tenaculum or vulsellum forceps.
- Sponge or ring forceps (2).
- 10-20 ml syringe and 22-gauge needle (for paracervical block).
- MVA Instruments:
  - MVA vacuum syringes, single or double valve.
  - Flexible cannulae of different sizes.
  - Adapters (if double valve syringe).
  - Silicone for lubricating MVA syringe o-ring.
- Light source (to see cervix and inspect tissue).
- Swabs/gauze.
- Antiseptic solution (preferably an iodophor such as povidone iodine).
- Gloves, sterile or high-level disinfected surgical gloves or new examination gloves.
- Utility gloves (heavy).
- Strainer (for tissue inspection).
- Simple magnifying glass (x 4-6 power) (optional).
- Clear container or basin (for tissue inspection).
- Items that should be on hand but are not required for all provider cadres or MVA procedures:
  - Curettes, sharp.
  - Tapered mechanical dilators (Pratt [metal] or Denniston [plastic]).

Furniture and Equipment

Before beginning the MVA procedure, make sure that the following equipment and supplies are in the treatment room and in working order:

- Examination table with stirrups.
- Strong light (e.g., gooseneck/angle poise lamp).
- Seat or stool for the surgeon performing the clinical procedures (optional).
- Plastic buckets (at least 3) for decontamination solution (e.g. 0.5% chlorine).
- Puncture-proof container for disposal of sharps (needles).
- Leak-proof container for disposal of infectious waste.
- Battery operated torch/spotlight.

For High-level Disinfections or Sterilisation of Instruments

These items should be available for processing instruments:

- Normal (plastic) containers with lids for HLD and storage.
- Detergent.
- Clean Water.
- Chlorine solution (concentrated solution or dry powder).
- High-level disinfectant or sterilization agent; – gluteraldehyde (Cidex, Steraneous, Totacide) (optional).
- Large pot for boiling cannulae (optional).
- Autoclave (steam) or convection oven (dry heat).
- Heavy duty gloves.
- Cleaning brush (e.g. toothbrush).

For Emergency Resuscitation

These items are seldom required in uterine evacuation cases but are needed for possible emergency use:

- Spirits of ammonia (ampules).
- Atropine.
- IV infusion equipment and fluid (DSW or D/S).
- Ambu bag with oxygen (tank with flowmeter) with oxygen.
- Oral airways.

*Esentail drugs for emmergency Comprehensive Postabortion*** care*

Drugs used for anaesthesia **
Atropine
Diazepam
Ketamine
Lignocain, 1% without epinephrine

Analgesics
Paracetamol
Diclofenac

Indomethazine
Ibuprofen
Pethidine (or suitable substitute)

Antibiotics
Broad spectrum antibiotics such as:
Ampicillin
Amoxyl
Benzylpencillin
Chloramphenical
Metronidazole
Sulfamethoxazole-trimethoprim
(C0trimoxazole)
Erythromycin
Tetracycline

Antiseptics
Chlorhexidine, *** 4% (Hibitane, Hibiscrub)
Iodine preparations, 1-3%
Iodophors (Betadine)

Disinfectants
0.5% chlorine solution constituted from Sodium hypochlorite tablets/ chlorine powder/ commercial chlorine solution

Formaldehyde, 8% (Formalin)
Glutaraldehyde, 2% (Cidex, Steraneous,Totacide)

Tetanus Toxoid***
Oxytocics**
Ergometrine injection
Ergometrine tablets
Oxytocin Injection

Intravenous Solutions
Water for injection
Sodium lactate (Ringer's)
Glucose 5%, 10%, 25% and 50%
Glucose with isotonic saline
Sodium Chloride

Blood Products**
Capability for blood transfusion or access to blood transfusion services.

** Should be available at all secondary or referral facilities.

*** Savlon, which contains chlorhexidine, is not listed because the concentration of chlorhexidine varies from country to country from as little as 1% to 4%. (Check local products for approximate concentration before using).

**** Anti-D tetanus immunoglobulin (human) or antitoxin, if available, should be provided when indicated.

Post Training Tasks of a Service Provider Trained in Comprehensive Postabortion Care

In addition to the usual official duties the Comprehensive PAC trained service provider while applying various national service guidelines and standards

- Establishing and maintaining positive interaction between him/herself and clients, clients relatives and with other members of the health team.
- Advocating for comprehensive postabortion care in the respective catchment area.
- Managing complications of incomplete abortion.
- Providing counselling services in the following areas:
  - Support for comprehensive postabortion emotional issues.
  - Family Planning including dual protection and emergency contraception.
  - STD/HIV/AIDS.
  - Other reproductive health, medical and social uses contributing to abortion.
  - Other preventive health services such as cancer screening, nutrition or malaria in reproductive age, tetanus toxoid and others.
- Managing STI and HIV/AIDS among comprehensive postabortion clients.
- Practicing/providing integration of comprehensive PAC with general and other reproductive health services.
- Providing a mix of family planning methods to comprehensive postabortion clients.
- Establishing and maintaining a referral mechanism for clients, needing services not provided at the facility and/or specialised care or support.
- Organising the health facility to provide quality comprehensive PAC.

  Maintaining and sustaining supplies, equipment, furniture, environment and records for comprehensive PAC service.
- Performing and assuring that infection prevention practices are in place and adhered to.
- Involving the community to facilitate timely referral and transport of comprehensive postabortion clients.

Overall/General Objectives

By the end of the two weeks training, based on national service standards, the participant should be able to:

1. Advocate for Comprehensive PAC services within the health facility, community and among policy makers.
2. Counsel clients for Comprehensive postabortion care, family planning, medical care, social and other related reproductive health issues.
3. Provide emergency care for clients with Comprehensive postabortion complications.
4. Provide family planning including dual method use and emergency contraception according to client needs.
5. Manage STD/HIV/AIDS and other medical conditions encountered during Comprehensive PAC services.
6. Organise the health facility to provide sustainable Comprehensive PAC services.
7. Involve the community to facilitate timely referral and transportation for women who need Comprehensive PAC services.

Specific Objectives of the Training

By the end of the two weeks training, based on the national standards, the participant should be able to:

1. *Advocate for Comprehensive PAC services*

- Create an enabling environment for access to Comprehensive PAC services at health facility and community levels.
- Solicit the support of all stakeholders at facility, community and district levels in improving the quality and access to Comprehensive PAC services.
- Display a positive attitude towards Comprehensive PAC clients and activities in the facility and other forum.

2. *Counsel Clients*

- Provide emotional support to clients during comprehensive postabortion care.
- Counsel comprehensive Comprehensive PAC clients on other reproductive health (e.g. syphilis, HIV/AIDS), medical (e.g. diabetes, malaria) and other social (e.g. rape, incest, wife battering) issues that may have contributed to abortion.
- Counsel comprehensive postabortion clients for informed choice of family planning methods, medical, reproductive health and social services.

3. *Provide Emergency Care*

- Rapidly assess the client for shock and other life threatening complications.
- Initiate resuscitative measures and treatment for life threatening complications.
- Assess the client to ascertain the diagnosis and plan the management.
- Perform uterine evacuation using MVA.
- Manage pain associated with Comprehensive postabortion complications and treatment.
- Manage complications encountered among Comprehensive postabortion clients.
- Identify clients with complications that cannot be managed at the health facility for referral.

4. *Offer Family Planning and other Reproductive Health Services*

- Provide Comprehensive postabortion clients with a mix of family planning methods including dual method use and emergency contraception.
- Diagnose STD using diagnostic flow charts.
- Provide selected STD/HIV/AIDS care and treatment during Comprehensive PAC service delivery.

5. *Organise Comprehensive PAC/RH Services*

- Apply universal precautions for reducing infections during Comprehensive PAC and other health services.

- Maintain a mechanism for assuring timely availability of supplies, equipment and other necessary materials.

- Use records to evaluate and improve the quality of Comprehensive PAC services.

- Use a variety of approaches of ensuring the Comprehensive postabortion clients who choose family planning methods, receive them.

- Conduct on-the-job training (OJT) for other health workers according to their functions in the continuum of PAC service delivery.

6. *Involve the Community*

- Mobilise the community to provide timely referral and transportation for women who need Comprehensive PAC services.

Trainee's Note

Comprehensive PAC Clinical Skills Training Schedule

Tentative Schedule PAC Clinical Skills Training for Service Providers - Tanzania

DATES: From ..... To ..... 20 ..... ***VENUE:*** .....

WEEK ONE - Morning Sessions

MONDAY ***DAY 1 - Morning***	***TUESDAY*** ***DAY 2 - Morning***	***WEDNESDAY*** ***DAY3 - Morning***	***THURSDAY*** ***DAY 4 – Morning***	***FRIDAY*** ***DAY 5 - Morning***	***SATURDAY*** ***DAY 6 - Morning***
8.30 - 8.45 a.m. Welcoming Remarks	***8.30 - 9.00 a.m.*** Where are We?	***8.30 - 9.00 a.m.*** Where are we?	***8.30 - 9.00 a.m.*** Where are we?	***8.30 - 9.00 a.m.*** Where are we?	***8.00 - 9.00 a.m.*** Where are we?
8.45 - 9.45 a.m. Registration/Biodata Form (for all) circulated ***9.45 - 10.30 a.m.*** Introductions; Expectation, Norms, Housekeeping	***9.00 - 10.30 a.m.*** Providing Emergency Care and Introduction to comprehensive PAC Practice	***9.00 - 10.00 a.m.*** Manage comprehensive post abortion complications ***10.00 - 10.30 a.m.*** Processing instruments for re-use	***9.00 - 10.30 a.m.*** MVA practicum in Gyn Ward when clients available MVA practice on Madam Zoe using checklist Practice of preparation of equipment for re-use Processing, generalising and application session	***9.00 - 10.30 a.m.*** MVA practicum in Gyn Ward when clients available Practice of preparation of equipment for re-use using checklist IMROVEMENT OF SCORES Practice of preparation of equipment for re-use using checklist Processing. generalising and applicationsession	***9.00*** Comprehensive Postabortion family planning
10.30 – 11.00 a.m.	***Tea Break***	***Tea Break***	***Tea Break***	***Tea Break***	***Tea Break***
11.00 - 12.00 noon Pre-Training Questionnaire ***12.00 – 1.00 p.m.*** Introduction to comprehensive PAC training: Goals; Rationale; Objectives; Methodology; Monitoring and Evaluation of Training	***11.00 - 1.00 p.m.*** *Continuation:* Providing Emergency Care and Introduction to comprehensive PAC Practice	***11.00 - 11.30 a.m.*** Processing instruments for re-use ***11.30 - 1.00 p.m.*** Introductory practice in ward including processing, generalising and application session	***11.00 - 1.00 p.m.*** Comprehensive PAC counselling: Lecture/Discussion/Role-plays	***11.00 - 1.00 p.m.*** Counselling role-plays using checklist	***11.00 -12.00 noon*** Counselling role-plays using checklist ***12.00 - 1.00 p.m*** Film: The Mauritius Conference (IPPFAR)
1.00 – 2.00 p.m.	***Lunch Break***	***Lunch Break***	***Lunch Break***	***Lunch Break***	***Lunch Break***

WEEK ONE - Afternoon Sessions

MONDAY DAY 1 - Afternoon	TUESDAY DAY 2 - Afternoon	WEDNESDAY DAY3 - Afternoon	THURSDAY DAY 4 - Afternoon	FRIDAY DAY 5 - Afternoon	SATURDAY DAY 6 - Afternoon
2.00 - 3.30 p.m. Advocating for comprehensive postabortion care	***2.00 - 3.30 p.m.*** *Continuation:* Providing Emergency Care and Introduction to comprehensive PAC Practice	***2.00 - 4.00 p.m.*** Providing comprehensive Postabortion support	***2.00 - 3.30 p.m.*** Counselling practice in ward role plays	***2.00 - 4.00 p.m.*** Infection Prevention - Universal Precautions	***OFF DUTY***
3.30 - 4.00 p.m.	***Tea Break***	***Tea Break***	***Tea Break***	***Tea Break***	
4.00 - 4.30 p.m. OPEN	***4.00 - 4.30 p.m.*** Continuation: Providing Emergency Care and Introduction to comprehensive PAC Practice	***4.00 - 4.30 p.m.*** Introduce and prepare for group project on organistion of the health facility	***4.00 - 4.15 p.m.*** ***Continuation*** Counselling practicein ward role plays	***4.00 - 5.00 p.m.*** Individual Assignment or Project	***OFF DUTY***
Reflection/Closure	***Reflection/Closure***	***Reflection Closure***	***Reflection/Closure***	***Reflection/Closure***	
4.30 - 5.00 p.m. ***Evening:*** Film	***Evening:*** Film: M.V.A (Ipas) Assignment: Module 4 providing emmotional support Individual review of of work done	***Evening:*** Film: Infection Prevention practices Simulation: Using Models	***Film: on STD/HIV/AIDS:*** "(Raphael Tuju in Kiswahili: Mambo Bado)"	Film: Put yourself in her shoes	***OFF DUTY***

WEEK TWO - Morning and Afternoon Sessions

MONDAY	***TUESDAY***	***WEDNESDAY***	***THURSDAY***	***FRIDAY***	***SATURDAY***
DAY 7 - Morning	***DAY 8 - Morning***	***DAY 9 - Morning***	***DAY 10 - Morning***	***DAY 11 - Morning***	***DAY 12 - Morning***
8.30 - 9.00 a.m. Where are we?	***8.30 - 9.00 a.m.*** Where are we?	**8.30 - 9.00 a.m.** Where are we?	**8.30 - 9.00 a.m.** Where are we?	***8.00 – 9.00 a.m.*** Where are we?	***9.00 – 10.30 a.m.*** Resource persons post-training meeting and recommendations
9.00 - 10.30 a.m. Involving the community in improving comprehensive PAC access and quality	***9.00 - 9.45 a.m.*** Introduction to skills application plan **9.45 - 10.30 a.m.** Counselling role play	***9.00 - 10.30 a.m.*** Practicum in the PAC room using Madam Zoe	***9.00 - 10.30 a.m.*** On-the-job training	***9.00 – 10.00 a.m.*** Post Training Questionnaire	
10.30 – 11.00 a.m.	***Tea Break***	***Tea Break***	***Tea Break***	***Tea Break***	
11.00 a.m. - 1.00 p.m. Community involvement, participation and ownership	***11.00 a.m. - 1.00 p.m.*** MVA Practice in PAC room using Madam Zoe	***11.00 a.m. - 1.00 p.m.*** *Continuation:* Practicum in the PAC room using Madam Zoe	***11.00 a.m. - 3.00 p.m.*** Practicum and completion of Back-home implementation plan	***11.00 a.m. - 1.00 p.m.*** Sharing skills application plan	***11.00 a.m. - 12.00 noon*** Resource persons post-training meeting and recommendations ***12.00 a.m. – 1.00p.m.*** Resource persons post-training meeting and recommendations
1.00 – 2.00 p.m.	***Lunch Break***	***Lunch Break***	***Lunch Break***	***Lunch Break***	***Lunch Break***
2.00 p.m. – 3.00 p.m. Management of STD/HIV using algorithm/syndrome charts	**2.00 p.m. – 3.00 p.m.** Maintaining a mechanism for assuring equipment and supplies	***2.00 p.m. – 4.00 p.m.*** Practicum in the PAC room using Madam Zoe	***2.00 p.m. – 4.00 p.m.*** Practicum in the ward	**2.00 p.m. – 4.00 p.m.** Individual feedback on performance-based on skills monitoring tools/checklists. Grand verbal process review	***2.00 p.m. – 4.00 p.m.*** Training report writing
3.30 – 4.00 p.m.	***Tea Break***	***Tea Break***	***Tea Break***	***Tea Break***	
4.00 p.m. – 5.30 p.m. Outline of VCT and STD counselling Role-plays	**4.00 p.m. – 5.30 p.m.** Use records to evaluate and improve the quality of services	***4.00 p.m. – 5.00 p.m.*** Practicum in the PAC room using Madam Zoe	***4.00 p.m. – 5.30 p.m.*** Presenting project on organisation of sustainable comprehensive PAC services	**4.00 p.m. – 5.00 p.m.** End of training and closure	***OFF DUTY***
Evening Film: Bushfire	***Evening*** Film: Consequences (Majuto)	***Evening*** Film: Time to Care: Lets face it	***Evening*** Film:		***OFF DUTY***

Time Allocated to Modules

Module No.	Module Title	Theory Hours	Practice Hours
1.	Developing a climate for learning	3	-
2.	Advocating for comprehensive postabortion care services	2	As part of Module 7
3.	Providing emergency comprehensive postabortion care	7	- do -
4.	Counselling to identify and respond to women's emotional and physical needs and other concerns	6	
	4.1 Providing comprehensive postabortion, emotional and other related support	1	
	4.2 Providing counselling to comprehensive postabortion clients	1	
	4.3 Counselling comprehensive postabortion clients for informed choice of family planning methods, medical, reproductive health and social services	1	
	4.4 Counselling comprehensive PAC clients on STD/HIV/AIDS	1	
	4.5 Managing medical conditions encountered during comprehensive postabortion service delivery, including STD/HIV/AIDS.	1	
	4.6 Providing comprehensive postabortion clients with a mix of family planning methods including emergency contraception and dual methods use	2	
5.	Organising the Health Facility for sustainable comprehensive PAC/RH Services	7.5	
	5.1(a) Preventing infection spread	2	
	5.1(b) Processing instruments for re-use		
	5.2. Maintaining a mechanism for timely supplies and equipment	2	
	5.3. Using records for improvement of comprehensive PAC/RH services	2	
	5.4. Ensuring comprehensive PAC clients receive timely FP methods	0.5	
	5.5. Conducting on-the-job training for other comprehensive PAC/RH providers	0.5	
6.	Involving the community to improve comprehensive PAC service Access and Quality	4	
7.	Practising comprehensive PAC Clinical Skills	-	35
8.	Evaluating Training, Skills application plans at work sites and closure.	3	-
	TOTAL (10 X 7 Training hours)	**35**	**35**

Trainee's Note

Section 4

Participant's/Trainer's Material

4a. Materials for General Training/Learning Activities

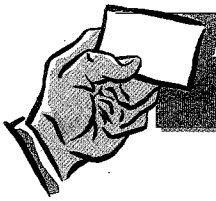
4b. Monitoring and Evaluation of Training (Trainees and Activity)

Section 4a

(Materials for General Training/Learning Activities)

Module 1

Developing a Climate for Learning



Handout No. 1.1

Trainee's Journal

Purpose:

- To have information important to you as the trainer or the trainee recorded for use during the training and after, at your work-site.

Examples of Important Information:

- What I have learned from the sessions and experiences during training.
- What I intend to do in order to keep improving on the new skills and knowledge that I have acquired.
- What will I now do differently as a result of this training?
- What help do I need to perform the new acquired skills and apply the knowledge at my work site?

  Who will I contact for this assistance?

How to keep The Journal:

- Use a recording method of your choice, but it must be easy to find when needed

When do you collect the information?

- During the session e.g. when discussing learning insights, what to do differently, what would I apply in my work.

When you will use the information:

- Anytime during the training.
- Near the end of the training for including in the Skills Application Plan.
- After the training, at your work-site.

Instructions:

- Use the information during all sessions when giving feedback or comments to speaker. (Trainer or trainee, client, community).

Feedback in training and service delivery

1. Meaning of Feedback:

- A method of receiving or giving information.
- Feedback means letting the receiver know in a timely and descriptive manner the quality of the observed performance. Feedback includes making positive or negative observations. The description is not about the person but the behaviour (e.g. action, non verbal sign/communication observed, results of the skills or knowledge assessment).
- "Feedback" is also a way of helping another person understand how his or her behaviour affects the receiver.

2. Purposes:

a) To help the receiver know about her/his performance e.g. Skills Acquisition.
b) To enable the giver to express feelings, observations and recommendations.
c) To inform someone about her/his behaviour and how it may affect others.

3. Who should receive feedback?

a) Supervisors from their service providers and service providers from their supervisors.
b) Trainees from trainer and,
c) The trainer from the trainees.

4. Timing of giving/receiving feedback

a) Supervision visits and training.

5. Feedback and Facilitation Skills

- Active Listening.
- Paraphrasing.
- Summarising and helping to focus on the session's major ideas.
- Use open-ended questions.
- Ability to show concern.
- Use of encouragers e.g.:
  - Smiling;
  - Nodding;
  - Eye contact;
  - Saying "aha",
  - Picking up last word etc.

Rules for Giving and Receiving Feedback:

Giver

- Gives timely feedback
- Provides a descriptive and objective feedback (does not judge)
- Using questions starting with "what", "how", and not "why": and also, "I", rather than "you".
- Uses clear and straightforward language. States supportive and specific examples.
- Prepares to give the feedback (think before saying something)
- Provides both positive and negative feedback, as necessary

Both listen Actively

Receiver

- Asks for Feedback timely.
- Does not react angrily or defensively explaining that "I did it because…"
- Using questions starting with "what", "how", and not "why": and also, "I", rather than "you".
- Where needed, seeks clarification e.g. by paraphrasing or using open ended questions
- Thanks giver and says what he/she will do as a result of being given the feedback
- If recording sender' views, clarifies, paraphrases and writes the statements as provided, by sender, not changing them

Matters resolved in feedback should be followed up by the individuals concerned.

NB: *Following these rules consistently promotes positive interpersonal relationship and team building.*

Module 2

Advocating for Comprehensive postabortion Care Services

A Reference and Job Aid for the Comprehensive PAC/ RH Service Provider (Glossary - Operational Definitions)

Maternal morbidity:	Any disease or ill-health in a woman associated with pregnancy or within 42 days after termination of pregnancy
Maternal death:	Death of a woman while pregnant or within 42 days of the termination of pregnancy, irrespective of the site and duration of the pregnancy from any cause related to and/or aggravated by the pregnancy or its management but not from accidental or incidental causes (WHO definition).
Maternal mortality Ratio (MMR)	Number of maternal deaths per 100,000 live births.
Perinatal death:	Refers to deaths of foetus or baby from 28 weeks of gestation up to 1st week of life.
Perinatal mortality rate (PMR):	This is the number of perinatal deaths per 1000 life births.
Still birth:	A baby born after the 28th week of pregnancy and showing no sign of life after delivery. The still-births rate is calculated from every 1,000 recorded total births per year.
Early neonatal death:	Death of a live-born infant occurring within seven days of birth.
Late neonatal death	Death of a live-born infant occurring after 7th day and before 28 days after delivery.
Infant mortality rate (IMR):	Total number of deaths in children under one year per 1,000 live births.
Delays: *(related to maternal Mortality):*	This refers to four areas, if addressed could make major difference in reducing maternal mortality.
The three delays	1. ***Delay in recognising complications;*** their seriousness and waiting too long to seek or reach for help. 2. ***Delay in making decision*** 3. ***Delay in transporting women to a facility:*** e.g. not making any advance arrangements for emergency transport, money not set aside, finding transport for emergency care too late for woman to receive life-saving treatment. 4. ***Delay in receiving care at facility:*** e.g. delay in treatment may be due to bureaucratic procedures or discriminatory treatment (especially of Comprehensive postabortion clients), lack of available trained staff, lack of appropriate drugs, blood and other medical supplies, corruptive practices, gender bias.

NB: *The first two delays can be further negatively influenced due to undervaluing of female's life and her lack of power in making important decisions.*

Emergency Obstetrical Care (EOC):

This is the total care given to a woman with an obstetric complication.

Components of EOC

1. Blood transfusion.
2. IV transfusion.
3. Antibiotics/Oxytocic.
4. Eclampsia management.
5. Cesarean section.
6. Ventous/forceps.
7. Manual removal of placenta.
8. Evacuation of retained products of conceptus.
9. Suturing.
10. Laparotomy.
11. Resuscitation.

Life Savings Skills:

Refers to skills required to provide emergency obstetric care (see above description of EOC).

Human rights approach to maternal mortality:

This refers to the approach which addresses special issues such as:

- Maternal mortality in the context of complex social, economic and cultural conditions that keep the incidences high.
- Discrimination against women and against the poor and minority groups in a particular country or context.
- Gross inequality between developed and developing countries (This could be applied to similar inequality between the HAVES and HAVE-NOTS in a country).

Gender:

Refers to the set of characteristic behaviour (roles) that social groups assign to male and females.

Dual method use:

Refers to the concept of using the condom with another FP method to prevent pregnancy and transmission of HIV/AIDS.

Post Abortion Care:

An intervention to reduce maternal morbidity and mortality through providing care to women who suffer complications from spontaneous or unsafely induced abortions. The intervention has four elements (see Handout 2.2)

Gender empowerment:

Refers to the ongoing practice of enhancing a woman or man's capacity to make responsible decisions and to act on them.

Essentials of Safe Motherhood:

These include:

- antenatal care.
- intrapartum care.
- post partum care.
- postabortion care.
- inter-concept ional care.
- family planning.

Domestic Violence:	A term used to collectively mean all violence or hurt to women and men at household level.
Advocacy:	An approach of harnessing support of various person for enhancing establishment and sustainability of a particular issue. Aim of advocacy in health is to influence policies, strategies and programs in order to shift and maintain attitude positions on special issues. (e.g. Comprehensive PAC access and equality to RCH services, harmful practices and unequal powers in decision-making process on RCH.) Advocacy may: 1. Support marginalized groups; 2. Create an enabling environment for access to affordable care or; Effect changes through various arms of persuasive communication on prevailing practices imposed by authorities at different levels. (MOH, National RCH Communication Strategy 2001 – 2005. Page 25)
Quality:	Refers to: a) A measure of value, based on specified expectations or standard OR b) Doing the best with available resources while maintaining standards. ***NB:*** *In health service there are various definitions and perspectives of quality. For example, Client Oriented Quality of Care described by Judith Bruce; 1988/89; Quality of reproductive health service described by the community: Tanzania RCHS/JHU, CCP: Quality Improvement Record System (2000). Other perspectives of quality are those of service providers, donors.*
Standard:	Expected service levels. It also describes the responsibilities for which the provider is accountable (to the client, community and the profession.)
Policy:	A statement that provides a broad framework within which issues of quality service practice and control must be closely addressed and monitored.
Access to services:	The proportion of the people in a catchment area who are able to use the various components of the service.
Continuity of service: for discussion	Services available daily (24 hours) uninterrupted. Where there are some services lacking an effective referral system is in place. Continuity also includes having records that are accurately used by all appropriate staff and keeping the client informed about his/her condition and care.
Quality Assurance:	A process of assessing care (against set standards) that has already been provided and taking action to improve it in future.

COPE (Client-Oriented, Provider-Efficient Services): A low-technology technique to improve the quality of the services provided. It encourages and enables local service providers and other staff to assess their own work against set standards in order to identify problems and find effective solutions at their own facilities. The process creates involvement and ownership and the COPE tools make quality real for supervisors and staff.

Facilitative or Supportive Supervision: An approach to supervision that emphasizes mentoring, joint problem-solving, and two-way communication between the supervisor and those being supervised.

Facilitative/ Supportive Trainee Follow-up: An approach of monitoring trainees' skill acquisition during and after training.

The trainer and trainee form a joint problem solving team, they maintain a two-way feedback / communication between them. This approach continues at regular periods during the first months after training. The on-site and distance-based supervisors are involved in the activities, led by a trainer who phases him/herself so as to "wean the graduate from his/her guidance. This helps the supervisor take responsibility as he/she provides facilitative/supportive supervision.

Whole-Site Training (WST): An approach to training that encompasses a range of strategies and methodologies designed to address the training needs that are identified at a site through COPE or through supervisory assessment. It also emphasizes teamwork. The WST approach may also include ***In-reach*** which addresses missed opportunities to reach clients visiting the site with information about family planning or other reproductive health services.

Reproductive Health (According to WHO 1994): RH refers to a state complete physical, mental and social well-being and not merely the absence of disease to the reproductive system, its functions and process.

Integration of R/CH Services: Integrated R/CH depends on needs and resources available and the service policy of the country. In the Tanzanian context, integration of R/CH is implemented by integrating. Family Planning, Child Health, STI and Safe Motherhood through two main approaches/modalities. These are:

i. Where R/CH services are available and are provided in different sections/rooms/corners in a health facility or service site. Thus making referral for services not provided possible. Service providers in each room recognize their major service (e.g. FP) while integrating others services (e.g. STI or SMI) by counselling, educating and then referring clients to the relevant sections/rooms/corners.

OR:

One service provider provides all R/CH services in one room e.g. provision of FP methods, giving immunizations and antenatal care to clients. This modality/approach is common in most of the rural and small health facilities where there is shortage of staff and space.

