MANUAL VACUUM ASPIRATION

COMPREHENSIVE ABORTION CARE TRAINER GUIDE

Version 1.0

WomanCare GLOBAL academy

WomanCare GLOBAL A COMPANY OF dkt INTERNATIONAL

CREDITS

This training manual has been drafted on behalf of DKT WomanCare Global.

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GUIDANCE FOR TRAINERS

INTRODUCTION

Welcome to DKT WomanCare Global Trainer Guide for Manual Vacuum Aspiration (MVA). This document is designed to guide team members who are providing information and education on MVA for internal and external stakeholders. It is suitable for both clinical and non-clinical audiences.

This guide covers subject matter related to indications for MVA which include induced abortion, early pregnancy loss (miscarriage) and postabortion care up to 12 weeks gestation.

Objectives

At the end of the training, the trainees will be able to:

- List the indications for MVA and the key points for patient counselling
- Describe key aspects of MVA equipment
- Demonstrate competency in performing MVA
- Describe best practice in pre- and post-procedure care
- List suitable methods of post abortion contraception

How to use this guide

This suggests a format for a half-day training on the MVA procedure, with pre- and post-operative information. It covers essential information related to provision of safe, effective, patient centred services. It also contains instructions to facilitate some additional exercises that can be useful in a training setting.

The time allocations suggested in the agenda are a guide only. Some audiences may already be familiar with the content and require less time in the classroom.

Trainer preparation

1. The trainer must have minimum knowledge of MVA and first trimester abortion management and must have passed the training program themselves. They must also possess planning and management skills to run classroom-based learning sessions.
2. For role plays, the trainers should be able to provide objective, supportive and challenging feedback where required.
3. Trainers should ensure that the trainees have all the information about the subject matter in advance of the event. This can take the form of the accompanying Trainee Manual, or job aids.

Training format

The content of this training is taken from Ipas Trainer Guides, WHO and RCOG sources. These are summarised in the Manual Vacuum Aspiration Reference Guide which should be distributed to all trainees in advance of training.

The training is classroom based, with supplementary training aids of a slide presentation and role play scenarios. It also provides guidance for managing practical training in small groups.

Who is eligible to attend this training?

Attendees of this training do not need to have a minimum level of competence or knowledge. They can be from a wide range of backgrounds including:

- Health care providers of all cadres including specialists, clinical officers, nurses, midwives, pharmacists
- Community or lay health workers
- Sales teams
- Other non-clinical members of the team who require correct knowledge of MVA equipment and procedure

Assessment

For health care providers, competencies should be assessed as set out. Participants who will not be providing MVA services directly do not need competency-based assessment.

These competencies provide the basis for ongoing clinical supervision; the trainees can use the checklist on (Table 1) for post training self-assessment and with their clinical supervisor. It is also contained in the relevant MVA Reference Manual.

The competencies also provide an objective way for the trainer to assess whether the trainees show adequate skills to provide MVA services.

These competencies are assessed through a knowledge test, which will take place during the training sessions. The pass mark for this is 80%.

Role plays are not formally assessed but feedback is encouraged.

The procedure is assessed by the trainer during the practical training.

You will need to assess whether trainees have reached essential competencies sufficient to 'pass' the course. Ideally, each trainee should be formally assessed at the end of the day as part of their feedback. Each participant should have the chance to practice then have another attempt to demonstrate competence.

On completion of this training, all trainees will be given a certificate of attendance. If they pass the knowledge and practical sessions, they will also receive a certificate of competence.

Table 1: Competencies for first trimester MVA

Competency	Achieved	Not Achieved	Plans for improvement
ASSESSMENT AND INITIAL MANAGEMENT			
Ability to take a complete medical, obstetric, and gynaecological history including gestational age			
Ability to carry out bimanual pelvic and speculum examinations			
Ability to assess for sexually transmitted diseases and treat as indicated			
Knowledge of all contraindications to medical and surgical abortion			
CLIENT COUNSELLING AND INFORMATION PROVISION			
Comprehensive knowledge of all CAC management options available, including post abortion family planning, and ability to present them in a language the client understands			
INFORMED CONSENT			
Ability to assess client's capacity to understand, retain, and use information provided to make informed decisions			
CERVICAL PREPARATION FOR SURGICAL ABORTION < 12 WEEKS			
Competent cervical preparation using accepted medical or physical preparation methods			
Ability to assess condition/state of cervix (ripeness – soft to allow ease of dilatation with dilators)			
MANUAL VACUUM ASPIRATION			
Ability to administer appropriate analgesia and prophylactic antibiotics			
Ability to monitor and manage clients for pain, bleeding, and vital signs			
Ability to accurately assess uterine depth			
Competent technique for evacuation of uterus using Manual Vacuum Aspiration			
Ability to assess completeness of procedure			
POST PROCEDURE			
Ability to recognise and manage complications and side effects arising from the above			
Ability to administer appropriate FP methods			
CLIENT DISCHARGE			
Ability to make discharge decision based on assessment of pain, bleeding, and vital signs			
Able to give discharge instructions, advice on warning signs and how to contact for follow up			
Ability to prescribe correct medication			

Training technique

Practical training can be conducted using the 4-stage technique – demonstration, deconstruction, formulation, and performance. This is because people learn in different ways: some through observation, others though listening. You can adapt this depending on time available.