Safe Motherhood: Safe Motherhood refers to prevention and curative services which is aimed at reducing the morbidity (ill health) and mortality associated with child-bearing and the new-born. Safe Motherhood is also accomplished through client education, counselling and attending to women of child-bearing age throughout their reproductive cycle.

Components of reproductive Health (ICPD and WHO):

i. Promotion of empowerment of women for R/CH services.

ii. Empowerment of men, for women's or their own family health.

iii. Adolescents' (male and female) health services.

iv. Services to reduce gender related abuse e.g. female circumcision (FGM) domestic violence, inability to decide on sexual health matters without partner.

v. Family planning services.

vi. Infertility care (preventive, diagnostic, curative where possible).

vii. Promotion of breast-feeding exclusively 4-6 months and LAM.

viii. STD/RTI management including their effects on babies.

ix. Safe Motherhood (ANC, delivery, post-partum, Comprehensive postabortion inter-concept ional.

x. Cancer screening (female and male).

xi. Menopause: pre-menopause and post-menopause services (service for women e.g. counselling about menopause and (in the near future in Tanzania) hormone replacement therapy.

Introduction to Comprehensive Postabortion Care (PAC)

Complications of abortion are preventable but serious

- Complications of abortion contribute to maternal mortality and morbidity significantly.
- 15% of all pregnancies end up in spontaneous abortion.
- Deaths and injuries from incomplete abortion are preventable.
- Addressing complications of abortion is one of critical life-saving services.
- Comprehensive postabortion complications are one of the "six" major causes of maternal mortality. Other causes are;
  - post-partum hemorrhage.
  - obstructed labour/ruptured uterus.
  - pre-eclampsia/eclampsia.
  - post-partum sepsis.
  - Infectious diseases e.g. malaria, AIDS, tuberculosis.
- Current approach to serving women with complications of abortion is not to insist on finding out whether the abortion was induced or not and not to be punitive/ judgemental (e.g. by reporting the patient to the police.)

The Context in which Comprehensive PAC takes place

- Abortion, in Sub Saharan Africa is perceived negatively.
- Policies supporting Comprehensive PAC are in early stage. The International Conference on Population and Development and other international forums including the 1999 International Meeting held in Mombasa have helped sub-Sahara African countries, including Tanzania, in committing themselves to expand comprehensive PAC.
- Factors that hinder Comprehensive postabortion Care are outline in Handout No. 2.3.

The scope of the problem of abortion in Sub-Saharan Africa

- Understanding the problem of abortion is to help provide non-judgmental Comprehensive postabortion Care.
- Estimated deaths due to abortion complications:
  - Africa: 13% of all maternal deaths.
  - Ethiopia hospital based study: nearly 40% of maternal deaths.
  - One in every 150 abortion is among African women.

Scope of the abortion problem in Tanzania

- Scanty or inaccessible data/literature.
- Mtimavalye L.A., Lisasi D and Ntuyabaliwe (1980) 1974 – 1977 at Muhimbili Medical Centre recorded:
  - 11534 abortions during the period.
  - Maternal mortality was 2.1 per 1000 deliveries.
  - 17 – 20 yrs age group formed the largest number of maternal deaths (from induced abortions).
- Kinoti S V, Mpanju, Shumbusho, Matija W. (1993):
  - Abortion contributed to 30% of all maternal deaths. Authors recommended contraceptive service promotion among special groups of women.
- Tanzania Demographic and Health Survey (1996):
  - Maternal mortality ratio is 529 per 100,000 live births of which abortion accounted for 16% maternal deaths.

Consequences of unsafe abortion

- Short Term:
  - Hemorrhage and shock.
  - Sepsis.
  - Injury to genital and intra abdominal organs.
- Long Term:
  - Chronic pelvic pain.
  - Pelvic Inflammatory Disease.
  - Secondary Infertility.
  - Increased risk of ectopic pregnancy.
  - Social stigma.
  - Psychological stress.

Some Reasons that make women resort to abortion

- This information will help Comprehensive PAC providers to counsel women for Comprehensive PAC services in a caring and non-judgmental manner.
- Remember that there are many women served in Comprehensive PAC facilities who experience spontaneous abortions.
- Many complex reasons make women resort to abortion when faced with unplanned/unexpected pregnancy. These include:

a) Economic reasons e.g.:

- Low income to care for baby.
- Lack of employment.
- Completed family.

b) Social and cultural reasons e.g.:

- Students want to finish school.
- Out of wedlock pregnancy not favoured in her community.
- Forced to have an abortion by her parents, boyfriend etc.
- Cultural and religious stigma attached to pregnancy out of wedlock and single motherhood.
- Pregnancy resulting from rape.

c) Family Planning related reasons:

- Lack of access to FP services.
- Failure of FP methods.
- Lack of FP information.

d) Medical reasons:

- Congenital abnormalities.
- Serious and chronic medical condition e.g. HIV/AIDS.

Laws and regulations on provision of PAC

- Tanzania Law allows therapeutic abortion, with life of mother as priority.
- However, few women and men know this law.
- Knowledge that the law does not allow abortion "by demand", makes women fear being reported to "justice" and thus they undergo unsafe abortion even when the law might have allowed it.

- Comprehensive PAC is provided by middle level service providers and the Safe Motherhood service policy guidelines and other RH ones are "new". But the legal implication for this "new" and decentralised Comprehensive PAC service requires to be studied and publicised. However, the above stated guideline and standards being official government document justify the "new" approach to Comprehensive PAC.

Provision of Comprehensive postabortion Care by Level of Service Site

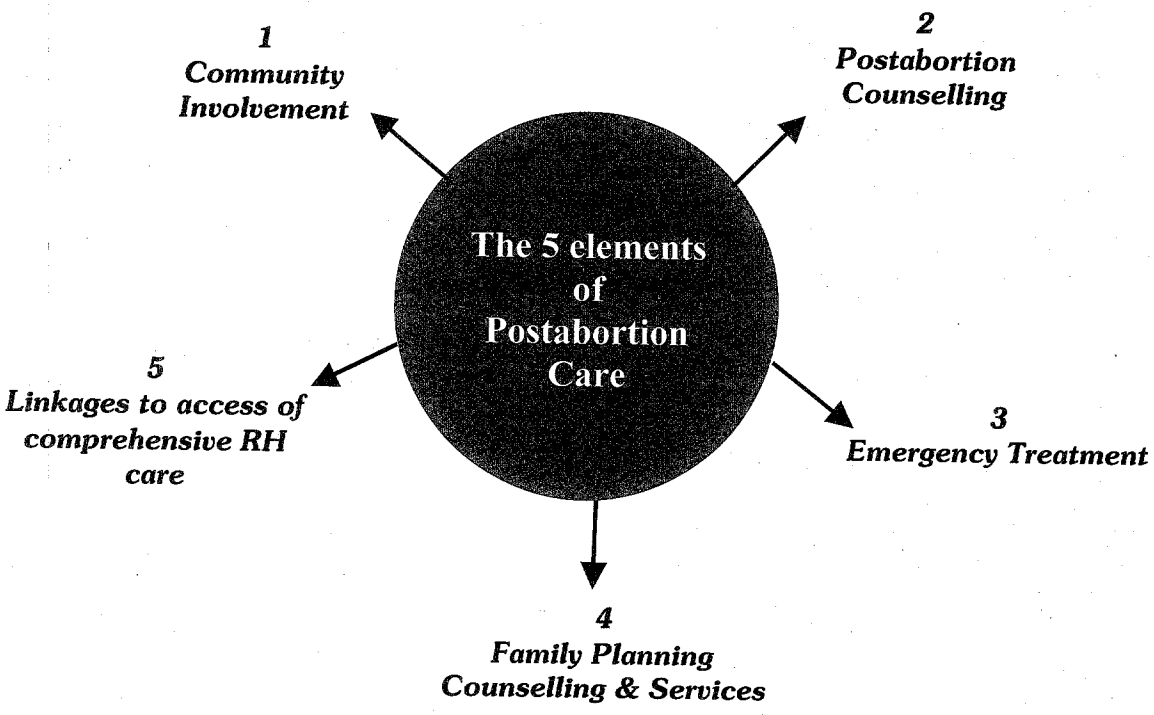
NB: Facilitator and Participants.

- See National Program Components of Safe Motherhood and Services Standards Section 6 "Types of Safe Motherhood services by Level of service providers".

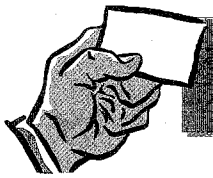
Comprehensive Postabortion Care Concept

Handout No. 2.3

Elements of Comprehensive Postabortion Care



- Emergency treatment for complications of abortions.
- Comprehensive postabortion Counselling:
  - On Family Planning (when, what, where).
  - To help client to cope with emotional problems.
- Links to other reproductive and general health care and social services:
  - Post abortion complication is often the women's first entry to the health care system.
  - Gives an opportunity to evaluate her overall health status.
  - Gives an opportunity for health education:
    * The importance of a healthy reproductive behaviour;
    * STD/HIV detection and treatment;
    * Pre-natal care;
    * Social services e.g. women groups, community education sessions.
- Involving the community to support Comprehensive PAC through minimising two of the three Delays (See Glossary Operational Definition of delays (Three Delays) – Handout No. 2.1).



Handout No. 2.4

Goals and Rationale for Comprehensive postabortion Care (PAC)

Goals of Comprehensive PAC

- Sustainable reduction of unwanted pregnancies by helping clients to decide on and select FP method.
- Sustainable reduction in maternal mortality by providing access to emergency treatment of incomplete abortion on site and at referral centres.
- Sustainable reduction in STD/HIV/AIDS transmissions through discussion of sexuality issues, preventing more complications, treatment, counselling and education.
- Increase use of family planning and RH services to prevent future unwanted pregnancies.
- Improved access to and quality of RH services to prevent future unwanted pregnancies.
- To create greater awareness of the problem of abortion so as to increase community involvement in efforts to provide comprehensive PAC.

Rationale for Post Abortion Care

- Providing Comprehensive PAC has been shown to decrease maternal deaths.
- To help change attitudes of governments, organisations, providers, communities and other barriers to Comprehensive postabortion care.
- To provide holistic Comprehensive postabortion care whether using the Manual Vacuum Aspiration or Sharp Curettage.
- To help improve access to Comprehensive PAC services to marginalized populations.
- To contribute to the alternative approaches of attempting to reduce maternal mortality. For example, Human rights approach (Post Colombo Review Conference on Safe Motherhood).
- To help women with abortion complications come openly to Comprehensive PAC services.
- There are national Safe Motherhood (SM) guidelines that direct Comprehensive PAC services.
- Comprehensive postabortion care is one of the essential services of SM.
- WHO has identified prompt treatment of incomplete abortion as an essential element of obstetric care.

Factors that hinder Comprehensive postabortion Care

- Negative reactions by service providers towards abortion clients, either due to work over load or due to personal feelings, attitudes, beliefs, and values.
- Misconception about "abortion vs. miscarriage" by providers due to the stigma attached to "abortion" and not to miscarriage.
- Restrictive professional acts e.g. midwives and clinical officers not to provide Comprehensive PAC.
- Community Stigmatisation on induced abortion.
- Lack of awareness among the community members on the availability and accessibility of post abortion care as part of RH services.

Factors that facilitate Comprehensive postabortion Care

- Positive attitude in service provider towards Comprehensive postabortion clients.
- Integration of Comprehensive PAC into other existing reproductive health services.
- Utilisation of facilitation skills when discussing and counselling a woman who has aborted so as to help her air out her feelings and concerns openly.
- Community support to comprehensive PAC.
- Supportive and explicit policies and service standards.

Trainee's Note

Module 3

Providing Emergency Comprehensive Postabortion Care

Comprehensive PAC client information (for initial history taking)

Instructions

- Use the normal facility clients record form/case note.
- Take the history under the following:

1. Personal/Social Information:
   - Name.
   - Age.
   - Level of education.
   - Occupation.
   - Marital status.
   - Husband's occupation.
2. History of present illness:
   - Onset, duration and amount of bleeding.
   - Date of onset of LMP.
   - Passage of products of conception.
   - History of instrumentation.
   - History of lower abnormal pain, fever and abnormal vaginal discharge.
   - Previous FP method use.
3. Past obstetric history:
   - Gravidity.
   - Parity.
   - Abortions.
4. Past medical history including STDs:
   - Allergies.
   - Renal disease.
   - Blood Pressure.
   - STD.
   - Epilepsy.
   - Tuberculosis.

- Heart Problems.
- Last pap smear.

5. General Examination:
   - Vital signs.
6. Abdominal and pelvic examination:
   - Abdominal:
     - ❖ Tenderness and rebound tenderness.
   - Vaginal examination:
     - ❖ External genitalia:
       - Discharges.
       - Bleeding.
     - ❖ Speculum:
       - Look for evidence of instrumentation e.g. evidence of trauma, laceration and foreign body
     - ❖ Digital exam:
       - Degree of cervical dilatation.
       - Uterine adenexa – tenderness and rebound/tenderness.
7. Systemic examination:
   - Chest.
   - Heart.
8. Investigations:
   - Hb.
   - Blood for grouping and cross matching.
   - UPT –Urine for Pregnancy Test.

Sample of

M.C.H. NO. 5 FAMILY PLANNING CARD

CLINIC NAME: DATE: CLIENT NO.:

SURNAME: FIRST NAME: AGE:

EDUCATION: OCCUPATION:

STREET: VILLAGE: TEN CELL LEADER'S NAME:

SUMMARY OF PREGNANCIES FIRST VISIT:

1. Total Pregnancies _____
2. No. of Miscarriages _____
3. No. of still Births _____
4. Children Alive _____
5. Last Delivery _____

PREVIOUS MEDICAL HISTORY:

		Yes (Tick)	No
1.	Headaches		
2.	Jaundice		
3.	Heart Disease		
4.	Hypertension		
5.	Diabetes		
6.	Severe varicose veins		
7.	Any other serious condition		

LOCAL EXAMINATION:

Abdominal Exam

1. Liver state:
   Not enlarged _____
   Enlarged _____
2. Masses _____

CONTRACEPTIVE:

Pill _____
Loop _____
Injection _____
Norplant _____
Other _____
None _____

OUTCOME OF PREVIOUS PREGNANCIES AT FIRST VISIT

MENSTRUAL HISTORY

1. Menarche
2. L.M.P. _____
3. MP Duration _____
4. Blood loss _____
5. Cycle length _____
6. Dysmenorrhoea _____

GENERAL EXAM

1. Weight _____
2. BP _____
3. Anemia _____
4. Jaundice _____
5. Thyroid _____
6. Breast Lump(s) _____
7. Legs:
   A. Odema _____
   B. Varicose Vein _____
8. Urine:
   A, Albumin _____
   B. Sugar _____

VAGINAL EXAM

Abdominal Exam

1. Speculum Exam:
   a. discharge _____
   b. cervix _____
2. Digital Exam
   b. Uterine size _____
   c. Uterine position _____
   d. Adnexa _____

METHOD CHOSEN

Date	Contraceptive Issued	Date of Re-visit

BREAST FEEDING (Tick)

Yes ☐ No ☐

Sample of

M.C.H. NO. 5 FAMILY PLANNING CARD (Back of card)

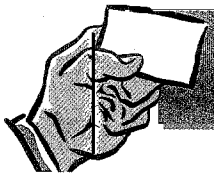
FOLLOW-UP VISITS

DATE	WEIGHT	B.P.	L.M.P.	COMPLAINTS	REMARKS AND TREATMENT	CONTRACEPTIVE ISSUED	DATE OF RETURN

PAC REGISTER BOOK

Month: ..... Year: .....

Serial Number	Hospital Registration Number	Date of Procedure	Time of Procedure	Name of Patient	Address	Age of Patient	Marital Status	Parity	Gestation Age	Diagnosis	Procedure	Type of Pain Medication	Provider's Name	Name of Assistant	Complications	Counselling	FP Method Taken	Referrals and Reason	***Remarks***



Handout No. 3.2

Hints for determining uterine size in the first trimester

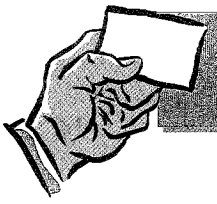
Weeks LMP	Cervical Signs	Uterine Signs
None (none-pregnant uterus)		Uterus is about 7 – 8 cm long, 4 – 6 cm wide
5^{th} – 7^{th} Week		Localised softening over the site of the placenta. Enlargement of uterus usually not palpable on abdominal examination.
6^{th} – 8 week	Chadwick's sign: Cervix becomes bluish in colour (due to increase blood supply). Cervix compressed during bimanual exam.	Uniform softening, round in shape. Uterus slightly enlarged.
12^{th} weeks or greater	Cervix bluish, soft.	Uterus soft, round. Uterus palpable above symphysis pubic during abdominal examination. Enlarged size dependent on gestational age.

Guide for selecting appropriate cannula size for MVA

The size of cannula for use in MVA is determined by assessment of uterine size in weeks since LMP and extent of cervical dilatation.

In general, the cannula should be large enough to allow passage of tissue expected according to gestation, but also to fit snugly into the cervix to maintain vacuum.

Approximate Uterine Size - Weeks LMP	*Approximate Cannula Size*
5 – 7 LMP	5 mm
7 – 9 LMP	6 mm
9 – 12 LMP	9 – 12 mm



Handout No. 3.4

MVA Procedure and other Procedures for Comprehensive Postabortion Care

PREPARING MVA Procedure

- Have drugs, instruments & equipment ready.
- Assess client's health status; specifically for incomplete abortion.
- Plan and implement client management (pain control, reassurance, counselling, emergency treatment or referral).
- Allow client to empty bladder.

PERFORMING MVA Procedure

- Put client in lithotomy position, clean vulva, perineum and drape her.
- Charge the syringe to create vacuum.
- Perform bimanual pelvic examination.
- Clean cervix with antiseptic.
- Insert speculum and hold cervix with tenaculum.
- Insert cannula of appropriate size.
- Attach syringe with vacuum to cannula.
- Evacuate the uterus.
- Check for signs of completion.
- Remove instruments (last in first out).
- Repeat bimanual examination.
- Reassure client of the procedure outcome.
- Document client's procedural information.

Process instruments for re-use.

-

AFTER MVA Procedure

- Monitor client's recovery.
- Counsel for informed choice of FP method & other RH services.
- Inform about warning symptoms
- Discharge when client is stable.
- Give date for follow-up or refer.

Danger signs after abortion and possible consequences arising from abortion

If the client has any of these symptoms after abortion or on reporting to the clinic, use local guidelines for dealing with the symptoms including referral where necessary:

- Delay (6 weeks or more in resuming menstrual period).
- Fever, chills.
- Muscle, aches and weakness.
- Abdominal pain, cramping or backache.
- Tenderness on pressure, in the abdomen.
- Prolonged or heavy bleeding.
- Foul smelling vaginal discharge.
- Nausea/vomiting.

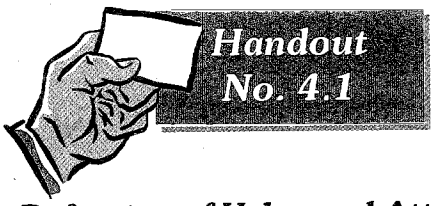
Source: *Editors Winkler Judith etc, Postabortion Care: A Reference Manual for Improving Quality of Care, Postabortion Care Consortium USA 1995.*

Module 4

Providing Comprehensive Postabortion Family Planning and other Reproductive Health Services

Sub-Module 4.1

Counselling Comprehensive postabortion Clients



Values, attitudes, and values clarification exercise

Definition of Value and Attitude

Values are what one believes in and principles one holds as important. An Attitude is a way of thinking and one's feeling about something.

Purposes of Value Clarification Exercise

- To explore individual/ personal feelings related to Comprehensive postabortion care.
- To stimulate trainee's process of behaviour change towards Comprehensive postabortion care.
- To identify different attitudes and beliefs towards Comprehensive postabortion care.
- Voluntarily share (publicize) personal feelings.
- Sharing something whose consequences the person is ready to deal with.

Advantages of Values Clarification Exercise

- Provides opportunity to express feelings, and begin change of attitudes towards the subject in question.
- Helps one to listen to and respect other person's point of view.
- Creates a sense of belonging when one hears similar points of view from others in the group.
- Helps to confirm and validate one's feelings.
- Stimulates discussion on the subject in question.

Limitations of Values Clarification Exercise

- Some participants may not share adequately for group to have a variety of points of view.
- Instructions/rules broken may make the exercise unable to help the "exploration of values".

Rules/Instructions for Individual Exercise on Comprehensive postabortion Care

1. Complete the exercise following the instruction given.
2. Do not judge right or wrong. Listen first.

Values Clarification Exercise

1. Give five personal opinions about Comprehensive PAC by completing the five statements below:
   a) I feel Comprehensive postabortion Care is .....
   b) I feel Comprehensive postabortion Care is .....
   c) I feel Comprehensive postabortion Care is .....
   d) I feel Comprehensive postabortion Care is .....
   e) I feel Comprehensive postabortion Care is .....

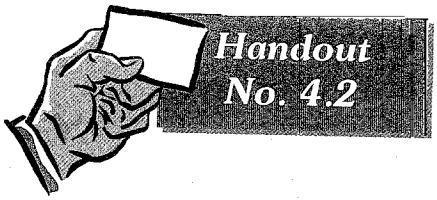
Indicate your reaction to each of the statements below:

		Strongly Agree	Agree	Don't Agree
a.	Any woman who requires Comprehensive postabortion care has had induced abortion.			
b.	Nurse/Midwives or other health workers need specialised training in order to offer post abortion care.			
c.	There is need to first establish Comprehensive PAC service policies before clinical providers can be established in Comprehensive postabortion care.			
d.	A Woman who has had a complete abortion does not require Comprehensive postabortion care (history taking, pelvic examination, counselling etc.)			
e.	Post abortion care can only be provided well in hospitals other than clinics.			

Trainer's:

- Let the participants share and discuss their feelings in small groups: *(10 min)*
- In plenary conduct:

- Processing. - Generalising.	- Application; and - Closure of the exercise.



Facilitation and Communication

If you follow these skills you will improve your counselling abilities. You will be able to help a client "Open up" to you:

1. ***Develop the ability to put aside your own values (ability to be objective)***
   - Keep your opinions and judgments to yourself, to help your client speak freely.
2. ***Learn to encourage your client to talk to you***
   - Get the client talking by asking open-ended questions. Example of open-ended questions are: "Tell me about ... "or" why do you feel worried about ..."
3. ***Cultivate the art of listening***
   - Listen carefully, actively and continuously.
4. ***Show empathy***
   - Empathy means, "caring without being too emotionally involved". Show your client that you care about what he or she is saying. Show wilingness to help and understand. Respond in a caring way to what your client is saying and let the client know that you are trying to help him or her solve the problem.
5. ***Observe and respond to your client's non-verbal behaviour***
   - Observe the non-verbal communications of your client, such as a confused or concerned look. Respond to these non-verbal cues. For example, you might respond to a confused look by saying. "You look like you do not understand". What questions do you have that I can try to answer?
6. ***Encourage the client through your verbal and non-verbal behaviour***
   - You might say "I understand", "Tell me more", "aha", "uh hu", "that's interesting". Leaning towards client sitting close to him/her, smiling, looking attentive, not doing other things during session.
7. ***Be receptive***
   - Remain positive, unbiased and receptive to all of your clients' questions, concerns and opinions.
8. ***Summarise***
   - Be sure that you understand what your client has said by paraphrasing or summarising what you have heard. This makes a client feel understood and also assures that you have an accurate understanding of the client's issues and problems.
9. ***Show respect***
   - Display an attitude of respect for your clients, regardless of their age, sex, tribe, background or marital status.
10. ***Accept clients' opinions***
    - Be ready to accept client's opinion, questions or situations non-judgmentally.

Client's Rights and Needs of Service Provider

Client's Rights:

The Comprehensive postabortion client has the same rights as the FP client

Right to:	
1. Information	All members of the community have a right to information on the benefits of R/CH for themselves and their families. They also have a right to know where and how to obtain more information and services for planning or caring for their families.
2. Access	All members of the community have a right to receive services from R/CH programs, regardless of their social status, economical situation, political belief, ethnic origin, marital status or geographical location. Access includes freedom from barriers such as policies, standards and practices that are not scientifically justifiable.
3. Choose	Individuals and couples have the right to decide freely whether or not to practice family planning. When seeking R/CH services clients should be given the freedom to choose which method of contraception or R/CH service to use.
4. Safety	Clients have a right to safety in the practice of family planning, other reproductive or child health care.
5. Privacy	When discussing his/her R/CH needs or concerns the client has a right to do this in an environment in which she/he feels confident that her/his conversation with the counsellor or service provider will not be listened to by other people. When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected.
6. Confidentiality	The client should be assured that any information she/he provides or any details of the service received will not be communicated to third parties without her/his consent.
7. Dignity	R/CH clients have a right to be treated with courtesy, consideration, and attentiveness and with full respect of their dignity regardless of their level of education, social status or any other characteristics that would single them out or make them vulnerable to abuse.

Right to:	
8. Comfort	Clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy of service delivery facilities and quality of services.
9. Continuity	Clients have a right to receive R/CH services and supply of contraceptives and other services for as long as they need them.
10. Opinion	Clients have a right to express their views on the services they receive.

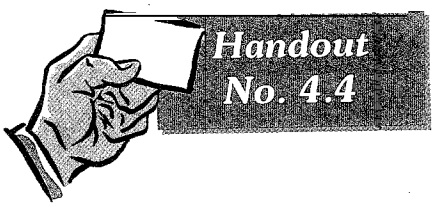
Needs of Service Provider

(Presented by Soledad Diaz of Chile):

This information helps the provider to be specific about their requirements in order to do a good job. Fulfilling these needs helps fulfill client's rights.

1. Need for training:
   - Technical FP Skills
   - Communication Skills
2. Need for information on issues related to their duties.
3. Need for supplies and equipment.
4. Need for guidance – clear objectives.
5. Need for infrastructure.
6. Need for a backup.
7. Need for respect.
8. Need for encouragement – Stimulus in the development of their potential and creativity.
9. Need for feedback – concerning achievement or guidance.
10. Need for self-expression.

Source: *IPPF, Medical Service Delivery Guidelines, London UK 1992. (Adapted in order to apply to the integrate RH/CH Policy of MOH, Tanzania.*



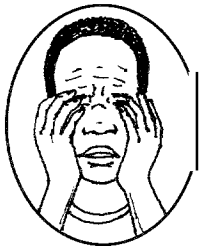
Psychological impact of an HIV positive test on an individual

Instructions for trainees:

Read the following reactions, and simulate with peers on handling those reactions through Counselling

Most people on learning that they are HIV positive may experience a number of reactions. This is part of a process of adjusting to the reality of being HIV infected. These reactions are commonly known as loss reactions.

Individuals upon receiving HIV positive test results or at any time when the news of possibly being HIV positive is received commonly experience the following emotional responses. The process is similar to the grieving process.



Shock

The client may experience physical and/or emotional shock on learning that he/she is HIV positive. He/she may be mute or violent, he may cry or laugh uncontrollably, or feel numb, confused and unable to think clearly.

Denial

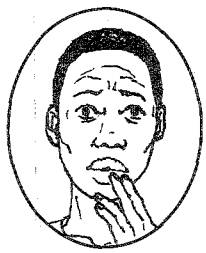
It can come in a form of disbelief. It can also come in a form of a "scape goat", the client thinking that it is someone else's result, or take it for granted and say he knew he/she would be positive therefore it does not matter.

Anger

This reaction often is in the form of blame, or envy, resentment of others who are healthy and have a long life ahead of them. Anger may be directed to anyone, such as oneself threatening suicide, revenge and threats, feeling guilty. A partner may be the recipient of this anger as the infected individual attempts to blame another for becoming infected. Blaming "God" or the "gods" may indicate that the person is feeling unlucky. Finally, anger may be directed towards others who are not infected by stating "I am not going to die alone".

Bargaining

This may be the first step towards coping with the news of HIV infection. A person may try to rid himself/herself of the disease - "help me God, and I will be good". He/she may look for a miracle or magical cure, resulting in wasting of money that will be needed in the future. Bargaining is often done privately and at spiritual level.



Fear

People with HIV/AIDS fear many things, e.g.:

- Pain.
- losing their jobs.
- other people knowing that they are infected.
- rejection, isolation, divorce.
- leaving their children.
- death.

These fears become less when they talk to someone who understands. Someone with HIV/AIDS might also find that he/she is worried about things that they need not fear about.

Loneliness

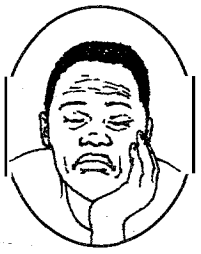
A person with HIV/AIDS might feel lonely. Such a feeling may come and go for a long time and depends on the support given by family and friends.

Anyone who has HIV/AIDS must be helped to remember that they are not alone, and that family, friends and the community surround them.

Self-consciousness

An HIV/AIDS person might think that everyone is looking or talking about them. This may make them want to hide because they feel unworthy of friendship.

One can help them to overcome their self-consciousness by encouraging them to stay active in the community. This would also increase the acceptance of people with HIV/AIDS by showing the community that people with HIV/AIDS are valuable members of society -- as everyone else is.



Depression

This reaction in relation to HIV infection may occur as a response to feeling utterly helpless, or as a response of experiencing repeated illness. The client may experience a loss of hope that will affect him/her planning for the long term coping mechanisms.

A fear of loss of certain relationships, illnesses and dying may be experienced. Lastly, he/she may experience the loss of self-confidence in one's ability to cope. Depression may manifest itself by withdrawal from people, social activities, and irritability, crying, loss of energy, sleep disturbances, loss of appetite, not caring about one's physical appearance, suicidal attempts, among many others.

Acceptance and Coping

This indicates an adjustment to a situation that cannot be changed. A person may begin to accept certain responsibilities associated with being HIV positive such as not spreading the virus to others; informing current and past sexual partners;

In coping, a person comes to terms with, many of the uncertainties in being HIV positive by seeking help and support.

Making the "BEST" of life and planning for his/her family's future may be decisions made at this time. Some people may gain strength by examining their spiritual life. He/she may live a positive life by making positive choices about the mental, and physical health of oneself and others he comes in contact with.

The person gains self-esteem, gaining independence and living positively.

Living positively includes:

- seeking medical attention promptly for any illness.
- eating a well balanced diet.
- exercising when physically well.
- getting enough sleep.
- resting when tired.
- avoiding hazardous health habits i.e. smoking, unwarranted use of drugs and alcohol.
- being able to continue with productive life.
- working towards preparing for his family after he/she dies.

Hope

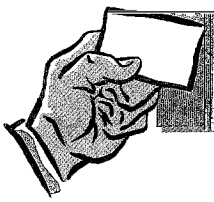
During this stage the HIV/AIDS patient has many hopes:

- hope that his/her will live a long time.
- hope that his/her baby will be healthy.
- hope that each sickness will be treated as it comes.
- hope because he/she is loved and accepted for who he/she is.
- hope that scientists will find a cure.
- hope because of belief in life after death.

It is important to have hope. Hope lifts spirits and gives strength to face each situation.

NB: An HIV/AIDS patient may not necessarily experience all the above reactions. The reactions may not also follow each other in the above sequence.

Source: HIV/AIDS A Guide for Nurses/Midwives and other Health Care Workers, 1999, The East, Central and Southern African College of Nursing (ECSACON)



Handout No. 4.5

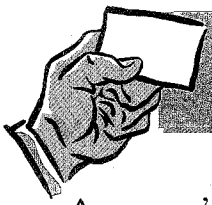
Examples of ways to respond to Comprehensive PAC client's feelings

Following are examples of ways in which you can respond to client's physical and emotional feelings that will support and help her to cope.

Feeling or Emotion	*Why?*	*Ways you can respond or resolve*
Pain	• Abdominal cramping, possible pain from infection or other complications. • Pain intensified during transportation to hospital.	• Assess the patient's need for relief and offer medication when appropriate. • Provide a comfortable area for the patient to rest before and after the procedure. • Streamline the process to allow patients to be treated as soon as possible. • Reassure the patient and be empathetic throughout Comprehensive postabortion care.
Grief	• Sadness at losing pregnancy.	• Be respectful of the patient's feelings. • Do not assume the abortion was induced.

Sub-Module 4.2

Providing Comprehensive postabortion Family Planning



Handout No. 4.6

Guidelines for Contraceptive Use for Comprehensive PAC Client

- A woman's fertility generally returns within 2 weeks after abortion in the first trimester.
- All modern FP methods can be used immediately after Comprehensive postabortion care.
- Recommend NO Sex until Comprehensive postabortion bleeding stopped (about 5 – 7 days after abortion).
- Natural FP to start after regular menses has resumed.

The table below shows guidelines for contraceptive Used by Clinical Condition

Clinical Condition	***Precautions***	***Recommendation***
No complication after treatment of incomplete abortion.	***Natural Family Planning:*** Do not recommend until a regular menstrual pattern returns. ***Female voluntary sterilisation*** The time of treatment for incomplete abortion usually is not the best time for client to make decisions about methods that are permanent. ***Diaphragm or cervical cap*** should be refit after a second-trimester incomplete abortion. ***Diaphragm or cervical cap*** do not begin use until vaginal or cervical injury has healed.	***Consider all temporary methods.*** ***Norplant® implants*** can begin use immediately. ***Injectable (DMPA)*** can begin use immediately. ***IUD:*** can begin use immediately. ***Oral contraceptives*** (combined or progrestin only) can begin use immediately. ***Condoms*** (male/female): can be used when sexual activity is resumed. ***Spermicidal foams, jellies, tablets, sponge or film;*** can be used when sexual activity is resumed. ***Diaphragm or cervical cap*** can be used when sexual activity is resumed.

Clinical Condition	Precautions	Recommendation
Confirmed or presumptive diagnosis of Infection. Signs and symptoms of sepsis/infection. Signs of unsafe or unclear induced abortion. Unable to rule out infection.	***Female voluntary sterilisation:*** do not perform procedure until risk of infection is ruled out or infection is fully resolved (approximately 3 months). ***IUD:*** do not insert until risk of infection ruled out or infection fully resolved (approximately 3 months).	***Norplant® Implant:*** can begin use immediately. ***Injectables (DMPA)*** can begin use immediately. ***Oral contraceptive*** (combined or progrestin only) can begin use immediately. ***Condom (male/female):*** can be used when sexual activity is resumed. ***Spermicidal foams, jellies, tablets, sponge or film:*** can be used when sexual activity is resumed. ***Diaphragm or cervical cap:*** can be used when sexual activity is resumed.
Injury to genital tract. Uterine perforation with or without bowel injury. Serious vaginal or cervical injury, including chemical burns.	***Female voluntary sterilization:*** do not perform procedure until serious injury healed. ***IUD:*** do not insert until serious injury healed. ***Spermicidal foams, jellies, tablets, sponge or film:*** do not begin use until vaginal or cervical injury healed. ***Diaphragm or cervical cap:*** do not begin use until vaginal or cervical injury had healed.	***Norplant® Implants:*** can begin use immediately. ***Injectables*** (DMPA, NET-EN): can begin use immediately. ***Oral contraceptives*** (combined or progrestin-only: can begin use immediately. ***Condoms:*** (male/female); can be used when sexual activity is resumed. ***Spermicidal foam, jellies, tablets, sponge or film:*** can be used when sexual activity is resumed (can be used with uncomplicated uterine perforation) ***Diaphragm or cervical cap:*** can be used when sexual activity is resumed.

Clinical Condition	Precautions	Recommendation
Severe bleeding (haemorrhage) and related severe anaemia (Hb<7gm/dl) or Hct < 20).	***Female voluntary sterilisation:*** do not perform procedure until the cause of haemorrhage or anaemia resolved. ***Progestin only pills:*** use with caution until acute anaemia improves. ***Norplant Implants,*** delay insertion until acute anaemia improves. ***Injectable (DMPA)*** delay starting until acute anaemia improves. ***IUD*** (inert or cooper-bearing): delay insertion until acute anaemia improves.	***IUD*** (progestin-releasing); can be used with severe anaemia (decreases menstrual blood loss) ***Combined oral contraceptives:*** can begin use immediately (beneficial when hemoglobin is low) ***Condoms (male/female):*** can be used when sexual activity is resumed. ***Spermicidal foams, jellies, tablets, sponge or film:*** can be used when sexual activity is resumed. ***Diaphragm or cervical cap:*** can be used when sexual activity is resumed. *"Some experts recommend starting COCs exactly 1 week Comprehensive postabortion, as there is a suggestion of a slight increase in coagulation factors measurable in the first few days after first trimester abortion, in women starting COCs immediately. If started later than 1 week, COCs may not be immediately effective because the ovary resumes follicular development as soon as 1 week after first trimester abortion".

How a Provider can be reasonably sure a client is not pregnant

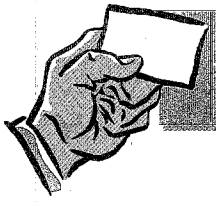
This approach of diagnosing pregnancy helps you provide FP methods without stress to clients. It is based on scientific information.

However, you may apply other ways of diagnosing pregnancy provided you ensure that the client's need for preventing pregnancy is achieved.

You can be reasonably sure a client is not pregnant if she has no signs or symptoms or pregnancy (e.g., breast tenderness or nausea) and:

- Has not had intercourse since her last menses, or
- Has been correctly and consistently using a reliable contraceptive method, or
- Is within the first 7 days after the start of her menses (day 1 – 7), or
- Is within 4 week post partum (for women who are not breast feeding) or
- Is within the first 7 days post abortion, or
- Is fully breast-feeding, less than 6 months postpartum and has no menstrual bleeding.

Source: *Hatcher RA, et al, The Essential of Contraceptive Technology, A Handbook for Clinic Staff, John Hopkins Population Information Program. July 1997, Page 4 – 6.*

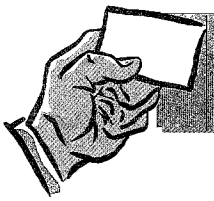


Handout No. 4.8

Similarities and differences within hormonal methods

COC	POP	Depo Provera®
Missing of pills uses back-up method for 7 days.	Missing of pills uses back-up method for 2 days.	Late 2 weeks or before 2 weeks Grace period.
Mechanism of actions stops ovulation.	Main mechanism of action: produce thick mucus or the cervix, stops ovulation sometimes.	Mechanism of action stops ovulation.
With drug interactions: rifampicin, anti-convulsants, griseofulvin.	With drug interactions: Same as COC.	No drug interaction.
Fertility usually resumes 3-6 months after stopping taking COC.	Similar to COC.	Fertility delay up to 9 – 12 months.
Warning signs include: - Severe headache. - Abdominal pain. - Chest Leg pains.	Warning sign include: - Severe abdominal pain accompanied with missing period.	Warning signs Include: - Depression. - Weight gain. - Frequent micturition.
Side effects: - Nausea. - Headache.	Side effects: - Amenorrhoea, spotting.	Side effects: - Amenorrhoea, spotting. - Abnormal bleeding.
Can be started once history shows no contraindication.	Same as COC.	Same as COC.
NB: Physical assessment done ONLY if history indicates so.	Same as COC:	Same as COC.
ALL HAVE HEALTH BENEFITS		

NB: The hormonal pills (Nordette/Microgynon) are effective as emergency contraceptive pills.



Handout No. 4.9

When to initiate clients on Family Planning methods (COC, POP, Depo Provera®)

Instructions

The information in this Chart are from chapters of the Procedure Manual and will be used by the provider once she has assessed that the client has no contraindications to the relevant FP method, if the woman is fully breastfeeding, amenorrheic and child less than 6 months.

Look up information on starting Tubal Ligation, NORPLANT® Implants, Fertility Awareness, Lactation Amenorrhoea Methods (LAM).

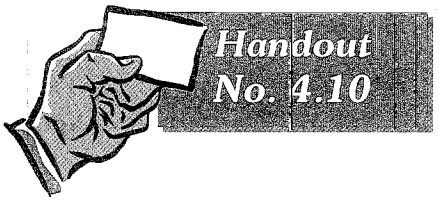
COC	POP	Depo Provera
• Day 1 – 7 of menstrual cycle. • First 7 days after post abortion or delivery if not breastfeeding. • 3 weeks after delivery for non-breastfeeding e.g. still birth. After 6 months post partum.	• Day 1 – 7 of menstrual cycle. • Immediately post abortion. • At 4 – 8 weeks post partum.	Any time of cycle - Drug interaction is anticipated or has led to spotting. - Client having diarrhoea or vomiting.
• Changing from Depo Provera®, or POP (even if not having menses/after ruling out pregnancy, IUCD or Implants.	• Changing from COC or IUCD or NORPLANT® Implants.	• Changing from COC, POP, IUD or Norplant®.
• Client had no sexual intercourse since last normal menses.	• Client had no sexual intercourse since last normal menses.	• Client had no sexual intercourse since last normal menses.
• Anytime when provider feels Reasonably Sure the client is not pregnant.	• Anytime when provider feels Reasonably Sure the client is not pregnant.	• Anytime when provider feels Reasonably Sure the client is not pregnant.

Highlights on Comprehensive postabortion FP

- FP is a major contributor to reducing unsafe abortions.
- An effective FP method is a priority for Comprehensive postabortion women if they wish to delay the next pregnancy.
- Postabortion ovulation returns within 7-11 days after first trimester abortion. FP is therefore a priority need for those not wanting an "unplanned pregnancy".
- Postabortion hormonal methods can be provided during early Postabortion period because, unlike postpartum, there is no fear of oestrogen related problems.
- Counselling for informed choice of FP method is important for Comprehensive PAC clients to avoid "coercion.
- All family planning methods can be safely offered, depending on eligibility criteria for initiating and continuing FP method. *(WHO 2000 and FP Procedure Manual, 2002).*

Sub-Module 4.3

Managing STD/HIV/AIDS and other Medical conditions



Syndromic Approach in STD Management

A syndrome is a group of signs or symptoms that collectively indicate a particular disease or abnormal condition.

Description of Syndromic Management

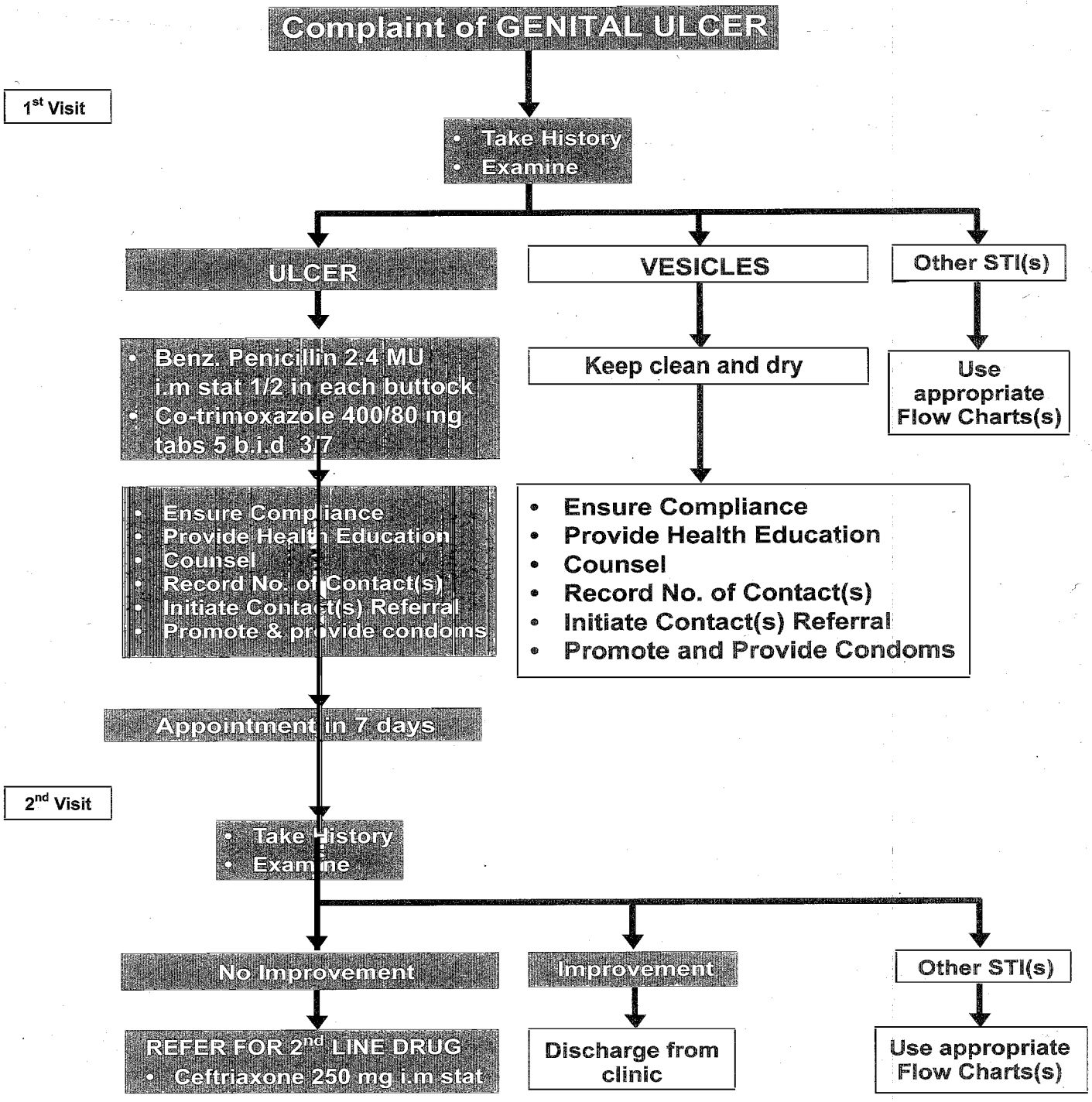
- This is the comprehensive care through screening by taking history, treating the syndrome, counselling and education on risk reduction of STDs, including importance of compliance and partner/contact treatment.
- It is a simple but effective way of helping all service providers to treat almost any patient suffering from a STD.
- A series of specially designed flow-charts guide the service provider into correctly identifying a STD associated syndrome and treatment for that syndrome.
- With syndromic management, service providers do not need sophisticated laboratory equipment or to be specialists in order to make a diagnosis. This means that STD services could be offered at all clinics by all qualified health personnel. If the clinics are supplied with drugs, good quality care could be made available throughout the country.

Making a syndromic diagnosis

- There are more than 20 different bacteria and viruses that can be transferred from person-to-person during sexual intercourse. The symptoms and signs of these different infections vary. To make an exact diagnosis of the cause requires very sophisticated laboratory equipment and highly skilled staff.
- Fortunately, the symptoms and signs caused by different STDs are similar enough to be easily recognized by qualified health personnel. By treating the syndrome, we treat the patient and also cover all the infections that might have caused that particular set of symptoms and signs e.g. a patient might complain of a discharge from his penis. Examination shows a discharge from the urethra. The Urethra discharge syndrome can be caused by both gonorrhoea and chlamydia infections. So, any treatment prescribed should be effective against both these possible causes. Making a clinical diagnosis this way is known as Syndromic diagnosis.

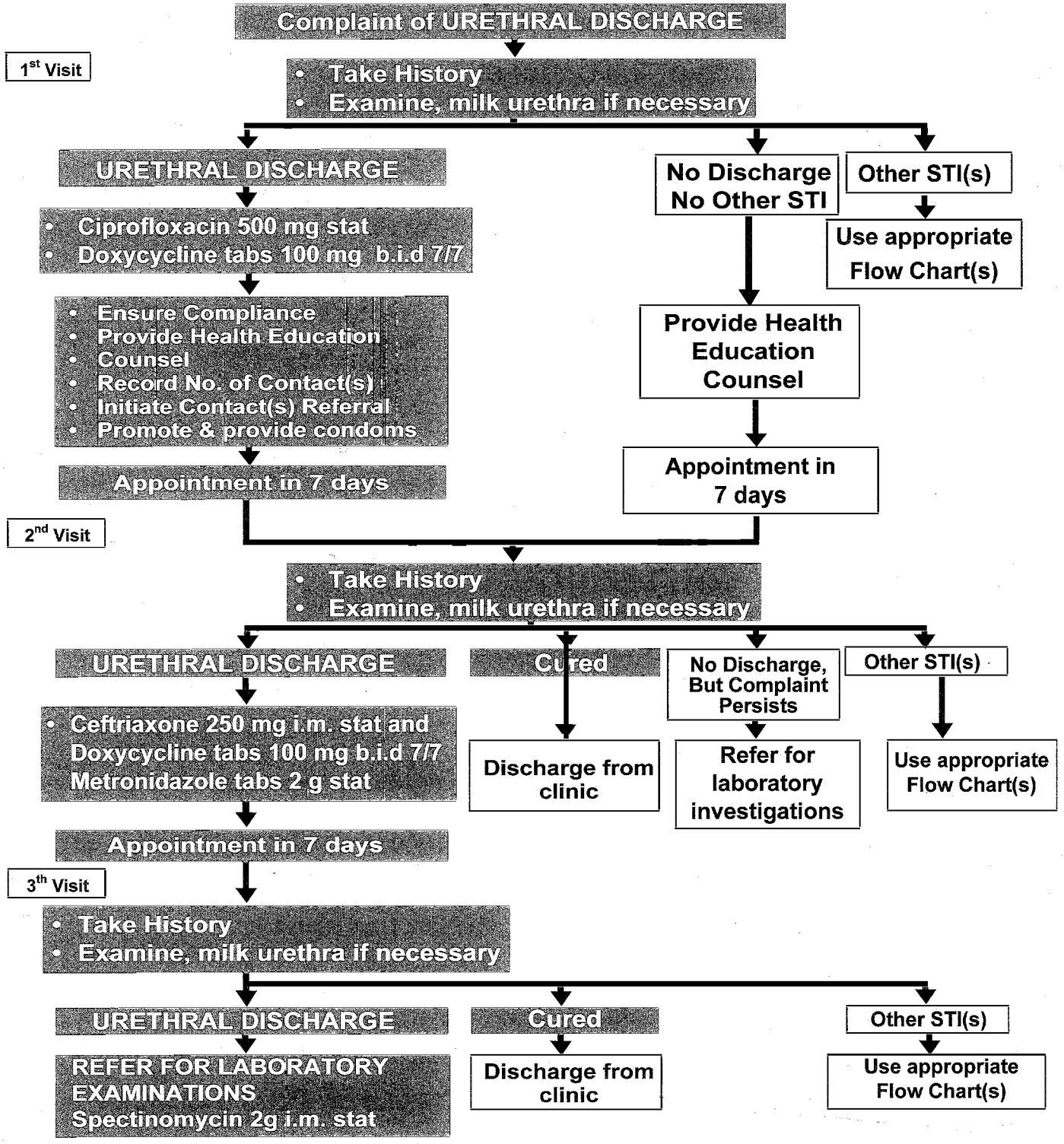
9. STD SYNDROMES: FLOW CHARTS
FLOW CHART1:

GENITAL ULCER SYNDROME (GUS)

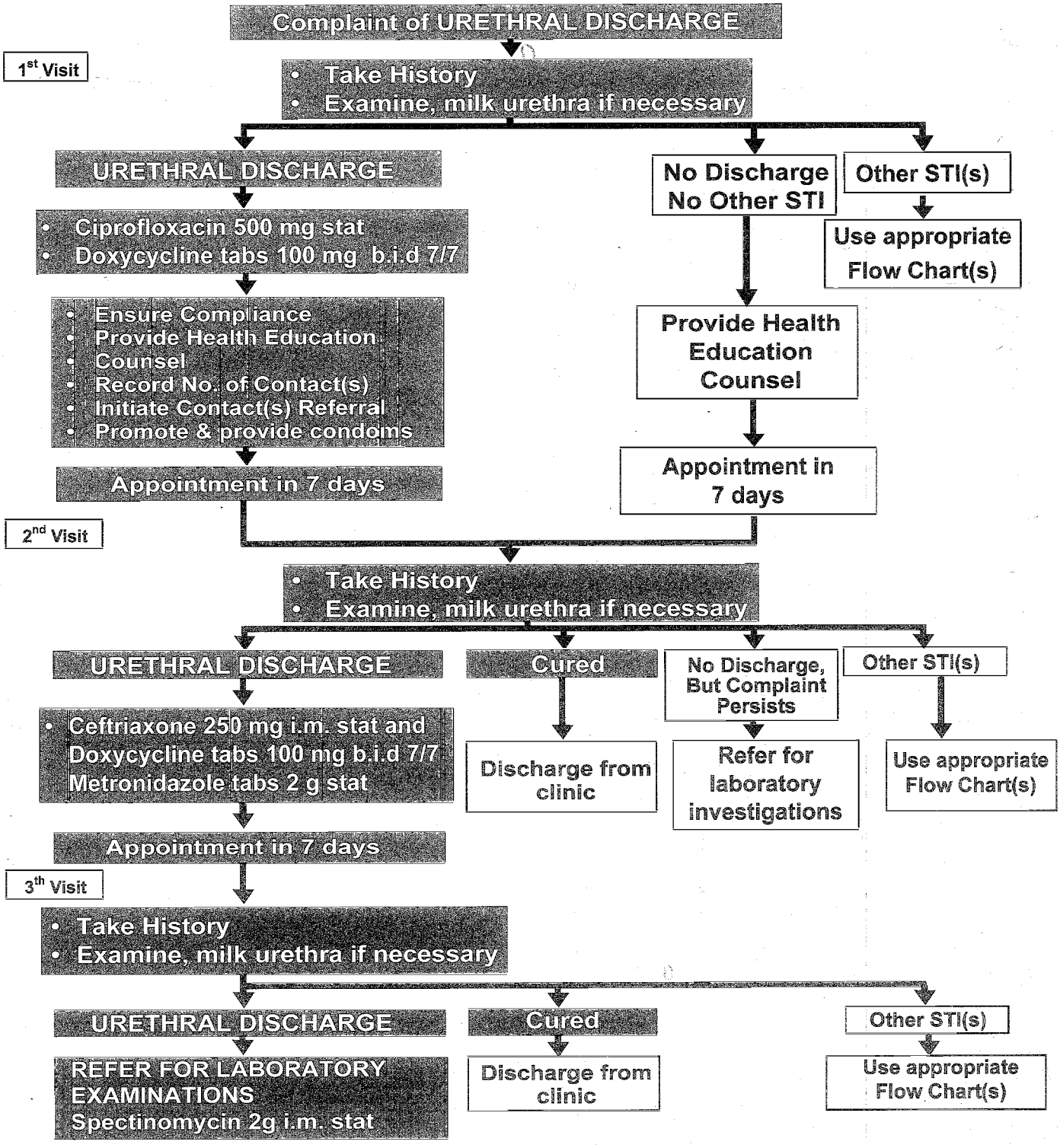


- Do not give Co-trimoxazole during pregnancy, substitute with Erythromycin tabs 500mg t.i.d 7/7
- Patients allergic to penicillin substitute with Erythromycin tabs 500mg t.i.d for 15 days

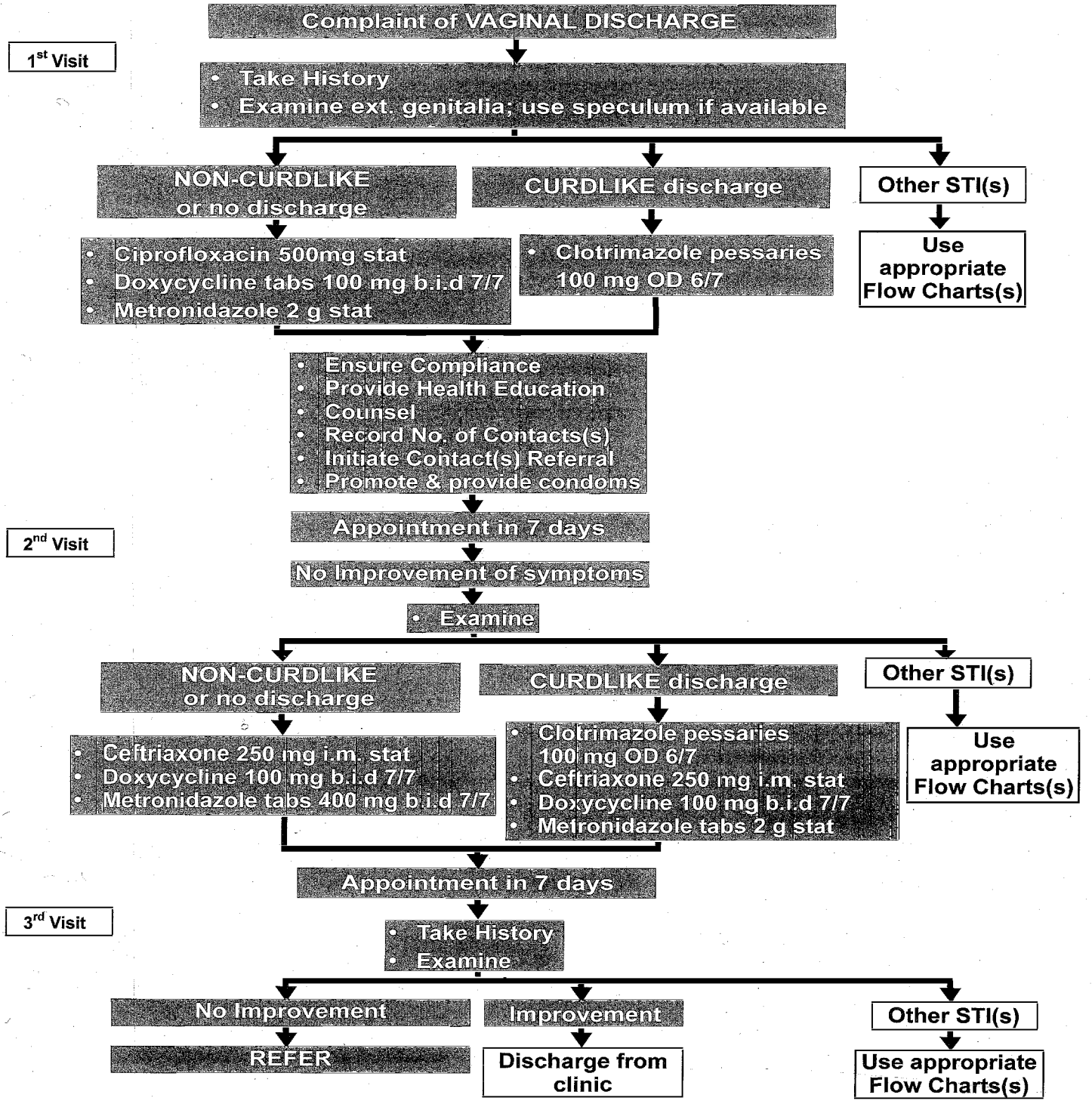
FLOWCHART 2: URETHRAL DISCHARGE SYNDROME (UDS)