Stage 1: Silent demonstration by the trainer in real time without any comments or explanation

Stage 2: Demonstration by trainer with commentary and explanation. You can take more time at this stage to demonstrate each step in greater detail

Stage 3: Demonstration by trainer but this time ask a volunteer trainee to provide commentary. If there is time, ask each trainee to provide some commentary

Stage 4: Ask a trainee to perform the skill and provide their own commentary. If there is time, each of the trainees can do this

A one-to-one meeting at the end of the training is crucial and provides the opportunity to discuss where improvement and support are required and to provide encouragement and motivation. At the end of the training, you may also decide that some trainees need more practice to become proficient under supervision in their home training environment. This feedback can be part of their individual post training debrief. Additionally, you may make the decision that some trainees should have to repeat training to attain competency. These expectations and possible outcomes should be communicated at the start of training.

Course evaluation

It is critical to collect information on your training session and its outcomes so that future courses could be improved. Collect information using a scale of 1-4 using one feedback sheet per trainee. Ask if the trainees were satisfied with:

- Length of the course
- Appropriateness of course content for their role
- Quality of the training components – slide presentation, role plays etc
- Quality of reference materials
- How well the course is organised

Always collect information on the names of the people who have attended, their roles, and the score from their pre and post knowledge tests and any other feedback they were given.

Training on MVA for Comprehensive Abortion Care:

Summary outline with indicative timings

If you plan to open the training with validation by a key person, make sure you have allocated enough time in the beginning for this, and this does not cut into your training time.

If you invite a key person to open the course, request that they highlight the importance of the topic globally and locally and motivate participants to read and use all of the course materials suggested during the training.

Pre training preparation: ensure adequate numbers of relevant resources to give to trainees.

Detailed Session Guide

The following shows Indicative timings and provides an overview of the training. It is not intended as a handout.

Welcome & Introduction

Suggested time allocated:	5 minutes	Resources:	Flipchart, Name Tags.

Trainers should welcome participants to the course and let them briefly introduce their roles and backgrounds using the following activity.

Ask each trainee to introduce themselves. Put these questions on a slide or *flipchart.*

- Name, (how they wish to be addressed)
- Where they are located
- Their role
- How this training will be of benefit to them (in one word)

This can take a lot of time if number of trainees is large. In such cases, the trainer can give each participant a plastic/paper name tag/plate where they can write these details and stick them on their dresses/ coats etc for others to read

The trainer, taking the lead, should thank participants for attending. Remind everyone that **this is an assessed course**, and there will be a knowledge test at the beginning and end of the training with assessment of practical competencies for those being assessed.

Overview and expectations

Suggested time allocated: 5 minutes

Resources: Flipchart,
Start with Slide 2
Summarise Objectives Slide 3

The purpose of this is to clarify expectations and involve the trainees in their learning.

Give an overview of the course objectives on a *flipchart* and the proposed agenda, ask the trainees if they have any learning needs from the session.

Ensure that these are written on a *flipchart*, and they are returned to at the end of the training to decide if these have been met.

Distribute any materials such as guidelines and technical information

Explain to trainees any logistics related to the venue and timings of breaks

At the end of the training the trainees will be able to:

- List the indications for MVA and the key points for patient counselling
- Describe key aspects of MVA equipment
- Demonstrate competency in performing MVA
- Describe best practice in pre- and post-procedure care
- List suitable methods of post abortion contraception

Ask the group if anyone has any questions at this point.

Ground rules

Suggested time allocated: 5 minutes

Resources: Flipchart, Slide 4

The purpose is to build trust within the group and establish a supportive learning environment.

This is good practice for all group trainings and should be led by the trainees themselves.

Ask trainees in the group for rules on how people should behave during the training. This may include rules about no mobile phones, not interrupting other people, respecting other people's opinions, active participation and being on time. Ensure that these are written on a *flipchart* and agreed by the group.

Quiz

Suggested time allocated: 15 minutes Resources: Test Handouts, Slide 5

Give each trainee the Pre and Post Course knowledge test handout

Ask them to take 15 minutes to answer the questions.

Make it clear that this test is not part of the competency assessment but a tool to see how their knowledge and skills have progressed over the day.

Definitions (from WHO, Clinical Practice Handbook for Abortion, 2023)

Suggested time allocated: 15 minutes Resources: Slides 6 and 7

Emphasise that **comprehensive abortion care** includes not just information and management of induced abortion, but provision of information and management of care related to pregnancy loss and post-abortion care (PAC).