FLOWCHART 2: URETHRAL DISCHARGE SYNDROME (UDS)

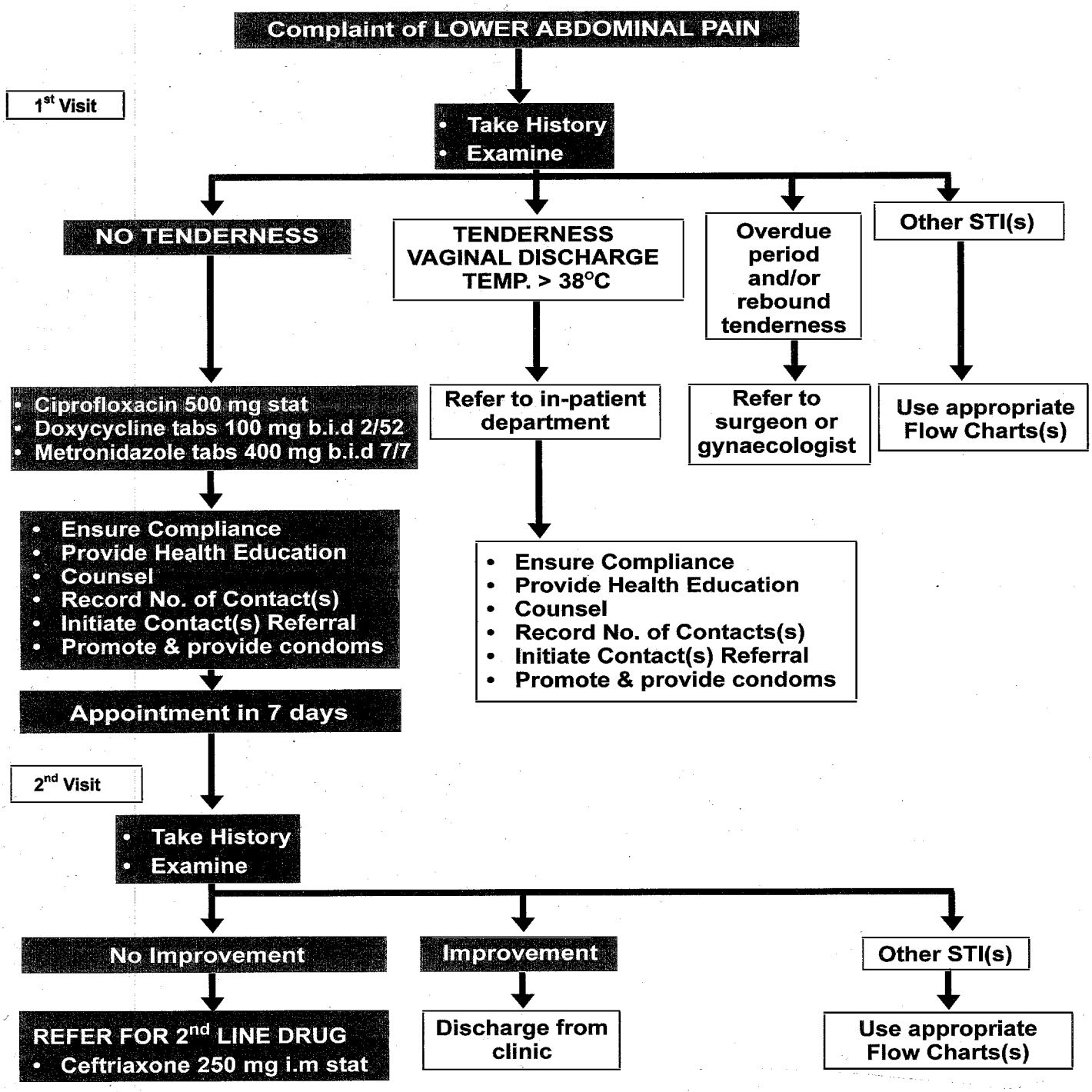


FLOWCHART 3: VAGINAL DISCHARGE SYNDROME (VDS)



- Do not give Metronidazole in 1st trimester of pregnancy: substitute with Clotrimazole pess. 200 mg od 3/7
- Do not give Doxycycline or Ciprofloxacin in pregnancy or to lactating mother: substitute with Erythromycin 500 mg t.i.d 7/7 or Ceftriaxone 250 mg i.m stat

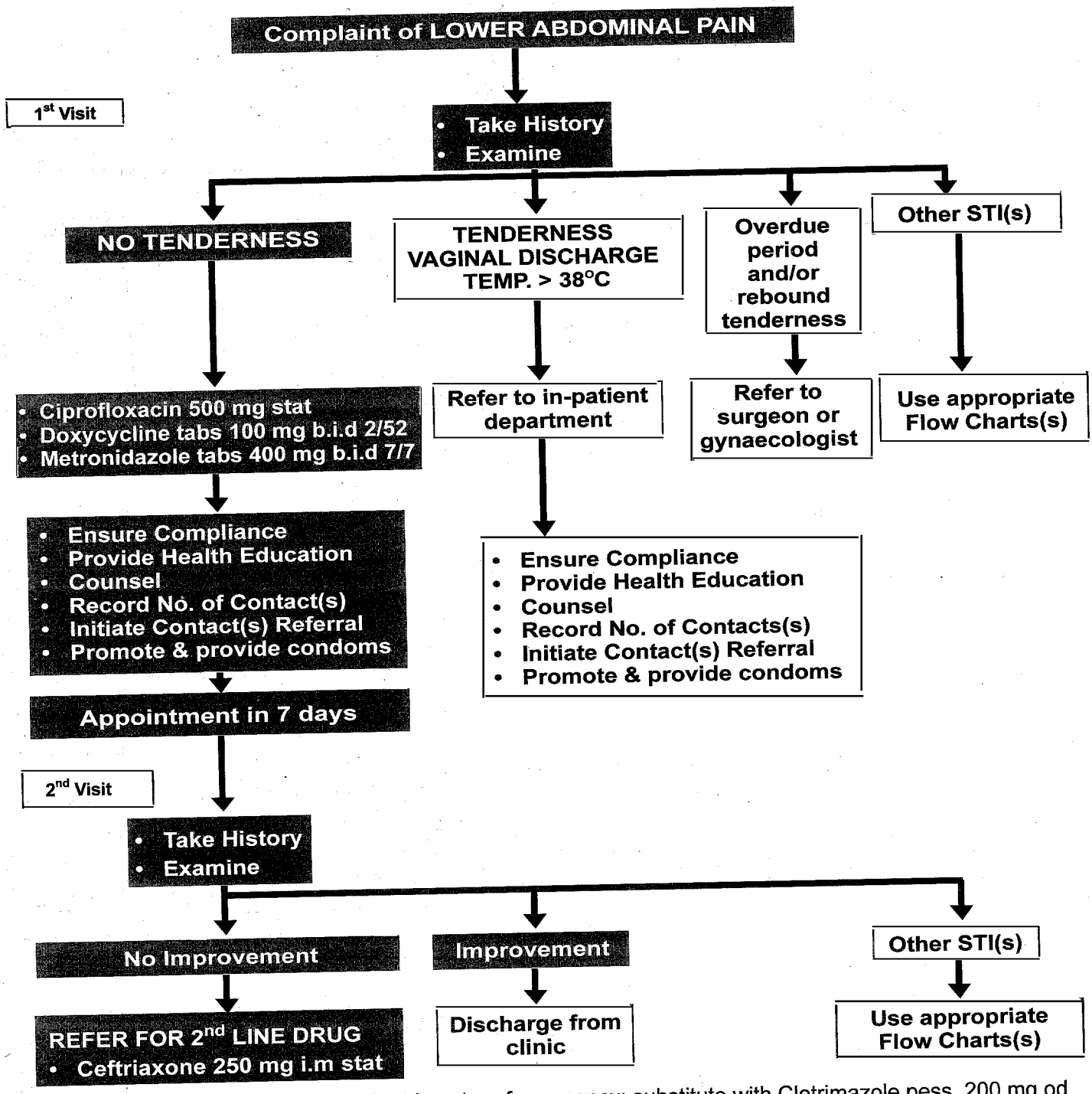
FLOW CHART 4: PELVIC INFLAMMATORY DISEASE (PID)



- Do not give Metronidazole in 1st trimester of pregnancy: substitute with Clotrimazole pess. 200 mg od 3/7
- Do not give Doxycycline or Ciprofloxacin in pregnancy or to lactating mother: substitute with Erythromycin 500 mg t.i.d 7/7 or Ceftriaxone 250 mg i.m stat

* Even with no tenderness the risk for infection in someone complaining of lower abdominal pain is considered so great that treatment is necessary

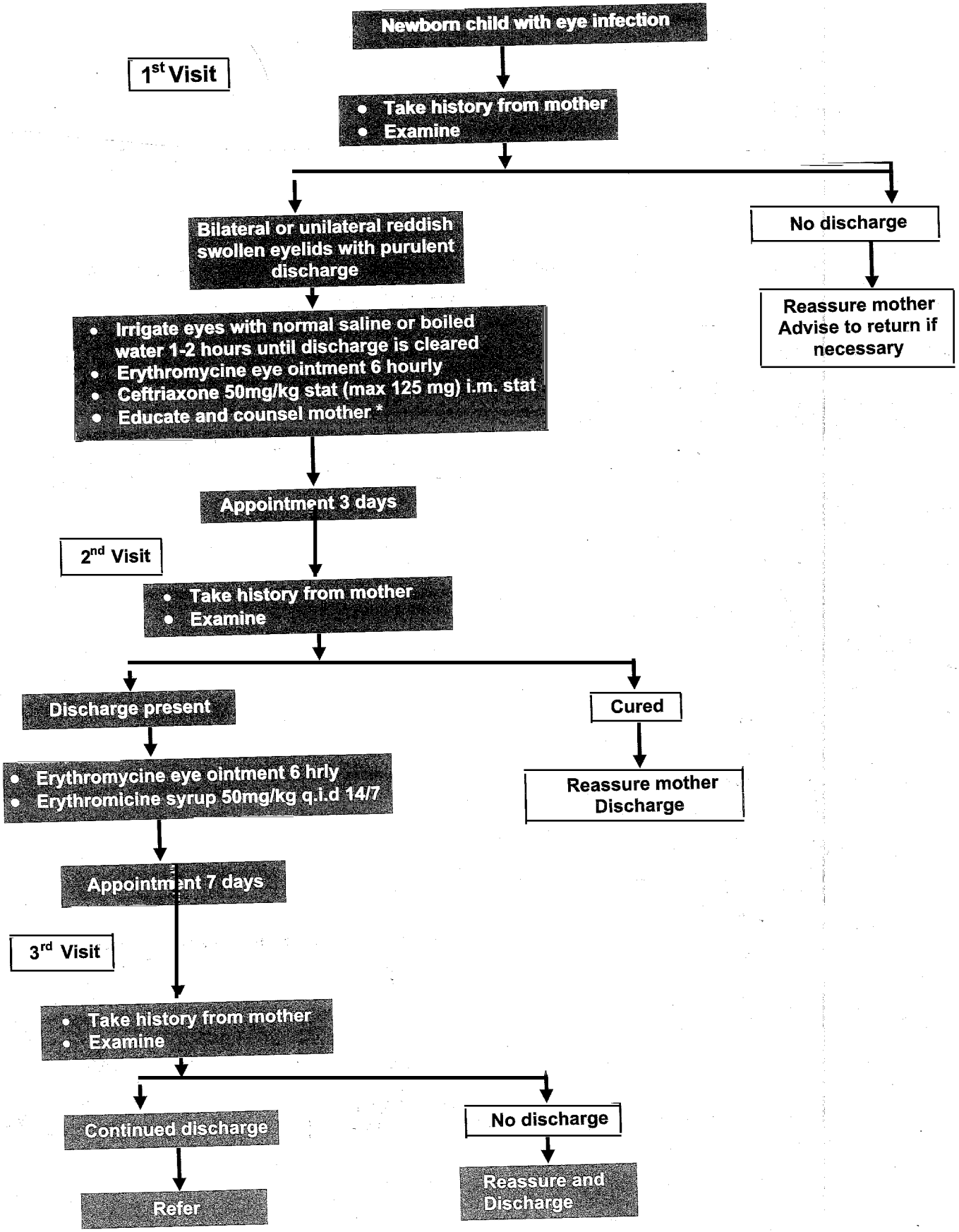
FLOW CHART 4: PELVIC INFLAMMATORY DISEASE (PID)



- Do not give Metronidazole in 1st trimester of pregnancy: substitute with Clotrimazole pess. 200 mg od 3/7
- Do not give Doxycycline or Ciprofloxacin in pregnancy or to lactating mother: substitute with Erythromycin 500 mg t.i.d 7/7 or Ceftriaxone 250 mg i.m stat

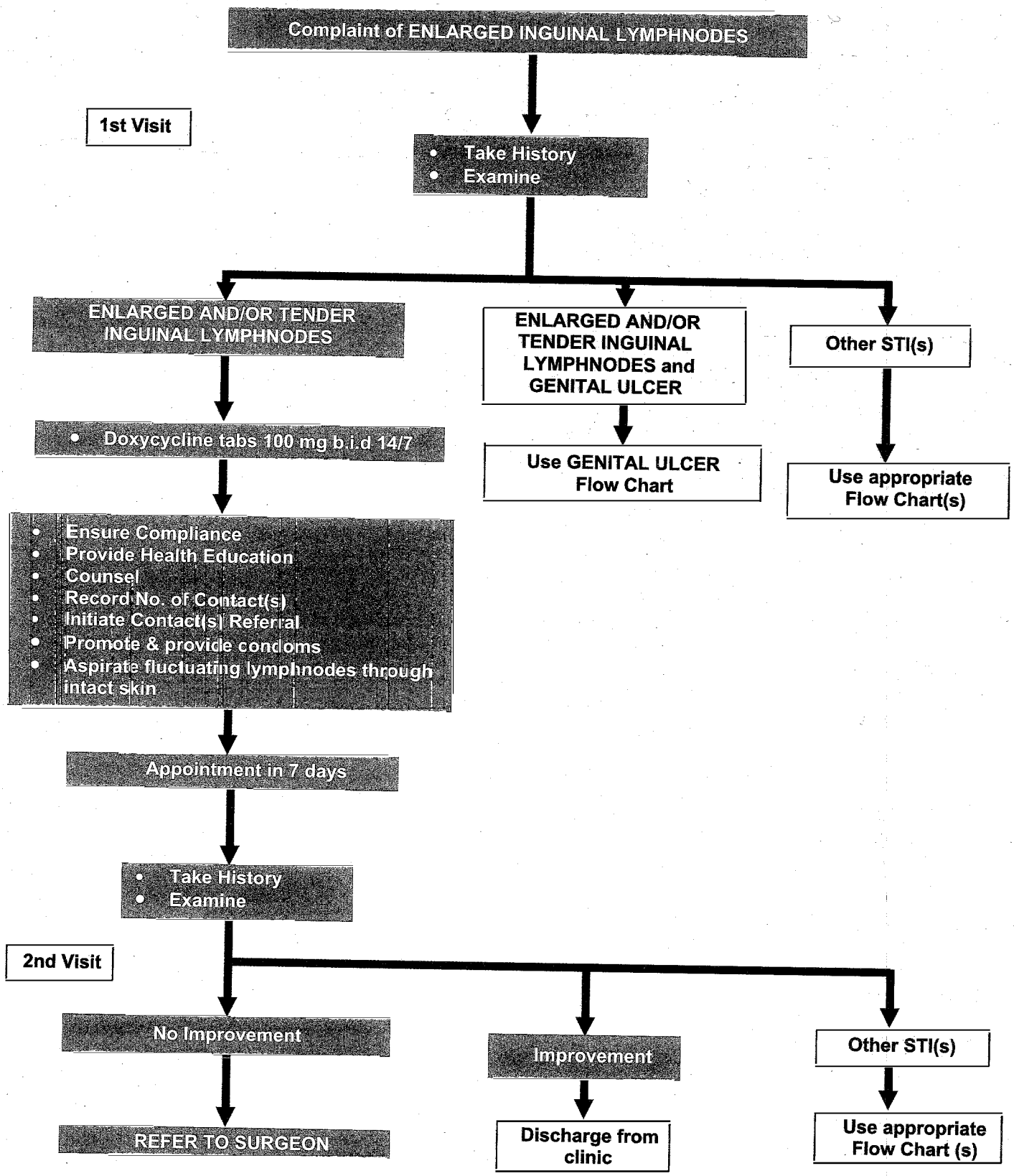
* Even with no tenderness the risk for infection in someone complaining of lower abdominal pain is considered so great that treatment is necessary

FLOWCHART 5: NEONATAL CONJUNCTIVITIS

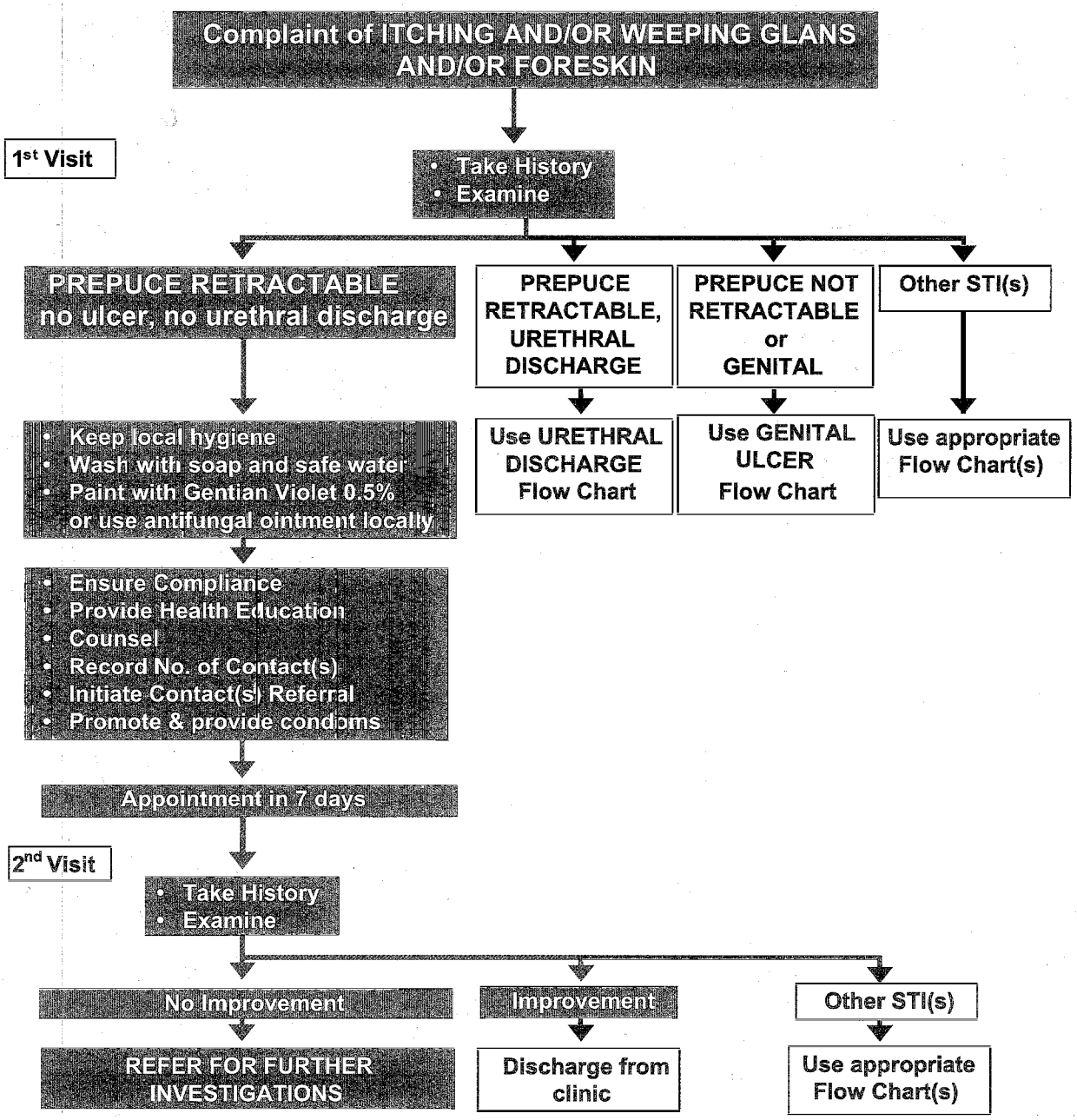


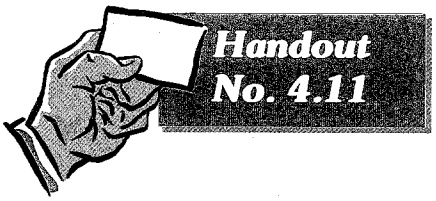
*** Mother should be examined and treated as per flow chart on vaginal discharge**

FLOWCHART 6: INGUINAL BUBOS



FLOWCHART 7: BALANOPOSTHITIS





Value Clarification Exercise

Indicate your answer to these statements

Statements	Agree	Disagree
• Sex before marriage is O.K.		
• Condoms ruin the enjoyment of sex.		
• I would feel uncomfortable working next to someone who has AIDS.		
• It is O.K. for a man to have sex outside marriage.		
• It is O.K. for a woman to have sex outside marriage.		
• Women are responsible for the spread of HIV/AIDS.		
• If people catch STD is it their own fault.		
• People with AIDS should be isolated from the rest of the community.		
• If a woman wants to use a condom but her partner refuses, the woman has a right to refuse sex.		
• A person with AIDS deserves what he or she gets.		
• It is more important to maintain certain cultural traditions and practices than it is to change behaviour to prevent STDs and HIV/AIDS.		
• AIDS is mostly a problem of commercial sex workers.		

Instructions for Trainer's:

Follow the Experiential Learning Cycle and example for conducting of Values Clarification Exercise (See Module 4.1.)

STD Risk Assessment and Ways of Reducing the Risk

Risk Assessment

Throughout the world there are risk assessment tools designed to help identify those most likely to acquire STD/HIV infections and AIDS.

None are perfect

The risk assessment tool that follows is present in a CEDHA training manual series (CEDHA, 1995). Simply put, the more yes responses a person has, the greater his or her risk.

Risk reduction or "Safer Sex"

Meaning of Safer Sex: Once a client understands his/her risk, the topic of risk reduction or safer sex should be introduced. All clients should understand what safer sex means, regardless of their risk. If they do not need the information perhaps they can listen and share with a friend or relative who is at risk. Safe sex means there is no exchange of blood, semen or vaginal fluids during the sexual act.

Procedure on discussing STD risk assessment and safer sex with a client

1. Prepare private setting; assure client that the information collected from him/her will be kept absolutely confidential.
2. Ask these following personal questions in a culturally appropriate manner.
3. Ask question related to STD risk:
   a) During the last five years:
      - Have you had sex without using a condom? (Alternative: Do you know about condoms?
      - Have you ever had sex with a prostitute or Sugar Daddy/Mummy? (Alternative: have you ever had sex with a person you did not trust?)
      - Have you had sex with more than one sexual partner?
      - Have you had sex with anyone who already had another sexual partner?

      If the client does not know, the provider should take it as "Yes".

      - Have you ever had a sexually transmitted infection?
      - Do you get injections from non-professional people who may not use sterile needles and syringes?

b) Do you feel that your partner may have, at any time:

- Had sex with a prostitute?
- Had sex with other women?
- Ever been unfaithful to you? If the client does not know, provider should take the answer as "yes".
- Had an STD?

4. Explain results of the STD risk assessment to client

- Explain to the client that everyone probably has some risk, but the more "yes" responses a person has, the greater his or her risk.
- Say that some other factors that might increase a women's risk of STDs are:
  - An absent husband, that is, one who works far away, especially in a city.
  - Polygamous marriage
  - Marriage where the wife is shared.
  - Lack of access to treatment for a suspected STD.

5. Clarify questions and concerns of the client and explain reasons for the STD risks, as needed.

6. Discuss ways of reducing STD risk enhancing safer sex e.g. The client and partner:

- Abstain; it is the only certain way of avoiding STD/HIV.
- Be faithful to one partner who is uninfected and insist on his or her fidelity. Just because you are monogamous does not mean your partner is.
- If abstaining is difficult for one reason or another:
  - Use latex condoms with every act of intercourse from beginning to end.
- Consider alternatives to penile insertive intercourse:
  - Practicing "non-penetrative" sex erotic massage, body to body rubbing, and mutual masturbation. This prevents the exchange of blood, semen or vaginal fluids and is considered a way of reducing STD risk. This is especially important if you and/or your partner is already HIV positive. You can continue to express your sexuality without putting yourself or your partner at risk (Adapted from Kenyatta University, Ku-Peer, 1995).
- Get any suspected vaginal infection treated promptly (sexually acquired or not). The presence of a sexually transmitted infection increases the risk of HIV infection if the women continue to have unprotected intercourse. Women must make efforts to overcome the barriers of being too busy, too modest or too poor to get treatment.
- If one suspect an infection one should stop having sex and get the infection evaluated and medical care provided.

Service provider's guide for answering some of client's and relatives questions on HIV/AIDS

The purpose of these notes is to provide information that is not in the usual health education leaflets.

Information on HIV/AIDS

1. The HIV virus attacks and slowly destroys the immune system.
   - It may take 3-7 years or more for HIV infected persons to develop immune deficiency medical/health condition.
   - The infected person looks well during this time (3-7) years but can spread the virus.
   - Signs and symptoms develop after the immune system is weakened due to:
     - The virus itself.
     - Opportunistic infections, some which were lying dormant e.g. T.B. Herpes or cancer.
2. The immune system develops antibodies to HIV but is not able to destroy the virus.
   - The antibodies form the basis of HIV (antibody) test.
   - They can be usually detected in blood stream 4-12 weeks after infection.
3. The most infectious phase of HIV infected people are:
   - Soon after becoming infected (in first 12 weeks).
   - When symptoms of HIV/AIDS appear.
4. Mother-to-child HIV transmission:
   - Occurs during pregnancy and childbirth. There is a 30% chance that the child will be infected or a 1 in 3 chance of the HIV pregnant mother's infant to be born with HIV infection.
   - HIV transmission through breast feeding is likely if:
     - Infant has disease or sores in the mouth, pharynx and oesophagus
     - The mother is infectious during breastfeeding, or if she becomes pregnant soon after HIV infection or is in the late stage of the disease.
     - The infected mother's nipples are cracked and the areola has sores.
   - HIV positive mothers who can safely and adequately bottle-feed should be encouraged to do so. Those who cannot should breast feed.

5. Infected (HIV) children do not normally pass the virus to other children:
    - They should be accepted in school, day care schools, unless they are unable to attend school for medical reasons.
    - All childhood vaccinations (BCG, DPT etc.) should be given to the child with HIV infection.
    - The brothers and sisters or the HIV infected child should have BCG if they have not been immunized already.
    - Avoid admitting HIV infected children to hospitals unless it is essential. Keep the children with their parents at home as much as possible.
6. Why women are more vulnerable to HIV infection than men?
    - Women are the receptive sexual partners during sex:
        - Infected semen is deposited in the woman's vagina and remains there for sometime, giving the HIV opportunity to enter the body.
        - Cervical conditions e.g. erosion, cervical ectopy, STDs etc promote HIV transmission to the woman.
        - Sores or damage to the vaginal walls allows HIV to easily enter the body.
        - STD are usually unnoticed or hidden in the woman's genital tract and these allow the HIV infection to spread in the body.
        - Menstruation results in a large raw, exposed area in the endometrium, making HIV enter easily in woman's body just before, during and after menstruation.
7. Why are adolescent females physiologically more vulnerable to HIV infection than adult women?
    - Adolescent genital tract especially where cervix meets the vagina is "immature" compared to adult women. This gives chance for the virus to enter through that area.
8. HIV testing should be encouraged using the informed choice concept.
    - It should be accompanied by support and careful and adequate counselling before and after the HIV test. Confidentiality is important.
9. Problems affecting people with HIV/AIDS include:
    - Need for psychosocial support.
    - Coping with feelings of fear, guilt, anger, depression, shame or blame.
    - Adjusting to safer sexual practices.
    - Adjusting to the fact of having acquired a serious life threatening disease and other uncertainties (e.g. source of infection, whether he/she will continue to live a normal life).

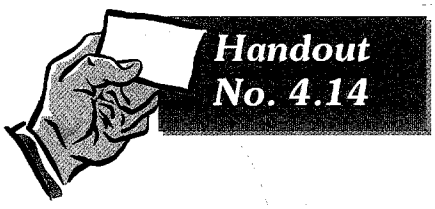
- Denial of having been infected or the severity of the disease.
- Relationships with families and friends.
- Making decision about subsequent or current pregnancy, if applicable.
- Coping with consequences of the illness (e.g. unemployment), financial loss; stigma).
- Dealing with dying children, death and bereavement.
- Coping with current or future loss of a loved one or close friend.

10. Counselling usually helps the people living with HIV/AIDS because it helps solve some of the problems above.

11. Pre and post test counselling helps the client and family address life goals especially those which are related to preparing for the adjustment and future of the family after the HIV/AIDS client has died.

12. Safer sex means:

- Having one sexual partner who is uninfected.
- Preventing exchange of body fluids during sexual intercourse (protected sex) e.g. use condoms.
- Finding ways of enjoying sex without penetration: masturbation between partners, body caressing, talking or discussion about best areas which are sensitive and help reach a climax, sex between body parts e.g. thighs or armpits.



Teaching Client on Condom Negotiation with Partner (to promote Dual Method Use): Hints for Provider

- Condoms are the only known and scientifically proven means of protecting against transmission of STD/HIV/AIDS during intercourse.
- Empower your clients to believe that they have the right and ability to convince their partners to use condoms for dual protection, or use other reproductive or child health services. For example: Acceptance of STDI treatment by a contact; or acceptance of different reproductive health related decisions, such as going for an HIV test, having a child with malnutrition treated using nutritious diet instead of insisting on herbs.

Hints on teaching client on negotiation for condom use:

- Assist the client to come up with a strategy or approach that may be conducive to successful negotiation of condom use.
- Discuss myths and misconceptions about condom use and provide facts to clear these myths.
- Find out the arguments the partner may bring up and possible responses that the client may use.
- Perform a condom use negotiation role-play with the client, using facilitation/communication skills.

(Role-play, negotiation for condom use with provider as provider, client as partner, then with provider as partner and client as her/him the initiator of negotiation).

The purpose of this procedure is to help providers teach and show the client how to hold a private discussion in which the couple has free flow of ideas, even if the partner "receiving" the information has arguments or myths.

Setting and materials

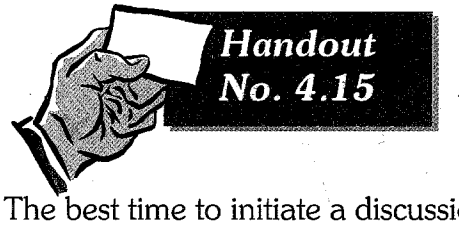
- Comfortable, private quite place to sit.
- Samples of condoms for use as visual.
- Leaflets on condoms and their benefits.
- Leaflets on STD/HIV/AIDS, if needed.

Steps of the procedure

The provider can explain and demonstrate by giving examples of each step. OR by Role Play with the provider acting as "the client" and the client acting as the resistant or doubtful partner".

1. Create rapport:
   - Greet your partner, offer a comfortable chair and favourite non-alcoholic drink (or one glass or two of beer or wine, if applicable)
2. Prepare your partner for the discussion
   - Ask him/her for discussion of a serious matter which needs privacy and may take some time. If he/she is ready, go on to the next steps below. If, he/she is not ready, agree on time, later that day. (Find a way of ensuring the discussion will take place).
3. Use the facilitation skills learnt from me (the service provider) to begin, encourage the discussion to go on.

   For example, you can begin by saying "I was informed by the clinic nurse/doctor about advantage of a device which can help both of us to maintain our health and use it well. "How would you like me to tell you about it? The device is a condom. There is so much I learnt about it.
4. Once your partner reacts, listen and continue from an appropriate point (in relation to what you were taught about responding to arguments or myths).
5. Explain good things about the condom that applies to why you want both of you to use it:
   - It will protect from pregnancy while I am waiting for my chosen FP method to work. OR
   - Using it all the time over and above the family planning method we/I choose, will protect us from STD/HIV.
6. Explain other facts about the condom: (not addressed earlier in the discussion):
   - Effectiveness in protecting the couple from STD/HIV infections, how to place and remove it.
   - Benefits for "love play".
   - Not needing time from the service provider for examination before receiving condoms.
7. When your partner is talking, make encouraging remarks or noises, listen attentively, and paraphrase.
8. Respond to the arguments or misconceptions with facts; use the leaflets and actual condoms to help remember facts. Pull out one condom to show how strong or how it can stretch.



Hints for initiator on Condom Negotiation

The best time to initiate a discussion on condom use is when you and your partner are in a private atmosphere and your partner is relaxed.

When initiating the discussion, be ready to:

- ***Provide rationale and factual responses*** to the argument (see example provider below) of his/her partner. Such readiness and facts will increase the initiator's confidence.
- ***Do not intimidate or threaten.*** This is positive assertiveness. ***ALSO:***
- ***Prepare alternative solutions or options*** and use them as needed during the discussion.
- Establish ***personal limits,*** what he/she will do and what he/she will not do, in advance so that his/her health is foremost and will not be compromised.
- ***Find strength*** in numbers. For example letting the partner know that everyone who cares about himself or herself uses condoms for health benefits.
- Use statements using "I" rather than "you". Tell me more about .... And use questions that are open, and non threatening. For example using How, What, Where .... When but not "Why".
- Use visuals collected from the clinic and actual condoms to let the partner touch and check for strength of the rubber.
  - Demonstrate/discuss how to use the condom correctly.
- Use ***arguments*** about condom use, (see next page for examples).

1. "I can't feel anything. It's like wearing a raincoat.	"I know there is some reduced sensation, but there is still plenty of sensation". (Open condoms and feel how thin it is?
2. I'll lose my erection by the time I stop and put it on. By the time I put it on; I won't be in the mood."	"I can help you put it on. That should give you lots of extra sensations and help keep you in the mood".
3. "It's messy and it smells funny".	"Sex is like that. But this way we'll be safe".
4. "Condoms are unnatural, fake, total turnoff".	"STDs, especially AIDS are a turnoff too".
5. "You never asked me to use a condom before".	"Now I have information about AIDS and how serious it is. We both have to protect ourselves.
6. "Are you implying that I haven't been faithful? Or is it that you have been going around with other men?"	"No, of course not. I just want to be sure that we're both protected

Source: *National AIDS Control Program/AMREF/AIDSTECH (Oct. 1994) STD/AIDS Peer Educator Training Manual pages 88-90, Ministry of Health, P. O. Box 9083, Dar es Salaam Tanzania, Phone 255 22 220261.*

Condom use negotiation role-play

Teach how to negotiate Condom Use through a role-play with the client.

NB: *Do this role-play at a time convenient to both you and the client without delaying other services. You may wish to do this at a time specially set aside for this rather than during usual R/CH services.*

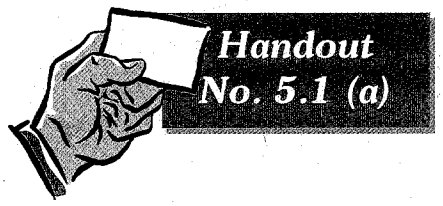
Instructions for role-play

- Provider act as "the client" or partner who needs to Negotiate Use of Condom.
- The "Client" will act as the partner who needs to be convinced.

Trainee's Note

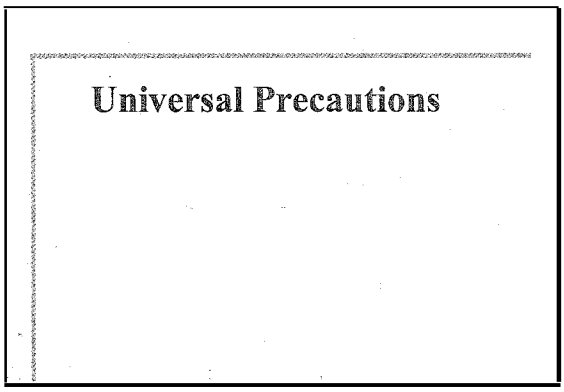
Module 5

Organising the Health Facility for Sustainable PAC/RH Services

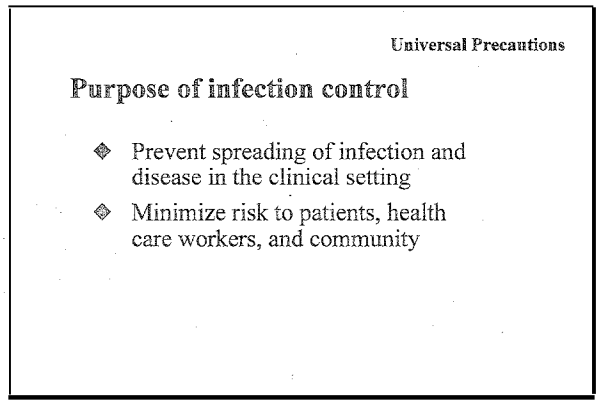


Applying Universal Precautions of Infection Prevention

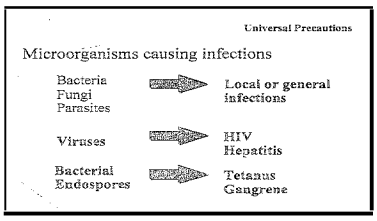
Slide 1



Slide 2



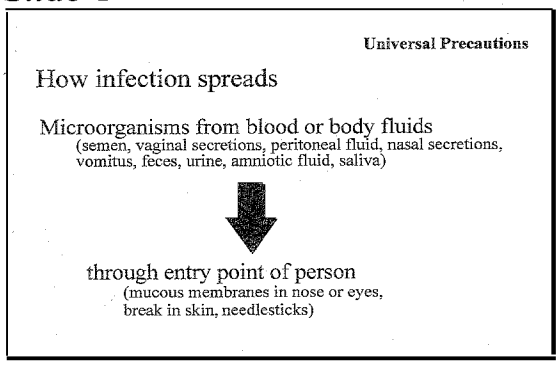
Slide 3



Microorganisms causing infections:

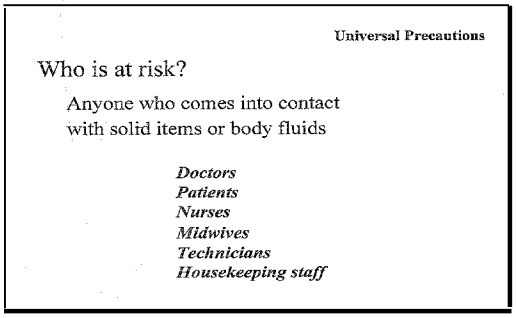
- Bacteria, fungi or parasites cause local or general infections.
- Viruses cause HIV and hepatitis.
- Bacterial endospores cause tetanus and gangrene.

Slide 4



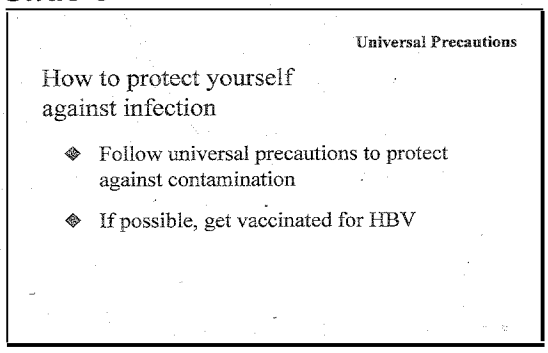
How does infection spread?
Microorganisms are transmitted from blood or body fluids (e.g.) semen, vaginal secretions, peritoneal fluid, nasal secretions, vomitus, feces, urine, amniotic fluid, saliva) through entry point of susceptible host (mucous membranes in nose, eyes, break in skin, needle sticks).

Slide 5



Who is at risk? Doctors; patients; nurses; midwives; technicians; people who clean instruments, linens, clinic rooms; people who handle or dispose of medical waste—ANYONE who comes into contact with soiled items or patient body fluids.

Slide 6



How can we protect our patients and ourselves?
Follow "universal precautions" to keep blood and body fluids from contaminating you and your patient. If possible, health care workers should be vaccinated against HBV.

Slide 7

Universal Precautions

Universal precautions include:

- Handwashing
- Use of barriers
- Wearing gloves
- Safe waste disposal
- Decontamination and processing instruments
- Protection from sharp instruments

Slide 8

Universal Precautions

Following universal precautions

requires

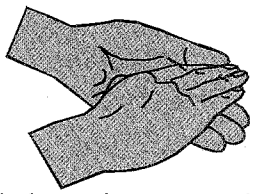
Anticipating possible hazards

Slow down and think!

Slide 9

Universal Precautions

Handwashing



The single most important step in preventing infection

Hand washing is the single most important step in preventing infection, because we touch surfaces with our hands and then touch our face: eyes, nose, mouth - carrying microorganisms into the body.

Slide 10

Universal Precautions

When to wash your hands

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

Slide 11

Universal Precautions

How to wash your hands

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

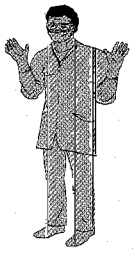
Slide 12

Universal Precautions

Use of barriers

Wear gowns, aprons, goggles, gloves

- **whenever doing patient care involving blood or body fluids**
- **whenever handling bloody items including instruments or sheets**

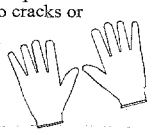


Slide 13

Universal Precautions

Gloves

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



Wash hands and change gloves between patient contacts

Slide 14

Universal Precautions

Gloves

Use clean, heavy utility gloves when cleaning :

instruments
equipment
tables
rooms

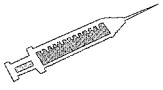
(make sure gloves have no cracks or holes)

Slide 15

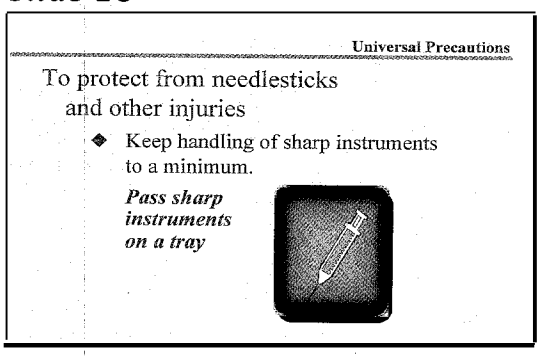
Universal Precautions

Protection from sharp instruments

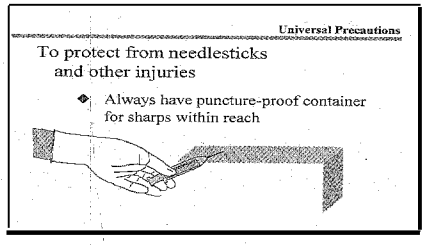
Injuries from sharp instruments are the most common way HBV and HIV are transmitted in health care situations



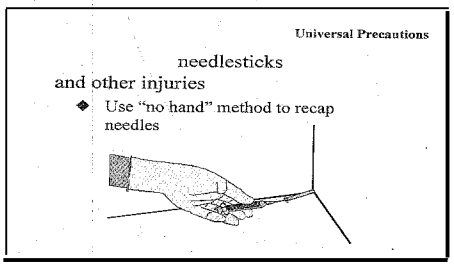
Slide 16



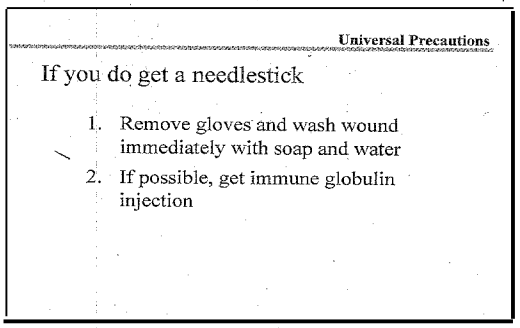
Slide 17



Slide 18



Slide 19



Slide 20

Universal Precautions

If blood or body fluids splash in your eyes

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

Slide 21

Universal Precautions

Waste disposal

Two methods to dispose of medical waste

1. **Careful incineration**
2. **Burial in sealed containers**

Waste disposal:

Handling contaminated solid or liquid waste carries risk; waste must be disposed of properly. Careful incineration is one method of disposal; burial in sealed containers is another

Slide 22

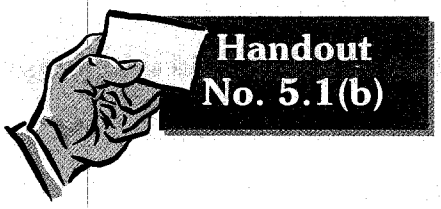
What's wrong with this picture?

Slide 23

Universal Precautions

Cleaning of room and exam table

1. Use utility gloves and chlorine solution when mopping up spills to decontaminate surfaces
2. Wash with detergent and water



Preparation of Chlorine 0.5% Solution

Using Liquid Bleach

Chlorine is bleach comes in different concentrations. You can use any concentration to make a 0.5% chlorine solution by using the following formula:

$$\left(\frac{\text{\% Chlorine in liquid bleach}}{0.5\%} \right) - 1 = \text{Total parts of water for each part bleach*}$$

Example: ***To make a 0.5% chlorine solution from a 3.5% chlorine concentrate, you must use one part chlorine and six parts water.***

$$\left(\frac{3.5\%}{0.5\%} \right) - 1 = [7] - 1 = 6 \text{ parts of water for each part chlorine.}$$

Using Bleach Powder

If using bleach powder instead of liquid bleach, calculate the ratio of bleach to water using the following formula:

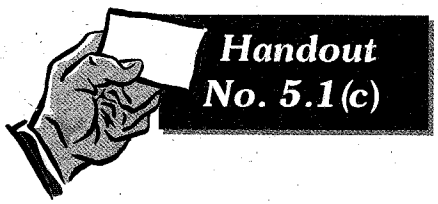
$$\left(\frac{\text{\% Chlorine desired}}{\text{\% Chlorine in bleach powder}} \right) \times 1000 = \text{Number of grams of powder for each litre of Water}$$

Example: **To make a 0.5% chlorine solution from calcium hypo chlorite powder containing 35% available chlorine.**

$$\left(\frac{0.5\%}{35\%} \right) \times 1000 = 0.0143 \times 1000 = 14.3$$

Therefore you must dissolve 14.3 grams calcium hypochlorite powder in one litre of water in order to get a 0.5% chlorine solution.

* Note that "parts can be used for any unit of measure (for example, ounce, litre or gallon) and need not even represent a defined unit of measure (for example, pitcher or container).



Handout No. 5.1(c)

High-level Disinfection (Using Chemical)

1

Decontaminate used instruments

in 0.5% chlorine solution for 10 minutes

2

Clean thoroughly

with soapy water using a soft brush

3

Rinse

instruments with clean water
then air dry
or
dry them with a clean cloth

4

High-level Disinfect

by immersing instruments fully for 20 minutes in either:

- 0.5% chlorine solution or
- Cidex 2% or
- Steranoios 2%

5

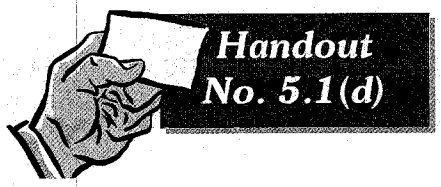
Rinse

with sterile water
or
normal saline
or
cooled boiled water

6

Store

in a dry, sterile or HLD container
(up to 7 days only)



Group Assignment on Observing Sustainable PAC/RH Services

Purposes of the group assignment:

- To contribute to strengthening the Comprehensive PAC trainees' knowledge and skills on organising the clinic.
- To help Comprehensive PAC trainee identify strengths and limitations of the quality of health facility organisations using simplified COPE.
- To help trainee use strengths and limitations observed to generate lessons for applying in his/her Comprehensive PAC/RH services site.
- To incorporate into individual trainee's Skills Application Plans: at least 2 strengths or "what you would change".

Objectives of the Module and assignment

- Introduce the General and Specific Objectives of Module.

Note to Trainers

- Conduct an Introduction to Clinic Organisation in the class (1 hour) and sharing session after assignment (1 hour).
- Create conducive atmosphere for the assignment in selected facilities to help facilitate effective completion of this assignment.
- With participants divide them into groups of 4 or 5. Encourage them to assign each other roles in conducting and reporting about the assignment.
- Be ready to respond to issues, using facts from the content outline, MTUHA and other RCH guidelines.
- Assignment to start mid-week of week 1 and end mid-week of week 2 of the training.

Instructions to Trainee Group

1. As a group (determined by you and the Trainers), use COPE tools to observe strengths and limitations of health facility organisation.
   - Interview staff and clients. At end of the observations, review facility records e.g. daily register, monthly report.
2. Complete the table below with your observations and suggestions.
3. Be ready to discuss with your Trainer and clinic/ward representatives about your observations and suggestions. Use feedback rules during observations and in this discussion.
4. Share what you have learnt from observations with colleagues in a special session set aside by Trainers e.g. during one of the process reviews (where are we sessions).

5. Include in you Skills Application Plan
   - at least two strengths.
   - at least one change ("To Be Done Differently") you will make in organising your own health facility/Comprehensive PAC/RH service.

Table 1: Results of Health Facility Observation based on COPE

Indicators for Observation	Observation/Observations: Strengths	Limitations	To be done differently (suggestion for improvement)
1. Interpersonal relationships - Provider/Provider - Provider/Client - Provider/Community			
2. Evidence of Upholding the 10 client rights			
3. (a) Client Flow - Waiting time - Clarity to all clients (interviewed) (b) Space - Adequately organised for service			
4. Comprehensive PAC & other related services availability and continuity: - Emergency Care. - Counselling for emotional support (Comprehensive postabortion counselling). - FP methods mix provision to Comprehensive PAC clients. - Other reproductive or general health services nearby or reachable. - STD/HIV/AIDS. - Community involvement?			

Factor/Area	*Description of Observations*		*To be done differently (suggestion for improvement)*
	Strengths	*Limitations*	
5. Comprehensive PAC/ FP/RH Education - Education material available? - can clients see the education material? - Is it written simply? - Client recruitment done? (Review record on H/Education)			
6. Adherence to Guidelines and Standards evident? - Universal Precautions. - Informed choice of FP methods or other RH services (clients may tell you; observe provider if possible) - STD Syndromic Management Flow Charts (Latest) - FP Procedure Manual used - Other guideline used - Guidelines and Standards reachable to all staff			
7. Logistic records show timely availability of supplies equipment?			
8. Are Service Records used to improve service? - Bar or line graphs on selected services? - Facility reports show result of use of records? - Staff discuss progress of service based on reports, bar and line graphs at least quarterly.			

Processing Instruments for re-use

Slide 1

Processing Instruments for Reuse

Slide 2

Instrument Reuse

Purpose of processing instruments

- Prevent spreading of infection and disease from contaminated medical instruments
- Protect providers
- Protect patients

Slide 3

Instrument Reuse

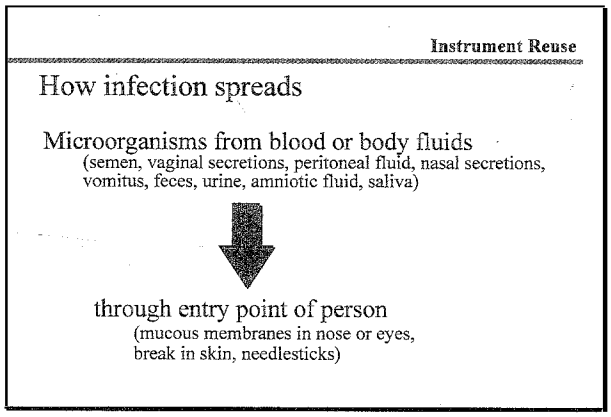
Microorganisms causing infections

Bacteria Fungi Parasites	→	Local or general infections
Viruses	→	HIV Hepatitis
Bacterial Endospores	→	Tetanus Gangrene

Microorganisms causing infections:

- Bacteria, fungi or parasites cause local or general infections.
- Viruses cause HIV and hepatitis.
- Bacterial endospores cause tetanus and gangrene

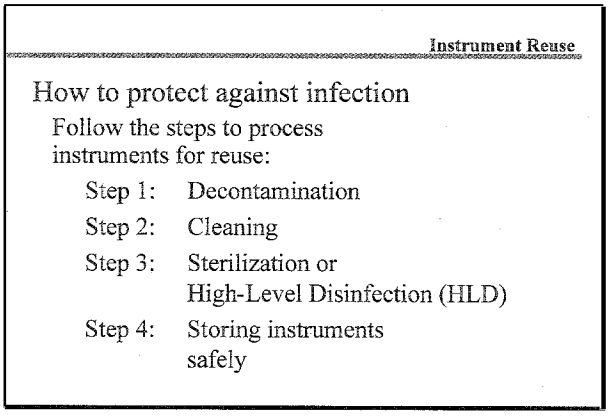
Slide 4



Definitions

HLD is high-level disinfection
LLD is low-level disinfection

Slide 5



How can we protect ourselves and our patients?

Always decontaminate, clean, and disinfect or sterilize instruments after each use. Store processed instruments safely, protected from recontamination.

Slide 6

Step 1: Decontamination — **Instrument Reuse**

Decontaminate all instruments and gloves immediately after use in a 0.5% chlorine solution.

1. Draw solution through cannula into syringe.

Slide 7

Step 1: Decontamination — **Instrument Reuse**

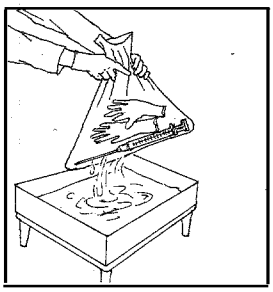
2. Drop soiled instruments – syringe, cannulae, gloves – directly into solution

   Soak for 10 minutes. (Longer soaking will corrode metal.)

The duration of decontamination and HLD is scientifically proven. HIV, HBV and other microorganisms except spores are prevented from growing further or killed when provider uses these times/duration.

Slide 8

Step 1: Decontamination — **Instrument Reuse**



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

   Change solution at least once daily.

Slide 9

Step 2: Cleaning **Instrument Reuse**

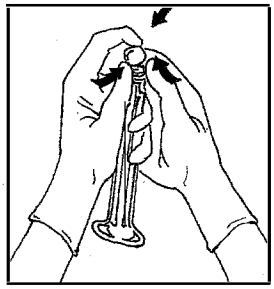
Washing Instruments

Wash the syringe and cannulae in lukewarm water with detergent (not soap).

Hot water will coagulate blood and make it harder to clean.

Slide 10

Step 2: Cleaning **Instrument Reuse**



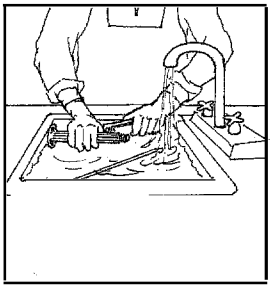
To Disassemble the Syringe:

Remove the collar stop, pull plunger out of barrel, Remove valve set, and open valves.

Remove o-ring from plunger

Slide 11

Step 2: Cleaning **Instrument Reuse**



To clean syringe:
Wash all parts in lukewarm sudsy water.

Wile holding syringe under surface of water, scrub with soft blush

Slide 12

Step 2: Cleaning — **Instrument Reuse**

After washing, rinse syringe and cannulae thoroughly with clean water.

Dry by air or with a clean towel

Slide 13

Step 3: Sterilization/HLD — **Instrument Reuse**

All clean, dry instruments should be either sterilized or high-level disinfected.

Use: Boiling
2% Glutaraldehyde
Other chemical high-level disinfection Methods

Do not use: Autoclaving (steam)
Dry heat

Slide 14

Step 3: Sterilization/HLD — **Instrument Reuse**

Sterilization vs. High-Level Disinfection (HLD)

Sterilization kill all microorganisms, including bacterial endospores.

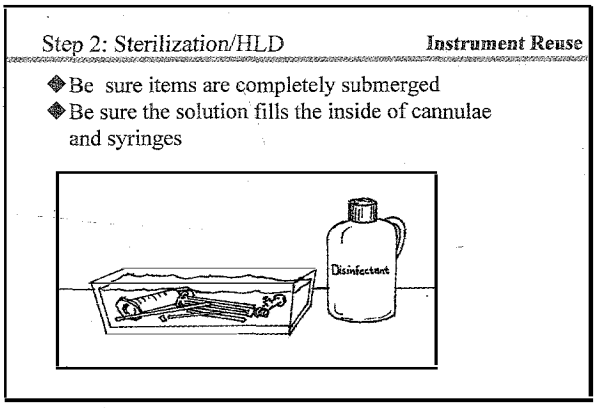
High-level Disinfection kills all microorganisms, but may not kill bacterial endospores

When sterilization of cannulae is unavailable, HLD is the only acceptable alternative for protecting against infection.

Sterilization versus High-Level Disinfection

Sterilization kills all microorganisms, including the bacterial endospores that cause tetanus and gas gangrene. HLD kills all microorganisms, except bacterial endospores. When sterilization is unavailable, HLD is the only acceptable alternative for protecting patients and staff against infection

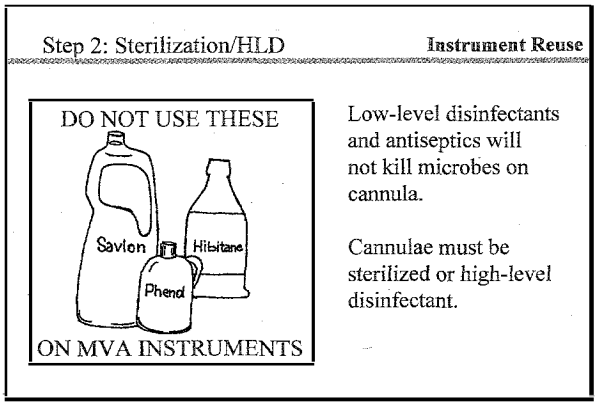
Slide 15



Sterilisation/HLD

Whenever using chemical sterilization or high-level disinfection, make sure items are completely submerged, and that the solution fills the inside of cannulae and syringes.

Slide 16



Low-level disinfectants or antiseptics such as Phenol, Savlon or Hibitane, will **not** kill microbes on cannulae and must **not** be used for this purpose.

Slide 17

Step 3: Sterilization — Instrument Reuse

Sterilizing Cannulae with 2% Glutaraldehyde (Cidex)

1. Soak cannulae for 10 hours
2. Remove with sterile forceps
3. Rinse with sterile water
4. Air dry

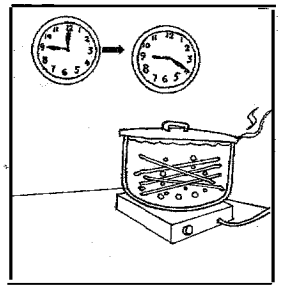
Note: Solution up to 14 days.

Sterilising Cannulae: 2% Glutaraldehyde (Cidex)

Glutaraldehyde works best at warm temperatures. Follow manufacturer's instructions for mixing.

Slide 18

Step 3: Sterilization — Instrument Reuse



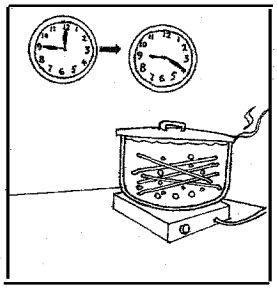
High-Level Disinfecting Cannulae by Boiling

1. Place cannulae in boiling water
2. Bring to boil agein
3. Boil for 20 minutes
4. Remove with HLD forceps
5. Rinse with boiled water & air dry

Note: Boiling syringes will crack the valves

Slide 19

Step 3: Sterilization — Instrument Reuse



High-Level Disinfecting Cannulae by Boiling

1. Place cannulae in boiling water
2. Bring to boil agein
3. Boil for 20 minutes
4. Remove with HLD forceps
5. Rinse with boiled water & air dry

HLD for Cannulae or Syringes: Chlorine

Follow instructions to mix 0.1% or 0.5% solution. Soak items in non-metal container for 20 minutes. Remove with HLD forceps; rinse with boiled water; air dry on HLD surface

Change solution at least every day

Slide 20

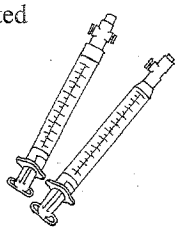
Step 3: Sterilization — **Instrument Reuse**

Disinfection: Syringes only

Can be high-level disinfected with cannulae

or

mid-level disinfected with alcohol or iodophors



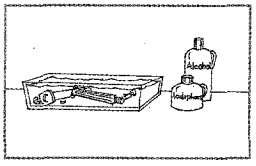
Disinfection for Syringes only

The syringe does not have to be high-level disinfected, because it does not come into contact with the patient. It can be processed with HLD along with the cannulae, or treated separately with mid- level disinfectants: alcohol and iodophors.

Slide 21

Step 3: Sterilization — **Instrument Reuse**

Mid-Level Disinfection for Syringes with Alcohol/Iodophors

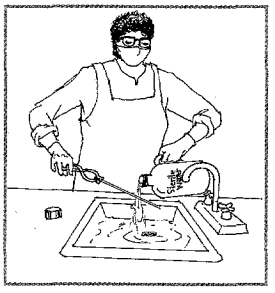


1. Soak for 20 minutes
2. Remove with HLD forceps
3. Rinse with boiled water
4. Air dry

Note: Change solution daily, or when cloudy.

Slide 22

Step 4: Storage — **Instrument Reuse**



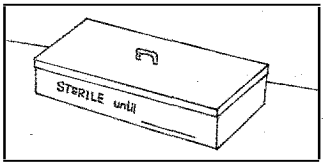
Handle sterile cannulae only with sterile instrument. Rinse in sterile water and air dry.

Slide 23

Step 4: Storage **Instrument Reuse**

Sterile cannulae should be wrapped in sterile paper or Cloth or stored in sterile covered tray.

Date instruments and use within one week, reclean and resterilize

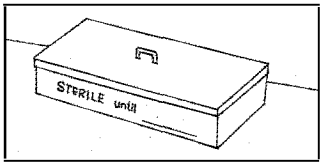


Slide 24

Step 4: Storage **Instrument Reuse**

Sterile cannulae should be wrapped in sterile paper or Cloth or stored in sterile covered tray.

Date instruments and use within one week, reclean and resterilize



Slide 25

Step 4: Storage **Instrument Reuse**

Removing Cannulae from Storage:

- Keep instruments in small amounts in each container
- Use sterile/HLD forceps to remove cannulae by the non-aperture end
- Avoid touching the rest of the cannulae

Introduction to Client-Oriented Provider Efficiency (COPE) Tool

1 What is COPE?

- The acronym stands for Client-Oriented Provider Efficiency
- It is a tool to assess quality of care and access to RH services at service delivery point (SDP) site by a team of service provider/clinic level supervisors.

2 Goal of COPE

- To make services Client Oriented and enhance Provider Efficiency.

3 What needs to be done to perform COPE?

1. Self assessment;
   - This is conducted using a set of ten guides that are organized according to the rights of clients and needs of providers. It also includes records review and observation of staff skills and performance.
2. Client interviews;
   - This is done by staff. It includes obtaining clients suggestions for improving the service.
3. Client flow analysis;
   - It is a method used to track clients going through the facility from the time they arrive to the time they are leaving the place. The outcome helps the staff to identify clients waiting time, contact time with staff and problem areas that need to be improved.
4. Action plan;
   - This is prepared by staff members to address problems they have identified through using the first three tools. Problems requiring supervisor's actions are specified and shared with him/her.

4 Characteristics of COPE

- COPE is a practical tool; simple, easy to understand and use.
- It:
  - Is cost effective, requires no outside inputs.
  - Is easily integrated in staff's routine work.
- Is flexible.
- Takes little time to implement.

- Is used by staff themselves. This empowers them to make decisions about their work.
- Is not threatening to staff once it is well understood.
- Builds the team and encourages team approach to work and in decision making.
- Builds respect and support for other's roles.
- Gives staff a forum for defining quality and how to measure it, stopping to look at the quality of their services, identifying existing problems, and recommending solution most of which they themselves can implement.
- Helps the RCH Coordinator/supervisor prepare or strengthen objectives of the supportive supervision visits.

5. *COPE is a process that facilitates Maximizing Service Access and Quality (MAQ) and adherence to national RHC guidelines and standards for service delivery*

- Involves staff and clients in continuous assessment of quality and improvement.
- Increasing staff commitment, ownership, empowerment, team-work and in using staff wisdom in problem solving to improve quality of services.
- Defining quality in relation to what staff do daily makes it realistic and measurable while using an approach with simple tools.
- Community can be involved in COPE.

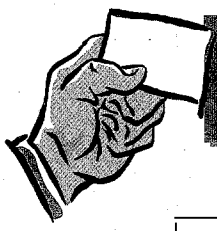
6. *COPE is also:*

- It is cost effective and adaptable.
- A process that allows the community to be involved in quality improvement.

Trainee's Note

Module 6

Involving the Community for Improving Comprehensive PAC Service Access and Quality



Handout No. 6.1

Involving the Community for Comprehensive PAC service Access and Quality

Note: Trainer and Trainee add more roles generated during the sessions.

1. Definition of community

A social group of people in a certain geographic area (e.g. village, urban ward) who share similar interests, a common culture and a "government".

(See Handout No. 6.3 for an elaboration of this definition).

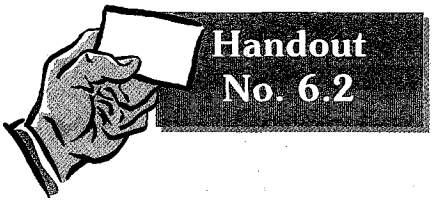
2. Advantages of involving the community in Comprehensive PAC service delivery

- Promotes common understanding of danger signs and early recognition of abortion complications.
- Promotes early decision-making in seeking medical care.
- Facilitates availability of transportation to a health facility.
- Facilitates timely/proper treatment and care at facility level.
- Increases community's commitment to comprehensive PAC.
- Encourages contraceptive use to prevent unwanted pregnancy.
- Increases access to comprehensive PAC service delivery.
- Advocates for establishment of community-based comprehensive PAC services from the government.
- Eliminates harmful cultural/traditional barriers that prohibit timely use of comprehensive PAC services.
- Addresses community-specific problems pertaining to comprehensive PAC services.
- Enhances more effective planning, management and use of resources.
- Creates a bridge to segments of the community that may be hard to reach through formal program channels, e.g. adolescents.
- Creates community-based emergency preparedness, including transportation and other costs.

3. Foster community ownership of the services

- Educate men, women, adolescents, extension workers, traditional health providers (TBA, healers) and various leaders or influential people on the importance of comprehensive PAC/RH services.
- Educate the community on the need for timely referral and possible means of available transportation.
- Negotiate help with the community to establish a mechanism, transport mechanism and other needs means for timely referral of comprehensive PAC clients to health facilities for emergency quality of care.

- Collaborate with community-based health workers, NGOs and private sector to improve Comprehensive PAC services:
  - Follow-up on the agreements, community work plan and help communities identify other identify emerging issues.
  - Provide needed technical assistance to trained community-based health workers and community members to improve their capacity to provide first aid care for emergencies.
  - Encourage non-emergency PAC clients to seek care after abortion e.g. physical assessment (postabortion assessment), counselling for voluntary and informed choice of FP/RH service and identified treatment or service.
  - Help the community evaluate jointly determined activities with the community.
  - Prepare report on experience progress of community involvement and share with all stakeholders.
  - Become an active community resource all the time.
- Assist trained NGO and private sector community-based health workers to:
  - Provide comprehensive PAC education to women, men, adolescents and communities about dangers of spontaneous and unsafe abortion and the need to seek immediate care at a health facility.
  - Recognise early signs of abortion.
  - Rapidly assess condition of emergency PAC clients.
  - Stabilise and refer immediately.
  - Guide relatives or escorts regarding transporting clients, and possible readiness for blood transfusion and payment of fees.
  - Promote comprehensive PAC at work and in their community consistently.



Role-play on mobilising the community for Comprehensive PAC/RH

Planning the PAC/RH Mobilisation Activities

Purposes of Role Play

1. To identify perspectives of different community members on unsafe abortion.
2. To help the service provider identify areas messages needed during interactions with the community.

Background information for the role-play on community perspectives on unsafe abortions:

Eight is Maji Maji village community members are waiting near the maternity wards, just before visiting time. They consist of a teenage girl, teenage boy, village government leader, parent, pastor, teacher, nurse and one community development worker. Then community area is Maji Maji village.

A 16 year old girl Bahati, gets rushed into the PAC emergency room and one unqualified worker says loudly *"watoto wetu hawachoki kuhatarisha maisha yao na utoaji wa mimba"*. "Our children never stop risking their lives by inducing abortion). The community group discusses the statement; each person has his/her own opinion.

Skit Guide

Teenage girl:	Shy in front of elders but is empathetic to the patient and understands the challenge.
Teenage boy:	Shy in front of elders. Feels it was the girl's responsibility to prevent pregnancy.
Village government leader:	Affirms the government's policy on no abortion and believes that the parents and teachers are not adhering to the policy and that the service provider should inform the police.
Parent:	Is empathetic but feels that the patient should have kept away from relationships. Feels that the teachers have not played their role and that by educating on FP have reduced the youth's morals. Also feels that the abortion was necessary to enable the patient continue with her education.
Pastor:	Asserts that the patient should not have indulged in sex, should not have had an abortion and that punishment is warranted for misbehaving. Emphasises that if a woman is pregnant, she has no right to take life.

Teacher:	Blames the parents for lack of guidance, though understands the difficulty of conducting family life education with adolescents. Feels the case of the girl should be kept a secret in case it should mislead the other students.
Nurse:	Feels overworked and not paid well. She feels somebody was paid to induce the abortion and therefore they should complete the job.
Community development worker:	Is empathetic and understands the cultural breakdown and challenges of modern life and pressures on youth.

Trainer information

1. Make 8 cards Manila or Newsprint pieces, each representing the above depicting mentioned above of paper with the nine community members ("Bahati Nasibu" Lottery type).
2. Request each participant to select one card/piece. Ask each trainee to play a role of the member depicted on his/her paper and prepare his/her reaction to Bahati's situation.
3. Ask trainees to take notes as listed in No. 4 below for presentation to the whole group as in No. 4 below.
4. Summarise:
   - Different attitudes expressed.
   - Similarities of opinion regarding teenage pregnancy and unsafe abortion or other opinion expressed.
5. Proceed with the usual steps of role-play in training (See Trainers Guide No. 6).

Community Profile Worksheet

Planning for Community Involvement

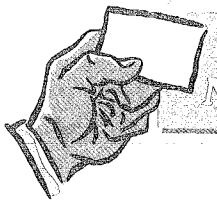
Instructions

Use this worksheet to describe the community served by the health facility where working.

NB: This handout helps elaborate the definition of "Community" in Handout No. 6.1)

Find out and have a written easy-to-refer-to record with: (Work with the staff dealing with EPI, Nutrition and other community workers to get the information you do not have.)

1. Name of community.
2. Names of local government officials.
3. Names of chiefs/elders.
4. Names of women's opinion leaders.
5. Names of men's opinion leaders.
6. Names of youth's opinion leaders.
7. Organisations that are important in the community (include names of leaders).
8. Is there a market place?
9. When are market days? How suitable are they for provider/community health education or meeting?
10. Types of religious groups.
11. Names of religious leaders.
12. Language(s) spoken.
13. Main sources of livelihood in the community.
14. What do community members feel about a woman who has had any abortion/miscarriage?
15. Where do women go for health care, including postabortion care?
16. How far it to the referral hospital.
17. How does the community handle emergency transport?
18. Are there other private midwives in your community? Who are they?
19. Are there traditional health workers with whom the Health Centre Staff can work with to solve health problems/support the PAC/RCH service?
20. Is there a functioning Village Health Committee or other groups that support health service?



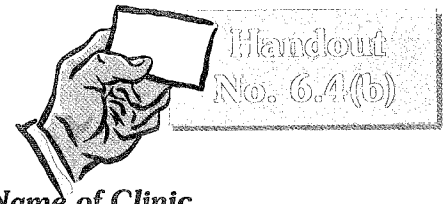
Handout No. 6.4(a)

Community Involvement Action Plan (Blank)

Name of Clinic _____ *Period* _____ *To* _____

Name of service provider _____

Intended Action "WHAT"	*What is to be Accomplished (Purpose or Goals) "WHY"*	*Steps to be Taken "HOW"*	*(Time when goal would have been achieved) "WHEN"*	*What shall be seen happening in the clinic, among the clients and community as a result of the Intended Action*	*Comments*



Community Involvement Action Plan (Sample)

Name of Clinic _____ ***Period*** _____ ***To*** _____

Name of service provider _____

Intended Action ***"WHAT"***	***What is to be Accomplished (Purpose or Goals)*** ***"WHY"***	***Steps to be Taken*** ***"HOW"***	***(Time when goal would have been achieved)*** ***"WHEN"***	***What shall see happening in the clinic, among the clients and community as a result of the Intended Action***	***Comments***
1. Attend regular monthly market meetings.	• To be visible in my community • To make women aware of my services.	• Meet with group leader to introduce myself and my services. • Find out venue and dates for meetings.	End of Oct. 2000		
2. Introduce myself to market vendors	• To be visible in my community • To make people aware of my services.	• Talk to market master to introduce myself and obtain permission to speak with vendors. • Go to market on market days. • Prepare handouts with name of my clinic and location.	End of Nov. 2000		

Intended Action *"WHAT"*	*What is to be Accomplished (Purpose or Goals)* *"WHY"*	*Steps to be Taken* *"HOW"*	*(Time when goal would have been achieved)* *"WHEN"*	*What shall see happening in the clinic, among the clients and community as a result of the Intended Action*	*Comments*
3. Give talk during local village about problem of unsafe abortion.	• To reduce incidence of unsafe abortion in my community. • To make people aware of my services	• Meet with village chief to help organise for talk. • Set venue and time • Make poster to put up in community to advertise my talk. • Prepare talk and visual aides	End of Feb. 2000		
4. Give talk to youth group on risks of unsafe abortion	• To reduce abortion among the youth • To make youth aware of my services	• Meet with group leader to help organize for talk. • Set venue and time. • Make poster and advertise talk • Prepare talk and visual aides	End of March 2000		

Planning the PAC/RH Mobilisation Activities

Using available data to prepare a community mobilisation session

Case Study:

Mr. Simbamwaka, the newly trained comprehensive PAC provider of Maji Maji Health Centre has heard the opinion of the visitors who saw the 16 year old Bahati admitted to the PAC room. He recognises that comprehensive PAC data includes information expressed by clients, their relatives and other community members.

He compiles the following information for the year 2000:

Population served by Maji Maji Health Centre:	50,000
Women aged 15 – 45 years:	20% of population (10,000)
20 – 29 year old clients referred for dilatation and curettage with incomplete abortion referred for evacuation every month:	250
Antenatal mothers served:	360
Teenage pregnancy in Maji Maji community among under 18 year olds:	9% of women served at Antenatal Clinics.
Some community opinion:	*(From Part I Situation with Bahati. Trainer provides trainees with the information gathered on "Community Perspectives" Handout 6.2).*

Mr. Simbamwaka met with Ms. Leo, RCH Coordinator in order to prepare the agenda and content of a session with the Chairman of the village first and then with all community leaders.

Instructions

1. Given the data above and your knowledge about comprehensive post abortion care:
   - 1.1 What important PAC related information do you derive from the data.
   - 1.2 Identify one or two messages based on the information in 1.1 above.
   - 1.3 Prepare purpose (objectives) of using the messages at the Village Chairman's meetings.
   - 1.4 Expected outcomes (2-3) only.
   - 1.5 What help would you ask from the Chairman based on your goal of mobilising the community with the help of community leaders?
2. Hold the session to help you and the Chairman achieve the above stated expected outcomes. Use available visual aids from RCHS, MOH or the training you are undergoing.

Mobilising the Community to contribute to Comprehensive PAC

Instructions

Use these short situations to simulate the mobilisation of the community through different ways:

Role-play No. 1: ***Talking about comprehensive PAC in the community***

- Talking to community elders about unsafe abortions and the availability of comprehensive PAC services.

Scenario

The comprehensive PAC trained service provider is attending a village meeting and is approached by a group of elders from her community. They tell her that they have heard that she is providing "abortion services" in her clinic. They want to find out if this is true, and who is coming to her clinic for this "service."

One participant will take on the role of the comprehensive PAC trained provider while the other participants will represent community elders.

Role Play No. 2: ***Talking to a women's group about unsafe abortion and the availability of comprehensive PAC services***

Scenario:

The comprehensive PAC trained provider has been asked by a local women's group to come to one of their meetings and give a health talk. They specifically want her to talk about the issue of teenage pregnancy, which has caused alarm in the community over the past few years. Utmost on their mind was the recent incident where by a 19 year old girl died from an unsafe abortion.

One participant will take on the role of comprehensive PAC trained provider while the other participants will represent members of a local women's group.

Role Play No. 3 ***Talking to a youth group about the prevention of unwanted pregnancy.***

Scenario:

The comprehensive PAC provider is a very active member of her religious group and is particularly involved in the youth group. She has agreed to act as a chaperon during the youth group's weekend retreat, and wants to use the opportunity to talk with them informally about pregnancy prevention and the dangers of unsafe abortions.

One participant will take on the role of the service provider while other members will represent members of a youth group.

How to hold successful meetings

NB: The content of this handout is also useful for Meetings on Advocacy of PAC Module 2

Meetings are quite costly in both money and time. If a meeting is to take place, it should be both necessary and effective, or it should not be held at all. Here are some tips and techniques to make your meetings more productive.

10 tips for holding effective meetings:

1. Know where you're going
2. Have a set agenda
3. Limit attendance to manageable number
4. Stay focused on the subject at hand
5. Be prompt!
6. Have a deadline/end time
7. Schedule intelligently
8. Deliver
9. Everything else can wait!
10. Kill it (Finalise it).

1 Know where you're going

- What do you want to accomplish between the beginning and the end of the meeting?
- What is the purpose?
- You should always have a specific, clear objective or purpose and major outcome whenever you conduct or participate in meeting; come up with a plan of action, brainstorm a long-standing problem, educate, inform, etc.
- Whatever it is you want and need to accomplish, make sure you and everyone in the meeting, are clear on why you are getting together.

2 Have a set agenda

- Having an agenda demonstrates to participants the thoughtful planning that you have done.
- Put together a simple outline before everyone arrives, and stick to it.
- List all the topics you need to discuss and the amount of time you will spend discussing each issue.

3 *Limit attendance*

- Meetings get less productive when there are many people present.
- So be selective or guide your host (e.g. community leader, peers, supervisor, programme manager) about choosing who will attend.
- Also, ask yourself if it's really necessary for everyone to stay through the entire session.
- If not, have and arrange for part-time participants who can come and leave without staying for the whole meeting.

4 *Stay focused on the subject at hand*

- Control the direction of the meeting and keep everyone focused on the agenda. Use feedback or facilitation skills (See Handout No. 2.1 on Feed-back Rules).

5 *Be prompt!*

- If a meeting is scheduled to begin at 8 a.m., start at 8 sharp, not at 8:05 or 8:10 a.m. Be punctual and begin every meeting on time, every time.
- If there will be possible delay, agree with person(s) to be met with, state how long the delay might be.
- When people, even village community know that your meetings start promptly, they will arrive on time more often.

6 *Have a deadline/end time*

- Meetings should not only begin at a precise time, but end on time, too.
- Time limits create a sense of urgency, and meeting participants will usually react by concentrating on the issues at hand, avoiding idle chatter, etc.
- Deadlines will encourage the attendees to be more efficient and effective, especially as the end of the meeting approaches.
- So at beginning of meeting discuss or modify the duration of meetings.

7 Schedule intelligently	• The best times for meetings are at 11 a.m. and 4 p.m. People are more likely to focus on the subject at hand before lunch or before office closing time. However, try to avoid scheduling meetings right after lunch. Most people experience an energy dip right after a meal, and the larger the meal, the less their ability to pay attention and participate. • Schedule meeting to match availability of the community members in case mornings interfere with other activities. • Also, the best time to schedule a future meeting is at the end of one. • Set a time and place to meet again while everyone is together. Rather than making phone calls and sending letters announcing an upcoming meeting.
8 Deliver	• There is a correlation between comfort and the length of conversations, and standing up is less comfortable than being seated. • Assure the audience is comfortable. • Be concise and to the point. • Encourage participation by all/many. • Summarise, paraphrase or clarify points. • Ensure decisions made are agreed upon, during the meeting.
9 Everything else can wait!	• Never, ever permit an interruption during a meeting unless there is an emergency. • Agree at beginning of meeting how to address emergencies should they occur.
10 Kill it	• Is your next meeting really necessary? • The meeting that appears to be essential on Monday sometimes loses its urgency by Thursday. • If the need for a meeting does not seem as great as it did when you originally planned it, please do everyone a favour. Cancel it! • Remember, no one likes meetings, and they will not be angry with you for calling it off. • Suggest or agree on day and date if you anticipate the need for another meeting.

Source/Adapted from: *Dave Wiggins, Human Resources Consultant, Lakewood Colorado USA*

Source: www.cedmagazine.com/pm/97wn/97wna.htm

Example of targeting PAC message to community members

Mobilising the community for Contributions to PAC Service Quality

Instruction

Use this handout as reference during role-plays and in relation to your worksite activities.

PAC Message	Target			
	Women of reproductive age (including adolescents)	Family members (husbands, mother and mother-in-law)	Community and religious leaders, policy makers, parliamentarians, women's groups and other influential people	Health care providers
Availability of modern family planning methods. Any campaign to reduce the impact of unsafe abortion should include information about: - What effective family planning methods, including emergency contraception, are locally available; - Where and how they can be obtained; - How they work; - How to use them correctly; - The relative risks of childbearing, contraceptive use and unsafe abortion. Also it is important to address common myths about the side effects of modern methods and to raise awareness about the relative ineffectiveness of traditional method of family planning.				

PAC Message	Target			
The symptoms of abortion complications. All community members, including traditional health care providers, should be trained to recognise the symptoms of complications from either spontaneous or induced abortions, and know when and where to seek medical care.				
Dangers and in-effectiveness of traditional abortion methods. Women and their families should fully understand the health risks associated with traditional abortion methods and unskilled practitioners in order to help prevent unsafe abortions and ensure that complications are treated promptly.	Women of reproductive age (including adolescents)	Family members (husbands, mother and mother-in-law)	Community and religious leaders, policy makers, parliamentarians, women's groups and other influential people	Health care providers
Reasons for delaying medical treatment when experiencing complications of induced abortions. Those who experience complications of induced abortion often delay or do not seek, medical treatment due to various reasons e.g.: - Fear or being reported to the police by the clinic or hospital staff, - Fear of harsh treatment and exposure by nurses, - Fear of reactions by parents, friends and community members. These are the primary reasons for avoiding medical attention.				

Roles of the CHMTs in mobilising the community

Roles of the CHMTs

- Identify individuals in the community who can actively participate in your programs, and develop a clear set of activities that these community members can undertake to actively support and sustain comprehensive PAC.
- Motivate and sustain community participation in comprehensive PAC:
  - Create bridges to the community by organising people to promote comprehensive PAC services. This can be developed and established with some of the following types of organisations:
    - Local NGOs: CHMT develop a mechanism for collaborating with other local NGOs to mobilise community members concerned with comprehensive PAC. These community organisations can carry out a variety of activities that will promote and educate members of the community about comprehensive PAC.
    - CBOs: CHMTs encourage service providers at facilities to collaborate with CBOs that provide services in areas such as literacy, education, agricultural extension and water and sanitation systems. Comprehensive PAC and FP education can be incorporated into the activities of these organisations.
    - Local governmental organisations: CHMTs can collaborate with other local governmental organisations, e.g. schools. By sharing information and resources, including government officials in local program planning, and looking for ways to promote understanding, danger signs and life-threatening complications of comprehensive PAC and how to prevent unwanted pregnancies.
    - Clubs: CHMTs develop a mechanism for collaborating with existing clubs for mothers, e.g., Mothers' Unions, youth and men clubs. These clubs can address the special needs, issues and problems that club members are likely to face when encountered with abortion complications. Clubs can promote greater awareness of the benefits of FP in preventing unwanted pregnancy, link members to RH, other medical and social services and inspire recognition and identify PAC complications and make timely decision and referral to an outlet where quality comprehensive PAC services are available.

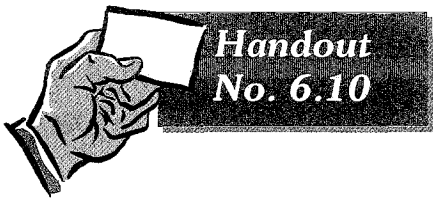
Orientation of CHMTs

- On return from training the service provider:
  - Gives feedback to the supervisor about the training and its benefits to the health facility and the community.
  - Shares and takes the supervisor though the back-home application plan.
  - Solicits the supervisor's support for implementation of the new skill including equipment and supplies.

- In consultation with the supervisor ascertains if it is necessary to orient the CHMT. If necessary requests the superiors to arrange a meeting to orient the CHMT on comprehensive PAC.
- Orients other service providers during continuing education meetings.

Preparation for the CHMTs orientation

- Decide on the agenda:
  - Objective of the meeting.
  - Expected outcome.
  - Presentation of the content.
- Create an agenda:
  - Date.
  - Time.
  - Place/venue.
  - Objective of the meeting.
  - Expected outcome.
  - Topics to be presented and presenters.
- Present the concept of comprehensive PAC, its advantages including reduction of opportunity cost to the facility and the community.



Male involvement in comprehensive PAC services

Male Leaders Participate in Mrs. Mdzomba's comprehensive PAC programme

Mrs. Mdzomba had just returned from a special meeting with other regional nurse supervisors. The meeting had included a study tour to two successful comprehensive PAC services that were operating in the north-east region of the country. Mrs. Mdzomba had been surprised that providers' service were actively working with the community members to promote the goals of comprehensive PAC. She had spent a morning talking to the manager of a local food processing factory who had been recruited by an outreach nurse of the local health centre to organise weekly talks about comprehensive PAC and other RH issues during lunch breaks. The clinic director was very excited about this new initiative because six months after this service had began, staff at the local clinic were able to clearly document that the number of clients discharged on FP increased two-fold, and the number of clients continuing use of contraception after comprehensive PAC at the FP/MCH clinic had risen. Building on the success of this experience, the clinic manager had made plans to recruit a number of influential community leaders to conduct similar activities in her area.

After returning from her trip, Mrs. Mdzomba wondered whether involvement of local male leaders in her programme might help her meet comprehensive PAC service goals and objectives. By using male volunteers, she could solve one of her major service problems—insufficient resources to recruit, hire and train new personnel for IEC activities. In Mrs. Mdzomba's area, awareness of access to comprehensive PAC services was lower than in many other regions in the country. In fact, the results of a recent study showed that among men in the area, knowledge of comprehensive PAC services was below 50%. Women, on the other hand, were considerably more knowledgeable about comprehensive PAC and FP methods for averting unwanted pregnancies. The results of the study revealed further that men in the community preferred talking with other men about RH issues. Mrs. Mdzomba believed that if males in the community were more aware of the benefits of comprehensive PAC services, they would be more likely to support their partners' during an emergency and on use of FP. In addition, increased understanding of comprehensive PAC services among men might lead to better RH practices and prevention of STIs—a real problem in her community. She recalled that several months earlier, there had been a major public health and sanitation initiative and that the male leaders had done an excellent job in organising men in the community to work on this project. She wondered, "Could she organise these male leaders to help support her comprehensive PAC services and to promote a micro-insurance scheme for emergency transportation within the community?"

Mrs. Mdzomba decided to try. Her first step in organising the male leaders was to invite eight prominent men from the community to a meeting with two of her comprehensive PAC trained service providers. During the first meeting, she focused the discussion on the benefits to the facility and to the community that the participation of these men might bring. This discussion generated considerable interest among the male leaders. In a second meeting, with Mrs. Mdzomba's help, the group looked at the objectives of comprehensive

PAC and then developed objectives for their own participation. For example, one objective was to improve timely access of comprehensive PAC services. Based on this objective, the group developed their own community participation objectives:

- To increase knowledge of comprehensive PAC, including STIs among males.
- To reduce the time taken by clients to access comprehensive PAC services.
- To increase contraceptive use among men, women and adolescents.

In subsequent meetings, the group developed a plan to involve other men in the community. Some members were assigned the task of preparing a plan detailing the activities and training that the men would undertake to achieve the objectives which had been set. There was a lot of discussion about the role of the male leaders and their potential activities in the area of comprehensive PAC. Some thought that the male leaders should be trained to recognise and refer PAC clients. As a step in preparing the plan of activities and training, the group generated a list of the possible activities that the male leaders might undertake.

Case discussion questions

1. How might community participation benefit the community?
2. How might the involvement of the community benefit the comprehensive PAC service at the facility?
3. What activities do you think the male leaders in this case could be trained to do?

Module 8

Evaluating and Closing the Training

Trainee's end of Course Evaluation Form

COMPREHENSIVE PAC CLINICAL SKILLS TRAINING

Training Dates:

From ..... 200..... ***To*** ..... 200.....

- The purpose of the Information you will fill on this Form is to help trainers receive your feelings about the strengths and limitations of the training you have just completed. This improves future training.
- Please respond to all statement on the form.
- Circle the number that best represents your response.
- You may or may not write your name at the end of this Form.

Evaluation Questions:

1. The training objectives were clear and were achieved:

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

2. The knowledge and skills addressed by the training were adequate for me to perform PAC activities.

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

3. The length of the training was adequate.

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

4. This training addressed some real PAC/Reproductive Health service related problems that I experience at my work-site:

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

5. Logistics for the training including travel, accommodation and classroom were satisfactory:

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

6. The trainers including practicum site staff have helped me acquire PAC/RH knowledge and skills I can apply at my work-site:

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

7. The classroom and clinical practice sessions helped me link the ***knowledge, skills*** and ***attitudes*** required for servicing post-abortion and other clients seeking reproductive health services:

Agree	Somehow Agree	Disagree
2	1	0

- Please explain your view in brief;

.....

.....

.....

.....

.....

8. The skills in which I feel particularly strengthened or competent as a result of this training are: (List as many as possible, in your own words).

.....

.....

.....

.....

.....

.....

.....

.....

9. Before I leave this training, I want to say ONE or TWO THINGS

(a) .....

.....

.....

.....

.....

.....

.....

(b) .....

.....

.....

.....

.....

Name (Optional) .....

Thank you for the feedback and time taken to give it

Date: _____

Ministry Of Health

Reproductive And Child Health Section
Daily Evaluation Form

From the day's activities and presentations:

1. Which things/topics did you like most?

   .....

   .....

   .....

2. Which did you like least?

   .....

   .....

   .....

   Give reasons:

   .....

   .....

   .....

3. Which areas do you feel need improvement?

   .....

   .....

   .....

   Give your suggestions:

   .....

   .....

   .....

4. Which ones do you find are most important for application in your PAC service provision?

   .....

   .....

Section 4b

(Monitoring and Evaluation of Training)

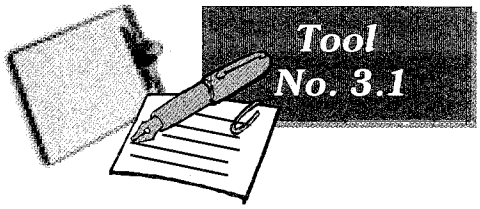
Information

1. For Monitoring Skills acquisition, where there are no tools/checklists:
   - Use the FP Procedural Steps or SM Standards relevant to skills being taught.
2. Use the checklist for trainee self-learning, monitoring skills acquisition and end of training assessment.
3. The tools are both handouts and assessment tools.

Trainee's Note

Module 3

Providing Emergency Post-Abortion Care



Checklist for Comprehensive Postabortion Care Clinical Skills Acquisition, Monitoring and Assessment

Instructions:

- Trainer and Trainee use this tool during and at the end of training.
- Rating scale guides trainer and trainee regarding learning progress and planning to ensure learning takes place.
- Total scoring is done at the end of the training.
- 100% is cut off because the steps are all critical for safe client care. (For Tasks A - E only).

Rate the performance of each task using rating scale below:

1	***Needs Improvement***:	Step or tasks performed incorrectly or out of sequence or completely omitted.
2	***Competently Performed:***	Step or task performed correctly in proper sequence, but participant does not progress from step to step efficiently.
3	***Proficiently Performed:***	Step or task efficiently and precisely performed in the proper sequence

	TASK/ACTIVITY	3	2	1	N/A	Comment
A.	**PERFORMING INITIAL ASSESSMENT**					
1.	***Assess patient for shock (vital signs)***					
	• BP					
	• Pulse					
	• Pallor					
2.	***Assess for other life threatening conditions***					
	• Severe vaginal bleeding					
	• Abnormal vaginal discharge					
	• Level of consciousness					
3.	***Take appropriate resuscitative actions for identified complications***					
	3.1 Establish and maintain clear airways					
	3.2 Establish IV line using a cannula and infuse with isotonic solution					
	3.3 Obtain blood for grouping and cross match					
	3.4 Perform digital evacuation when appropriate					
	3.5 Administer oxytocin to control severe vaginal bleeding					
	3.6 Administer pain relief medication					
	3.7 Initiate IV Broad spectrum antibiotics in case of sepsis					

Total score = ***39 Points***

Score attained = ...

Cut off Points = ***39 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
B.	**CONDUCTING MEDICAL EVALUATION**					
1.	Take history of the presenting illness including the reproductive health history using client care:					
	1.1. Age					
	1.2. Parity					
	1.3. Gravidity					
	1.4. Date of LNMP					
	1.5. Description of presenting problem					
	1.6. History of bleeding					
	1.7. Passage of clots or products of conception					
	1.8. History of fainting attacks					
	1.9. History of fever, chills					
	1.10. History of prior instrumentation					
	1.11. Prior treatment given					
	1.12. Previous contraceptive method(s)					
	1.13. Relevant past medical history including;					
	1.13.1. STDs					
	1.13.2. Bleeding disorders					
	1.14. History of known;					
	1.14.1. Allergies and					
	1.14.2. Current medications					
	1.15. Tetanus vaccination status/possible exposure					
	1.16. History and duration of;					
	1.16.1. Abdominal/pelvic pain,					
	1.16.2. Cramps and					
	1.16.3. Referred pain					

Total score = ***54 Points***

Score attained = ...

Cut off Points = ***54 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
B.	**CONDUCTING MEDICAL EVALUATION (cont.)**					
2.	Performing general physical and pelvic examinations:					
	2.1. Inspect for;					
	2.1.1. Appearance					
	2.1.2. Nutritional Status					
	2.1.3. Pallor					
	2.1.4. Cyanosis					
	2.1.5. Jaundice					
	2.2. Conduct systemic examination					
	2.3. Examine the cardiovascular system					
	2.4. Examine the respiratory system					
	2.5. Examine the abdomen and note any;					
	2.5.1. Distension					
	2.5.2. Tenderness					
	2.5.3. Masses					
	2.5.4. Bowel sounds					

Total score = ***36 Points***

Score attained = ...

Cut off Points = ***36 Points (100%)***

3.	Maintaining infection prevention before, during and after all procedures:					
	3.1. Wash hands					
	3.2. Ensure instruments are HLD					
	3.3. Cleaning with antiseptic					
	3.4. Wearing gloves					
	3.5. Wearing protection materials (barriers)					
	3.6. Ensure safe disposal of waste					

Total score = ***18 Points***

Score attained = ...

Cut off Points = ***18 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
B.	**CONDUCTING MEDICAL EVALUATION (cont.)**					
4.	Conducting a pelvic examination:					
	4.1. Ensure client empties her bladder					
	4.2. Position woman for pelvic examination					
	4.3. Inspect vulva/perineum for bleeding and or abnormal discharge					
	4.4. Insert bivalve speculum into the vagina correctly and open it					
	4.5. Inspect vagina and cervix for;					
	4.5.1 Lacerations, products of conception and foreign bodies					
	4.5.2 Abnormal discharge					
	4.6 Perform bimanual digital examination and determine					
	4.6.1. Extent of cervical dilatation, uterine position and;					
	4.6.2. Size and tenderness					
	4.7. Feel adnexae and fornices for:					
	4.7.1. Tenderness					
	4.7.2. Masses					
	4.8. Check for cervical excitation tenderness					

Total score = ***18 Points***

Score attained = ...

Cut off Points = ***18 Points (100%)***

5.	Performing appropriate investigations (Specify):					
6.	Explaining to the client what is the problem is and the treatment plan					
7.	Ensures client understands her problem and treatment plan					

Total score = ***6 Points***

Score attained = ...

Cut off Points = ***6 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
C.	**PREPARING FOR MVA PROCEDURE**					
1.	Explain the MVA procedure to the client at the beginning and at relevant intervals:					
	2.1. Assess patient's need for pain relief and;					
	2.2. Give appropriate medication after inquiring about allergies to antiseptics and analgesic					
3.	Ensures required sterile or high level disinfected instruments are present					
4.	Ensures that all required instruments for MVA procedure are in good functioning condition					
5.	5.1. Check syringe for vacuum tightness					
	5.2. Charge syringe before the MVA procedure					

Total score = ***18 Points***

Score attained = ...

Cut off Points = ***18 Points (100%)***

D.	**PERFORMING MVA PROCEDURE**					
1.	Positions patient in lithotomy position					
2.	Cleans vulva and perineum with antiseptic					
3.	Drapes patient with sterile towels					
4.	Performs bimanual pelvic examination to ascertain;					
	4.1. Size					
	4.2. Position of uterus					
	4.3. Extent of cervical dilatation					
5.	Inserts bivalve speculum into the vagina and removes blood or tissue from the vagina and cervical os using sponge holding forceps					
6.	Cleans vagina and cervix with antiseptic two times using gauze or cotton swabs					
7.	Holds the anterior lip of the cervix using a single toothed tenaculum at position 12 o'clock					
8.	Selects appropriate cannula according to assessment of uterine size					
9.	Selects appropriate syringe and adapter					
10.	Gently applies traction on cervix to straighten/align the cervical canal and uterine cavity.					
11.	Dilates cervix using progressively large cannulae if necessary.					

	TASK/ACTIVITY	3	2	1	N/A	Comment
D.	**PERFORMING MVA PROCEDURE (cont.)**					
12.	12.1. Pushes the cannula slowly into the uterine cavity while holding the cervix steady until it touches the fundus					
	12.2. Notes the uterine depth by the dots visible on the cannula					
	12.3. Withdraws the cannula slightly					
13.	Attaches the prepared syringe to the cannula by holding the end of the cannula in one hand and the syringe in the other					
14.	Releases the pinch valve(s) on the syringe to transfer the vacuum through the cannula to the uterine cavity.					
15.	Evacuates the contents of the uterus by moving the cannula gently and slowly back and forth within the uterine cavity rotating the syringe as he/she does so.					
16.	Checks for signs of completion of the evacuation;					
	16.1. Red or pink foam					
	16.2. No more tissue in cannula					
	16.3. Gritty sensation					
	16.4. Uterus grips cannula					
17.	17.1. Close the pinch valves on the syringe					
	17.2. Detaches syringe from the cannula					
	17.3. Release the valves on syringe					
	17.4. Push the plunger to empty contents in a kidney dish.					
18.	18.1. Inspects for bleeding for cervix					
	18.2. Removes the cannula, tenaculum and speculum in that sequence					
19.	Inspects the tissue removed from the uterus for;					
	19.1. Quantity					
	19.2. Presence of POC to assure complete evacuation					
	19.3. Checks for molar pregnancy					
20.	Reassesses situation to be sure it is not an ectopic pregnancy If no POC are seen,. AND					
	REFERS URGENTLY					

Total score = ***99 Points***

Score attained = ...

Cut off Points = ***99 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
E.	**MANAGING PROBLEMS DURING MVA PROCEDURE**					
1.	Loss of vacuum due to full syringe;					
	1.1. Closes valves					
	1.1.1. Disconnects syringe from the cannula					
	1.1.2. Empties the contents of the syringe into a kidney dish					
	1.2. Recharges syringe					
	1.2.1. Reattaches it to the cannula					
	1.2.3. Releases the pinch valve to resume aspiration					

Total score = ***18 Points***

Score attained = ...

Cut off Points = ***18 Points (100%)***

2.	If the aperture of the cannula is withdrawn beyond the cervical so, the vacuum is lost;					
	2.1. Removes the cannula taking care not to contaminate it through contact with the vaginal wall or other non-sterile surfaces.					
	2.2. Closes the pinch valve of the syringe;					
	2.3.1. Detaches the syringe from the cannula					
	2.3.2. Empties the syringe					
	2.3.4. Recharges the syringe					
	2.4. Reinserts the cannula if it has not been contaminated or inserts another sterile cannula if contamination has occurred;					
	2.5.1. Reattaches the syringe					
	2.5.2. Releases the pinch valve					
	2.5.3. Resumes aspiration					

Total score = ***27 Points***

Score attained = ...

Cut off Points = ***27 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
E.	**MANAGING PROBLEMS DURING MVA PROCEDURE (cont.)**					
3.	Cannula clogged with POC:					
	3.1. Removes the syringe and cannula, taking care not to contaminate the cannula through contact with vaginal wall or non sterile surface					
	3.2. Removes the material from the opening in the cannula using sterile forceps or sponge, without contaminating the cannula					
	3.3. Proceeds as in steps 2.2. – 2.5.					

Total score = ***9 Points***
Score attained = ...
Cut off Points = ***9 Points (100%)***

4.	Bleeding persists after MVA and uterus is still soft;					
	4.1. Repeats step 12 – 18 of the MVA procedure					

Total score = ***60 Points***
Score attained = ...
Cut off Points = ***60 Points (100%)***

	TASK/ACTIVITY	3	2	1	N/A	Comment
F.	**POST-MVA PROCEDURE ACTIVITIES**					
1.	Before removing gloves, disposes of waste materials in a leak proof container or plastic bag.					
2.	Places speculum and metal instruments in 0.5% chlorine solution for 10 minutes for decontamination.*					
3.	a) If reusing needle or syringe, fills syringe (with needle attached) with 0.5% chlorine solution and submerge in solution for 10 minutes for decontamination. OR					
	b) If disposing of needle and syringe, flushes needle and syringe with 0.5% chlorine solution three times, then places in puncture-proof container.					
4.	Attaches used cannula to MVA syringe and flushes both with 0.5% chlorine solution					
5.	Detaches cannula from syringe and soaks them in 0.5% chlorine solution for 10 minutes for decontamination.*					
6.	Empties POC into utility sink, latrine or container with tight fitting lid.					
7.	Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning inside out;					
	7.1 If disposing off gloves, places in leak proof container or plastic bag.* OR					

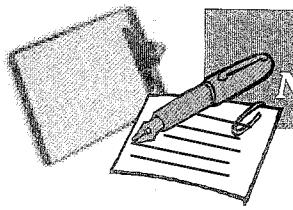
	TASK/ACTIVITY	3	2	1	N/A	Comment
F.	**POST-MVA ACTIVITIES (cont.)**					
	7.2 If reusing surgical gloves, submerges in 0.5% chlorine solution for 10 minutes for decontamination*					
8.	Washes hands thoroughly with soap and water and dries with clean, dry cloth or air dries.*					
9.	Allows the patient to rest comfortably for at least 30 minutes where her recovery can be monitored.*					
10.	Checks for bleeding at least once and ensures that cramping has decreased before discharge*					
11.	On discharge provides appropriate information concerning;					
	11.1 Normal recovery, and return to normal activities including sexual activity.					
	11.2 When pregnancy may occur after abortion*					
	11.3 Post evacuation medication if required					
	11.4 Signs and symptoms of complications*					
12.	Discusses reproductive goals and as appropriate, provides family planning counselling and method as appropriate.*					
13.	Based on non-verbal or verbal communication from the client*;					
	13.1 Counsels to assisting client cope with emotion issues, or other observed health problems OR					
	13.2 Makes an appointment with self or expert					
14.	Addresses other reproductive health problems if identify.					
15.	Tell her when to return if follow up is needed and that she can return anytime she has concerns.					

Total score = ***18 Points***

Score attained = ...

Cut off Points = ***85%***

(15 points including starred points)



Tool No. 3.2

Checklist on Comprehensive postabortion Care Counselling PAC Clients before MVA Procedure

Tasks/Activities	Yes	N/A	No	Comments
Pre-procedure				
1. Prepares room, space and materials.				
a. Materials:				
• STI and HIV/AIDS pamphlets or leaflets or posters.				
• Penile and female pelvic model, if available.				
• Condoms; male and female				
• Client card				
b. Space and seating:				
• To assure privacy (visual and auditory)				
• Seating for client and self.				
2. On arrival assesses a clinical situation for life threatening complications and whether counselling is appropriate at this time (if not, arrange for her to be counselled later).				
3. Uses appropriate introductory technique culturally acceptable greeting.				
4. Uses the following communication skills appropriately:				
a. Non-technical language.				
b. Smiles.				
c. Culturally acceptable eye contact.				
d. Listening actively, no interruption.				
e. Encourages e.g. aha, go on, nods at client.				
f. Focusing the discussion.				
g. Responding to client's non-verbal communication.				
h. Paraphrasing.				
i. Summarising.				
j. Allowing client questions.				
k. Being open and non-judgmental.				

Tasks/Activities	Yes	N/A	No	Comments
5. Assures the client that information given will be confidential.				
6. Enquires from the client in a friendly tone:				
a. When the bleeding started.				
b. How bleeding started.				
c. Quantity of blood loss so far in terms of number of pads and tissue used, clots passed out.				
7. Sensitively with discretion asks:				
a. If something was done to start the bleeding.				
b. Was the pregnancy wanted or not.				
8. Finds out whether clots were passed out if they included any tissue.				
9. Enquires about pain and when it started, where she feels pain the most and how severe it is.				
10. After examination explains in a simple language the client's overall physical conditions and the findings.				
11. Explains to the client in simple language taking into account the client's condition and what will be done to the client to:				
a. Manage her condition.				
b. Possible side effects or complications.				
c. Female reproductive process and what is happening in her particular case.				
d. Available contraceptive methods. If she chooses IUD inform her that it will be fitted in the same sitting if no infection is found.				
12. If referral is necessary inform the client about the timing, nature of referral and where she is being referred.				

	Tasks/Activities	Yes	N/A	No	Comments
	During PAC Procedure Counselling				
1.	*Greets woman respectfully and with kindness using culturally acceptable appropriate introductory technique*				
2.	*Tells client what you are going to do and encourages her to ask questions.* *Tells client that she can ask for pain medication if the pain is not bearable.*				
3.	*Kindly reminds the client that all the findings will be kept in confidence.*				
4.	*Gently covers the client with a draw sheet to reduce her emotionally feeling naked.*				
5.	*Introduces all service providers in the evaluation or MVA room to the client and tells her what their role will be in serving her.*				
6.	*Informs the client politely that she is required to lie on her back on the operating table and finds out if she has energy to climb or if she needs assistance.*				
7.	*Shows client how to take slow deep breaths to minimise the pain. Asks client to breath slowly in through her nose and out through her mouth to help her relax as she will focus more on her breathing and less on the pain.*				
8.	*Assesses need for pain management medication.*				
9.	*Explains each step of the procedure before it is performed.*				
10.	*Waits a few seconds after performing each step to enable the client prepare for the next step.*				
11.	*Avoids saying things like "this will not hurt", when it will hurt or "I am almost done" when you are not.*				
12.	*Moves slowly, without jerky or quick motions.*				
13.	*Uses instruments with confidence and avoids noisy, loud locking metallic instruments, knocking metallic surgical instruments among other metals.*				
14.	*Talks with the client throughout the procedure emphatically.*				
15.	*Informs the client of the findings when the procedure is over.*				
16.	*Kindly finds out from her if she is able with support to walk to the resting area or informs her that the problem is over and she is safe but for her comfort she has to be taken to the bed in the resting area on a trolley.*				

Tasks/Activities	Yes	N/A	No	Comments
Post MVA Counselling Skills				
1. ***Prepares room, space and materials.***				
a. Materials:				
◦ STI and HIV/AIDS pamphlets.				
◦ FP, RH, STI counselling flip charts.				
◦ FP methods samples.				
◦ Penile and female pelvic model, if available.				
◦ Client cards.				
b. Space and seating:				
◦ To ensure privacy (visual and auditory).				
◦ Seating for client and self.				
2. ***Approaches the client when she is already calm and recovering from procedure.***				
3. ***Takes care of the client's physical and emotional condition by considering if the client is strong enough to get up and walk to the separate room or prefers to stay in bed and have counselling.***				
4. ***Uses appropriate introductory technique culturally acceptable greeting.***				
5. ***Uses the following communication skills appropriately:***				
a. Non-technical language.				
b. Smiles.				
c. Culturally acceptable eye contact.				
d. Listening actively, no interruption.				
e. Encouragers e.g. aha, go on, nods at client.				
f. Focusing the discussion.				
g. Responding to client's non-verbal communication.				
h. Paraphrasing.				
i. Summarising.				
j. Allowing client questions.				
k. Being open and non-judgmental.				
6. ***Requests the client if she could discuss her future fertility and reproductive health intentions***				
7. ***Asks the client if she would like others who accompanied her to the service site to be included in the discussion.***				

	Tasks/Activities	Yes	N/A	No	Comments
8.	***Explores the client's feelings, questions and concerns after the post MVA procedure.***				
9.	***Explores the client's post procedure plans.***				
10.	***Determines client needs and understanding of FP, STI/HIV/AIDS and other related RH issues.***				
11.	***Asks what the client already knows or wishes to know about FP, STI/HIV/AIDS and other related RH issues.***				
12.	***Asks if client was using contraception before she became pregnant, if she was, finds out if she:*** ◦ Used the method correctly. ◦ Discontinued use. ◦ Had any trouble using the method. ◦ Has any concerns about the method.				
13.	***Provides general information about family planning.***				
14.	***Explores any attitudes or religious beliefs that either favour or rule out specific methods.***				
15.	***Gives the woman information about contraceptive choices available and the benefits and limitations of each method:*** ◦ Shows where and how each method is used. ◦ Explains how the method works and its effectiveness. ◦ Explains possible side effects and other health problems. ◦ Explains the common side effects.				
16.	***Discusses the client's need, concerns and fears in a thorough, emphatic manner.***				
17.	***Asks what the client already knows or wishes to know about STI/HIV/AIDS.***				
18.	***Asks client what signs or symptoms or situations show possibility of being at STI/HIV risk.***				
19.	***Provides the client with information on:***				
	a. STI/HIV/AIDS risk factors which are:				
	◦ Multiple sexual partners.				
	◦ Client's marital status.				
	◦ Client's occupation.				
	◦ Unprotected sex including rape.				
	◦ Sharing injection needles.				

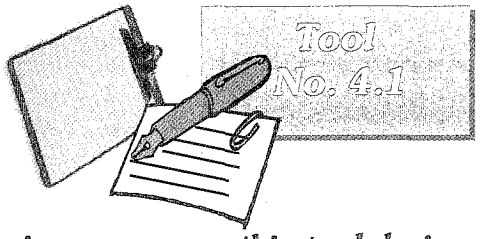
Tasks/Activities	Yes	N/A	No	Comments
• Frequent change of partners.				
• Sexual orientation (anal, homosexuality, oral and lesbianism)				
• Male or female has frequent bouts of STI (abnormal genital discharge, genital ulcers).				
b. HIV risk factors:				
• Genital ulcers (STI) in male or female.				
c. Reinforces right information and tactfully corrects client's misinformation				
20. *Provides STI/HIV/AIDS information related to comprehensive PAC/RH client needs and in build on manner:*				
a. Consequences of STI:				
• PID.				
• Infertility.				
• Mother to child transmission (MCT):				
❖ HIV				
❖ Gonorrhoea				
❖ Syphilis				
• Cancer of cervix (human papilloma virus)				
b. HIV transmission and progression increased in presence of STIs.				
c. STI/HIV preventive measures are the same.				
d. HIV can be transmitted even when symptoms are not evident.				
e. If adolescent, immature birth canal more prone to STI infection than in adult women.				
a. For immediate comprehensive PAC client is prone to STI/HIV infection due to:				
❖ Raw tissues e.g. uterine lining, cervix, vulva/vagina.				
❖ Having become pregnant (practiced unprotected sex).				
g. Explains that only condoms, not other FP methods prevent transmission of STI/HIV.				
h. Demonstrates us of condom:				
❖ Male.				
❖ Female.				

Tasks/Activities	Yes	N/A	No	Comments
i. Assists client to correctly return demonstration of condom use: ❖ Male. ❖ Female.				
j. Elicits/confirms client's understanding of preventing STI/HIV infection : ❖ Abstaining from sex. ❖ Being mutually faithful to a partner who has no other sexual partner. ❖ Health sexual styles. ❖ Consistent and correct use of condoms even when using another FP method. ❖ Correct use of medicines to prevent drug resistance.				
21. *Helping client make a decision or plan to prevent STI/HIV/AIDS:*				
a. Asks client how she would prevent or her plans to prevent STI/HIV/AIDS.				
b. Asks reason for the decision or plans shared.				
c. Helps client to make an appropriate decision if necessary.				
22. *Helping client choose an appropriate FP method, RH including STI/HIV/AIDS, social or other services.*				
23. *Provides the post comprehensive PAC, FP, RH including STI/HIV/AIDS, social or other services based on the client's decision and education level, provides leaflets/pamphlets and reviews them with her.*				
24. *Schedules a return visit.* ***AND / OR*** ***Refers client to other special RH facility including STI/HIV/AIDS, social or other services explaining why, where and to whom if possible.***				
25. *Helps client with whatever she needs as appropriate before saying good bye.*				
26. *Records relevant information.*				

Module 4

Providing Comprehensive Postabortion Support, Family Planning and other Reproductive Health Services

4.1.3 (a) Counselling Comprehensive PAC Clients on STD/HIV/AIDS



Checklist for Assessing Comprehensive PAC Provider's Counselling Skills in STD/HIV/AIDS Prevention

Trainees may use this tool during extra-curricular activities and share learning during the "where are we?" review sessions. The two week training is not adequate to acquire counselling skills.

	TASK/ACTIVITY	Always 2	Sometimes 1	Never 0	Comment
1.	***Preparing for the STD/HIV/AIDS Counselling Session***				
	1.1 Prepares room, space and materials; a. Materials				
	• STD and HIV/AIDS pamphlets or leaflets or posters				
	• Penile and female pelvic model, if available				
	• Condoms; male* and female				
	• Client card*				
	b. Space and seating				
	• To assure privacy (visual and auditory)*				
	• Seating for client and self.				

Total score = ***6 Points***

Score attained = ...

Cut off Points = ***85%***

(5 points including starred points)

	TASK ACTIVITY	Always 2	Sometimes 1	Never 0	Comment
2.	**Establishing and maintaining client/provider interaction.**				
	2.1 Uses appropriate introductory techniques;				
	a. Culturally acceptable greeting				
	b. Makes remarks that helps client to relax				
	2.2 Uses the following communication skills appropriately: a. Non-technical language*				
	b. Smiles*				
	c. Culturally acceptable eye contact				
	d. Listening actively, no interruption*				
	e. Encouragers e.g. aha, go on, nods at client, relaxed*				
	f. Focuses the discussion				
	g. Responds to client's non-verbal communication*				
	h. Paraphrases				
	i. Summarises*				
	j. Allows client to ask questions*				
	k. Is open and non-judgmental*				
	2.3 Uses visual aids interactively. ***NB: Skills in 2.2 and 2.3 should be assessed throughout the entire session***				

Total score = 13 Points

Score attained = ...

Cut off Points = 85% (5 points including starred points)

3.	***Determining client's needs and understanding of STD/HIV/AIDS***				
	3.1 Confirms client's readiness for STD/HIV/AIDS counselling sessions, IF THE COUNSELLING IS UNSOLICITED:				
	A) Post MVA PAC Client and other RH clients				
	• Comfort*				
	• General well being*				
	• Willingness for the discussion*				

	TASK/ACTIVITY	Always 2	Sometimes 1	Never 0	Comment
3.	***Determining client's needs and understanding of STD/HIV/AIDS (cont.)***				
	B) If NOT ready:				
	• Makes/offers appointment for STD/HIV/AIDS counselling session*				
	• Provides STD/HIV/AIDS visuals,				
	• Briefly explains important points.				
	C) IF READY: • Asks what the client already knows or wishes to know about STD/HIV/AIDS*				
	• Asks client about STD/HIV risk behaviour*				
	Provides client with information on risk situations/factors for STD/HIV/AIDS - Multiple sexual partners*				
	- Partner has multiple sexual partners*				
	- Client marital status				
	- Client occupation				
	- Unprotected sex* including rape				
	- Sharing injection needles*				
	- Unusual sexual practices (anal and oral) and orientation (homosexuality and lesbianism).				
	- Male or female has frequent bouts of STD:* ❖ Abnormal genital discharge				
	❖ Genital ulcers in male and female				
	3.2 Reinforces right information and tactfully corrects client's misinformation*				

Total score = 17 Points
Score attained = ...
Cut off Points = 14%
(85 points including starred points)

	TASK/ACTIVITY	Always 2	Sometimes 1	Never 0	Comment
4.	***Provides STD/HIV/AIDS information related to PAC/RH client needs:***				
	4.1 Consequences of STD:				
	• PID				
	• Infertility				
	• Mother-to-child transmission (MTCT)				
	- HIV*				
	- Gonorrhoea*				
	- Syphilis*				
	• Cancer of Cervix (Human Papilloma virus)*				
	4.2 HIV transmission and progression increased in presence of STIs.				
	4.3 STD and HIV preventive measures are the same.				
	4.4 HIV can be transmitted even when symptoms are not evident.*				
	4.5 If adolescent, immature birth-canal more prone to STD infection than in adult women.*				
	4.6 For Immediate PAC client*; • Client is prone to STD or HIV infection due to:				
	- Raw tissue (e.g. uterine lining, cervix, vulva/ vagina)				
	- Having become pregnant (practiced unprotected sex)				
	4.7 Explains that only condoms, not other family planning methods prevent transmission of STD/HIV.				
	4.8 Demonstrates use of condom one after other*; • Male • Female				

	TASK/ACTIVITY	Always 2	Sometimes 1	Never 0	Comment
4.	***Provides STD/HIV/AIDS information related to PAC/RH client needs (cont.)***				
	4.9 Assists client to correctly return demonstrations of condom use*: • Male • Female				
	4.10 Elicits/confirms client's understanding of STD/HIV infection prevention: • Abstaining from sex*				
	• Sticking to one faithful partner*				
	• Practicing safer sex				
	• Use condoms consistently and correctly even when using another family planning method. *				
	• Use medicines correccxtly to prevent drug resistance*.				

Total score = ***22 Points***

Score attained = ...

Cut off Points = ***19 Points***

(85 points including starred points)

5	***Helping client make decision or plan to prevent STD/HIV/AIDS***				
	5.1 Asks client how she would prevent or her plans to prevent STD/ HIV/AIDS.*				
	5.2 Asks reasons for the decision or plans shared.*				
	5.3 Helps client to make an appropriate decision, if necessary.*				

Total score = ***3 Points***

Score attained = ...

Cut off Points = ***3 Points (100%)***

	TASK/ACTIVITY	Always 2	Sometimes 1	Never 0	Comment
6.	***Providing the STD/ HIV/AIDS service or referring to special STD/HIV/AIDS service, inviting or scheduling a return client.***				
	6.1 Provides the service, based on client's decision and leaflets/pamphlets appropriate to her educational level				
	6.2 Invites for return visit				
	- Schedules a return visit				
	6.3 Refers client to special STd/HIV/AIDS service explaining why, where and to whom, if possible.				
	6.4 Thanks and bids client farewell				
	6.5 Records relevant information				

Total score = ***5 Points***

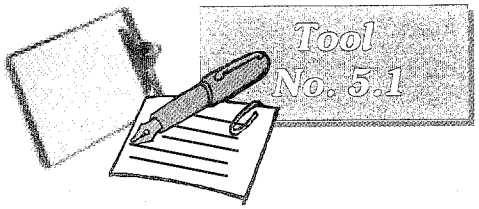
Score attained = ...

Cut off Points = ***5 Points (100%)***

NB: Where there is OR count only 1 point. Hence from 6.1. – 6.2 there is only 1 point.

Module 5

Organising the health facility for sustainable Comprehensive PAC/RH services



Checklist for PAC Provider Skills in Organising quality PAC services

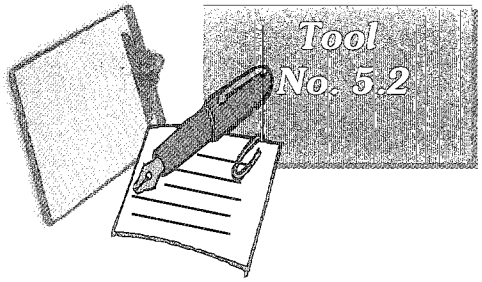
ACTIVITY	Yes 1	No 0	Comments
Offers integrated RH services.			
Ensures facility has space for: • Consultation/treatment • Sterilisation • Recovery			
Minimum equipment including: • Bivalve speculae (Cuscos); • Single or double toothed tenaculae; • Sponge holding forceps; • Buckets with covers for decontamination and high level disinfection; • Sterilizer/autoclave; • Kidney dishes and trays. • Couch for which stirrups could be fitted.			
Drugs, supplies and information, education and communication (IEC) materials			
Equipment and instruments that are functioning			
Ensures privacy for client			
At least two serviceable manual vacuum aspiration (MVA) kits			
Has a second qualified PAC provider within the facility and or at a near by facility for networking with while providing PAC services.			

ACTIVITY	Yes 1	No 0	Comments
Ensures infection control measures are observed.			
Maintains PAC/RH client and clinic records that support the national health information			
Periodically uses service data to evaluate and improve the PAC services provided.			

Total score = ***11 Points***

Score attained = ...

Cut off Points = ***100%***



Tool No. 5.2

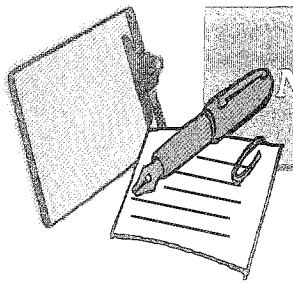
Checklist for Provider Skills in Infection Prevention and Control

ACTIVITY	Yes	No	Comments
Washes hands before and after every procedure.			
Uses protective devices e.g. aprons, gloves.			
Ensures safe waste disposal including that of sharps e.g. injection needles.			
Ensures availability of recommended antiseptics and disinfectants.			
Maintains good house keeping practices.			
Teaches clients and other health workers on infection prevention and control.			
Processes all instruments for re-use, using the following methods: ◦ Decontaminates soiled instruments by placing them in 0.5% chlorine solution for 10 minutes.			
◦ Cleans the instruments with soap and water.			
◦ Performs High Level Disinfection (HLD) by submerging instruments in 0.5% chlorine solution or CIDEX for 20 minutes.			
◦ Stores instruments in a dry and previously HLD airtight container.			
Using boiling: ◦ Decontaminates, cleans and rinses instruments.			
◦ Boils all metal instruments/equipment for 20 minutes from the boiling point.			
Using autoclaves: ◦ Decontaminates, cleans and rinses instruments.			
◦ Sterilises the instruments by autoclaving			

Total score = *14 Points*

Score attained = ...

Cut off Points = *100%*



Tool No. 5.3

Checklist for using Records to Improve AC Services

Documenting and Reporting Information on PAC Clients

	ACTIVITY	Yes 1	No 0	Comments
1.	Writes information regarding profile of clients according to the PAC client record.			
2.	Refers client if need arises:*			
	2.1. Ensures client/relative understands reason for referral and urgency if applicable.*			
	1.2. Written referral note includes; • Client Name* • Tentative diagnosis or actual problem* • Service provided* • Name and signature of provider*			
3.	Records feed back obtained from referral sites.			
4.	Treats client's records as confidential documents.*			
	4.1. Out of reach of lay persons			
	4.2. Shares information with client			
	4.3. Clients permission obtained if sharing is needed			
5.	Shares with other service providers necessary elements of care in the records for continuity of care in consultation with client or client's family*			
6.	Documents results of data analyses and interprets uses them for quality improvement.			
7.	Displays selected service data as feedback to peers, supervisor and community*			
8.	Ensures displayed data is current and understood through a variety of approaches;			
	8.1. Meetings at facility or community			
	8.2. Health education			
9.	Submits PAC reports to respective higher levels.			

Total score = ***16 Points***

Score attained = ...

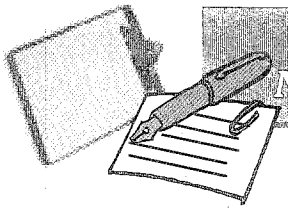
Cut off Points = ***14 Points***

(85% Including starred/critical skills.)

Trainee's Note

Module 6

Involving the Community for improving PAC Service Access and Quality



Tool No. 6.1

Checklist for carrying out Community Involvement Activities

	ACTIVITY	Yes 1	No 0	Comments
1.	Sensitizes the community on PAC service. *			
2.	Educates the community on how to recognize signs and symptoms of abortion complications and action to be taken.*			
3.	Identifies with the community factors contributing to maternal morbidity and mortality.*			
4.	Identifies community's and health facility's roles in reducing maternal morbidity and mortality.*			
5.	Helps the community to put into practice the agreed or roles.*			
6.	Identifies with the community ways of raising funds for payment of services received by clients who may not be financially okay.			

Total score = 6 Points

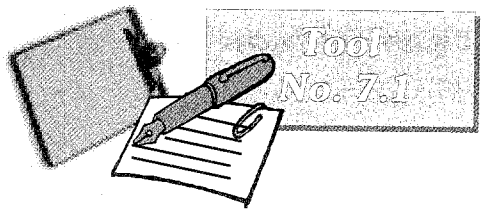
Score attained = ...

Cut off Points = 85%

Trainee's Note

Module 7

Practising PAC Clinical Skills



Checklist for Practising PAC Clinical Skills

Review Questions on PAC

Instructions for Trainers

Apply various approaches to get trainees to use these questions for reviewing:

- Grab-bag
- Review cards
- Competition/game on reviewing PAC knowledge

Trainees and trainers use references for responses. The scoring sheet for this is deliberately not provided.

Questions

1. ***Which of the following aspects must be taken into account when providing information on contraception to PAC clients?***

   a) Client's reproductive goal.

   b) Effectiveness of method.

   c) Client preference for a particular method.

   d) Availability of a wide range of contraceptive options.

   e) All of the above.

2. ***The term "informed choice" of a family planning method implies that:***

   a) The client has been informed about all family planning methods and agrees to use the contraceptive method the provider recommends.

   b) The client informs the provider about the methods she/he wants.

   c) The client chooses the method based on full information about the benefits and risks of all the family planning methods available.

   d) Provider takes time to educate and counsel family planning clients.

3. ***Which of the following are examples of non-verbal communication?***

   a) Stating instructions clearly.

   b) Looking directly at the patient.

   c) Using simple language.

   d) Making encouraging gestures.

4. ***If a woman comes for treatment of incomplete abortion and upon vaginal examination is found to have an infection, if she then requests to have an IUD inserted the service provider should:***

   a) Insert the IUD and give her an antibiotic.

   b) Not insert the IUD but wait for resolution of the infection (3 months) and suggest the use of another family planning method during those 3 months.

   c) Tell her to return for family planning after the next menstrual period.

   d) Counsel her for informed choice of a hormonal method with condom.

   e) Help her select another method such as long-term or COC depending on history findings and her choice.

5. ***Circle F for False and T for True***

   a) Abortion means illegal termination of pregnancy T/F.

   b) Confidentiality means you discuss the client's condition with another provider if he/she consents to having a third person T/F.

   c) A good counselor should be able to make good choices for the client based on analysis of the client's need T/F.

   d) Counselling is helping clients make an informed decision T/F.

6. ***The best way to provide Comprehensive postabortion family planning services is to:***

   a) Counsel, give a method and plan a follow–up.

   b) Give a method.

   c) Kindly tell the client to go to the nearest clinic for counselling and methods.

   d) Ask the client to come back for it after the next period.

7. ***What are some of the results for fostering an enabling environment where PAC services are provided?***

   a) The number of clients increases.

   b) Clients are satisfied.

   c) Providers get motivated in their work.

   d) Likely to win support from the community.

8. ***Types of support PAC providers may need from their managers and supervisors include:***

a) Longer holidays.

b) Equipment and supplies.

c) Performance feedback.

d) Supportive technical assistance.

9. ***In a health care setting, name 2 ways infection can spread from a client to a health care worker:***

a) Blood or body fluids splashing into eye, nose or mouth during procedure.

b) Shaking hands with an HIV client.

c) Blood from medical instruments getting into cut in skin.

d) Being stuck (pricked) by a needle with patient blood on it.

Clinical Aspects of PAC

10. ***Mention 5 important resuscitative measures in the management of a Comprehensive postabortion patient with a life threatening complication: State the life threatening complication and give responses related to it.***

Complication: _____

1. .....

2. .....

3. .....

4. .....

5. .....

11. ***What is the single best way to determine uterine size:***

a) Looking at the cervix.

b) Bimanual examination.

c) Checking the patient weight gain.

d) History of amenorrhea.

12. *Which is the best element to consider in the selection of the size of the cannula in the treatment of incomplete abortion.*

a) The age of the patient and LMP.

b) The position of uterus and the degree of cervical dilation.

c) Sign of infection and size of uterus.

d) Type of anesthesia used and the degree of dilatation.

e) The size of the uterus by bimanual examination and the degree of cervical dilation.

Attachements

BIODATA SUMMARY

S/N	Name	Designation	Qualification	PAC Services Provision	Facility	MVA Kits Availability	NGO / Private or Public	Urban / Rural

Key:

A.	Currently providing PAC services (MVA)	D.	Supervising FP services
B.	Currently providing PAC services (Pre & Post) Counselling Postabortion client.	E.	Educating client on RCHS services (Advocacy)
C.	Providing Counselling on FP method	F.	Involved in policy, guideline/administration issues
		G.	Others Specify

Individual Monitoring Tool

Name of Participant: ..... ***Hospital*** ..... ***Participant's performance (use tick P])***

Date	***S/No.***	***Name of Client***	***Procedure***			***Remarks***	***Trainers Signature***
			MVA	***Councelling Session***	***Processing Instruments***		

Trainer's Guide No. 17

Comprehensive PAC *Format for plan of action*

1. **NAME OF PAC PROVIDER:** _____
2. ***NAME OF CLINIC:*** _____
2. **DISTRICT / REGION:** _____
4. **DATE :** _____
5. ***PLACE OF TRAINING:*** _____

Objective	*Problem*	*Cause*	*Activity*	*Indicators*	*By Whom*	*By When*

Ministry Of Health

Reproductive and Child Health Section

Trainee's End Of Course Evaluation Form

Comprehensive PAC Clinical Skills Training

Training Dates:

From ..... 200 ..... ***To*** ..... 200 .....

- To purpose of the Information you will fill on this Form is to help trainers receive your feelings about the strengths and limitations of the training you have just completed. This improves future training.
- Please respond to all statement on the Form.
- Circle the number that best represents your response.
- You may or may not write your name at the end of this Form.

Evaluation Questions:

1. The training objectives were clear and were achieved:

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

.....

2. The knowledge and skills addressed by the training were adequate for me to perform PAC activities.

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

.....

3. The length of the training was adequate.

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

.....

4. This training addressed some real PAC/Reproductive Health service related problems that I experience at my work-site:

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

5. Logistics for the training including travel, accommodation and classroom were satisfactory:

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

.....

6. The trainers including practicum site staff have helped me acquire PAC/RH knowledge and skills I can apply at my work-site:

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

.....

7. The classroom and clinical practice sessions helped me link the knowledge, skills and attitudes required for servicing post-abortion and other clients seeking reproductive health services:

Agree	***Somehow Agree***	***Disagree***
2	1	0

- ***Please explain your view in brief;***

.....

.....

.....

.....

8. The skills in which I feel particularly strengthened or competent as a result of this training are: (List as many as possible, in your own words).

.....

.....

.....

.....

.....

.....

.....

9. Before I leave this training, I want to say ONE or TWO THINGS

(a) .....

.....

.....

.....

.....

.....

.....

(b) .....

.....

.....

.....

.....

.....

.....

Name (Optional) .....

Thank you for the feedback and time taken to give it.

Date: _____

END OF COURSE EVALUATION SUMMARY

Question	Agree	Somehow Agree	Disagree	Remarks
1. Were the Training Objectives clear and achieved?				
2. Was knowledge and Skills addressed adequately to perform PAC activities?				
3. Was the length of the training adequately?				
4. Did the training address some PAC/RH related problems at your work-site				
5. Logistics, travel, accommodation and classroom				
6. Did the trainers, site staff help you acquire PAC/RH knowledge and skills to happy at your work site?				
7. Did the classroom, practical sessions, help link the knowledge skills and attitudes required for offering PAC and other RH services?				

8. Which skills do you feel particularly strengthened?
   (a) MVA procedure =
   (b) Processing Instruments =
   (c) Postabortion Family Planning =
   (d) Infection Prevention =

9. Before living this training, I want to say one or two things:

(a) ..... = ...
(b) ..... = ...
(c) ..... = ...
(d) ..... = ...
(e) ..... = ...
(f) ..... = ...
(g) ..... = ...
(h) ..... = ...

PAC REGISTER FORM

Month _____ **Year** _____

Serial Number	Hosp.Reg. No.	Date of Procedure	Time of Procedure	Name of patient	Address	Age of Patient	Marital Status	Parity	Gestation Age	Diagnosis	Procedure	Type of Pain Medication	Provide Name	Name of Assistant	Complications	Conselling	FP Method Taken	Refferals and Reason	Remarks

PAC REGISTER FORM

Month _____ *Year* _____

Serial Number	*Hosp.Reg. No.*	*Date of Procedure*	*Time of Procedure*	*Name of patient*	*Address*	*Age of Patient*	*Marital Status*	*Parity*	*Gestation Age*	*Diagnosis*	*Procedure*	*Type of Pain Medication*	*Provide Name*	*Name of Assistant*	*Complications*	*Conselling*	*FP Method Taken*	*Refferals and Reason*	*Remarks*

COMPATIBLE INSTRUMENT PARTS

Cannulae Size	Adaptor Color	Syringe Type
4, 5, 6 mm	**No adaptor needed**	**Single**
4, 5, 6 mm		**Double**
7 mm	**Tan**	**Double**
8 mm	**Ivory**	**Double**
9 mm	**Dark Brown**	**Double**
10 mm	***Dark Green***	**Double**
12 mm	**No adaptor needed**	**Double**

References:

** Documents that all PAC Trainers and PAC Site "Resource Center" must have.*

Documents used for references during Tanzania PAC curriculum development:

1. "Draft" The United Republic of Tanzania Ministry of Health, March 2001, *National Policy Guidelines for Reproductive and Child Health**
2. The United Republic of Tanzania Ministry of Health, August 2000, *Quality assurance training guidelines for Health Workers.*
3. United Republic of Tanzania Ministry of Health, *Strategy for Reproductive Health and Child Survival 1997 – 2001.*
4. Rick Sullivan et al, 1995, *Clinical Training Skills for Reproductive Health Professionals,* JHPIEGO Corporation 16 Thames Street Suite 200 Baltimore, MD 21231 – 3447 USA.
5. United Republic of Tanzania Ministry of Health, Reproductive and Child Health Section, *National Package of Essential Reproductive and Child Health interventions in Tanzania**
6. AVSC International, 1995, *Talking with clients about family planning, guide for health care providers,* AVSC International, 79, Madison Avenue, New York, NY 10016, USA.
7. Jamhuri ya Muungano wa Tanzania, Wizara ya Afya, 2000, *Mwongozo wa Utekelezaji wa Huduma ya Wakunga wa Jadi Tanzania 2000.*
8. The United Republic of Tanzania Ministry of Health, *National Reproductive and Child Health Communication Strategy 2001 – 2005.*
9. AVSC International, 1995, *Family Planning Counselling, A Curriculum Prototype, Trainer's Manual.*
10. AVSC International, 1995, *Family Planning Counselling, A Curriculum Prototype, Participant's handbook.*
11. United Republic of Tanzania Ministry of Health, Reproductive and Child Health Section, May 2001, *Family Planning Procedure Manual**
12. United Republic of Tanzania Ministry of Health, April 2001, *Safe Motherhood Procedure Manual**
13. JHPIEGO Corporation, April 2000, *Post-abortion Care Course Handbook, Guide for Participants.*
14. JHPIEGO Corporation, April 2000, *Clinical Training Skills Course Handbook, Guide for Participants.*
15. JHPIEGO Corporation, April 2000, *Post-abortion Care Course Notebook for Trainers.*
16. "Draft" JHPIEGO Corporation, March 2000, Post-abortion Care on – the – Job Training, Supervisor's Guide.
17. "Draft" JHPIEGO Corporation, March 2000, *Post-abortion Care on-the-Job Training, Trainer's Guide.*
18. PRIME II, August 2000, *PAC Clinical Skills Training Curriculum (Centralized/Group Training Component) Trainer's Manual, Expanding Opportunities For Post-abortion Care For communities Through Private Nurse/Midwives in Kenya.*

20. "Draft" AVSC International, November 1999, *Post-abortion Care Trainer's guide, Counselling the Post-abortion Patient: Training for Service Providers,* AVSC International 440 Ninth Avenue, New York, NY 10001, USA.

21. United Republic of Tanzania, Ministry of Health, February 2000, *Post-abortion Care, A training manual for clinicians and midwives, Part II: Participant's/Facilitator's Handbook,* UMATI/MOH – RCHS.

22. World Health Organization (WHO), 1995, *Complications of abortion, Technical and managerial guidelines for prevention and treatment,* typeset in India, printed in England 93/9774 – Macmillan/Clays – 7000.

23. United Republic of Tanzania, Ministry of Health, April 2000, *Safe Motherhood Reference Manual for District Level,* Ministry of Health in collaboration with UNICEF.

24. National Bureau of Statistics, Measure DHS + Macro International Inco. November 2000, Tanzania Reproductive and child Health Survey 1999.

25. The United Republic of Tanzania, Ministry of Health, 1999, *STD Training for Clinicians, User's Manual,* National AIDS/STD Control Programme, Ministry of Health P. O. Box 11857 Dar es Salaam, Tanzania, ISBN 9987 650 00 7*

26. United Republic of Tanzania May 2001, *Programme Components And Service Standards For Family Planning,* Reproductive and Child Health Section*

27. Judith Winkler and Robert E. Gringle, Feb. 1996, *Post-abortion Family Planning, A Curriculum guide for Improving counselling and Services,* IPAS 303 E. Main Street P. O. Box 999 Carrboro, NC 27510, USA.*

28. Laura Yordy, et al. 1993, *Manual Vacuum Aspiration Guide for Clinicians,* IPAS 303 E. Main Street P. O. Box 999 Carrboro, NC 27510, USA.

29. Laura Yordy, et al. 1996, *MVA Trainer's Handbook,* IPAS 303 E. Main Street P. O. Box 999 Carrboro, NC 27510, USA.

30. Wizara ya Afya, 2000, *Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya (MTUHA).* Kitabu cha 1, 2, 3, 4, 5, 6.*

31. Jamhuri ya Muungano wa Tanzania, Wizara ya Afya, 1999, *Kutoa Huduma Teula za Afya ya uzazi na Mtoto,* Mwongozo wa Mtoa Huduma. ISBN – 9966 – 897 – 37 – 2.*

32. Program for Appropriate Technology in Health (PTH), 2001, *Reproductive Health, Gender and Human Rights: A Dialogue.* PATH, 1800 K Street NW, suite 800 Washington, DC 20006.

33. United Republic of Tanzania May 2001, *Programme components And Service Standards For Safe Motherhood,* Reproductive and Child Health Section, 2002 Draft *

34. Ministry of Health, 1999, *Curriculum for Training CBD Supervisors,* Reproductive and child Health Unit P. O. Box 9083 Dar es Salaam.

35. AVCS International, 2000, *Infection Prevention Multimedia Package Training CD-ROM and Reference Booklet,* AVSC International 440 Ninth Avenue New York, NY, USA.*

36. Cathy Sloter, et al. September 2000, *A comprehensive training course Module 11: Manual Vacuum Aspiration (MVA) for Treatment of Incomplete abortion,* Pathfinder International Medical Services.

37. United Republic of Tanzania, Ministry of Health, October 1996, *Basic Training skills curriculum (Trainers Guide),* National Family Planning Programme MOH – Tanzania and INTRHA under PRIME Project.

38. United Republic of Tanzania, Ministry of Health, *Integrated R/CH Clinical Skills Curriculum Volume I – III,* January 1998 Revision.

Trainee's Note