Post-abortion care is the provision of services after an abortion, such as contraceptive services and linkage to other needed services in the community or beyond. It can also include management of side-effects or complications after a safe or unsafe abortion or miscarriage including resuscitation, blood transfusion, uterine evacuation, genital tract repair and treatment of infection

Miscarriage (spontaneous abortion or early pregnancy loss) is the Spontaneous loss of a pregnancy before the foetus is usually viable outside the uterus. The clinical signs of miscarriage are vaginal bleeding, usually with abdominal pain and cramping. If the pregnancy has been expelled, the miscarriage is termed “complete” or “incomplete” depending on whether or not tissues are retained in the uterus.

PAC must be offered to all women under human rights principles regardless of whether abortion is restricted in that setting. All women must be able to access emergency care and contraception.

Induced abortion, spontaneous pregnancy loss and PAC are all valid indications for MVA.

Global Challenge of Abortion

Suggested time allocated: 10 minutes Resources: Slides 8 - 13

- Discuss key facts on abortion
- Emphasise the difference between safe and unsafe abortion methods and give definitions
- Describe the challenges of unsafe abortion globally
- Use this opportunity to discuss the short-, medium- and long-term consequences of unsafe abortion

Global Challenges of Early Pregnancy Loss or Miscarriage

Suggested time allocated: 5 minutes Resources: Slides 14 - 20

- Discuss the key facts related to early pregnancy loss ('miscarriage')
- Provide definitions of types of early pregnancy loss or miscarriage: threatened, missed and incomplete miscarriage
- Ensure that the disease burden of miscarriage is emphasised

What do providers need to know about MVA

Suggested time allocated: 10 minutes Resources: Slides 21 - 28

- Everyone involved in MVA should be aware of the advantages and risks of MVA.
- First, explain differences between dilation and curettage (D&C), surgical methods (electric and manual vacuum aspiration) and medical methods.
- Emphasize that D&C is not a recommended method.
- Ask the trainees why D&C should not be used, and present the global evidence that MVA and Medical Abortion are used as preferred methods for evacuation of the uterus in most parts of the world.

Discuss other advantages of MVA and ask the trainees about potential risks. Ensure that the audience know that the way to reduce risk is through training of competent providers, patient selection by gestation and providing quality services which increase patient satisfaction and promote safety and effectiveness by e.g. reducing infection risk, being prepared for complications.

Principles of MVA service set up

Suggested time allocated: 5 minutes Resources: Slides 29 - 40

Discuss that the quality of care relates to whole holistic patient experience as well and safety and effectiveness

Highlight the risks of poor-quality care

Providers should be trained to an assessed objective competency

Counselling: Ask the trainees what is required for a high-quality counselling service.

Ensure that the following areas are covered in the discussion:

- Counselling and choice, consent, privacy and confidentiality, comprehensive evidence-based information provision, high quality products, aftercare, signposting to other services, post MVA contraception

Emphasise the varied factors which can affect quality:

- Patient experience, safety and effectiveness and their consequences.

Discuss the importance of competent providers, on the individual responsibility after training of ensuring that skills remain up to date.

Summarise the key components of good counselling using REDI framework.

If you are performing competency assessments for providers, all if other trainees are interested and you have the time, you can conduct some role play exercises either at this stage of the training or later during the practical sessions.

See appendix 1 for examples

Pre-procedure care

Suggested time allocated: 30 minutes Resources: Slides 41- 46

Ask the trainees what the key steps of pre-procedure care are to ensure high quality MVA services.

Essential: establishing indication, consent, estimating gestational age through

- Comprehensive patient assessment by taking a medical history and performing a physical examination to ensure that the woman is eligible for MVA
- Assess gestational age

Provide scenario given below to the group then summarise the discussion with slides.

Scenario #1

If a client presents on **October 19th**, and says the first day of her last menstrual period was **August 20th**, what is her gestational age?

11 days until end of August + 30 days in September + 19 days in October
= 60 total number of days since LMP.

So a gestational age of **8 weeks and 5 days.**
Discuss the implications for inaccurate estimation

Emphasize that the following are not routinely required according to the WHO guidelines: blood tests, infection screening, ultrasound.

Discuss that antibiotics should be given to all women if available and anti-D if woman is Rh negative.

Cervical preparation: consult local guidelines. Not mandatory for first trimester MVA according to WHO guidance .

Discuss pain relief before the procedure. Emphasise that this needs to be tailored to the women and her preferences as well as her gestation.

There are special considerations for pain relief for all procedures that require dilatation at the cervix. These include MVA but also for IUD insertion and hysteroscopy.

MVA Procedure

Suggested time allocated: 30 minutes Resources: Slides 47 - 61

Before the patient comes in, check the room, and ensure that the equipment is complete and functioning. Particularly

- Essential supplies and equipment present
- Vacuum of the MVA
- Determine cannula sizes which may be required to complete procedure effectively

Discuss the importance of inviting the patient into the procedure room and introducing all personnel present, and to keep communication with her.

Perform abdominal palpation and bimanual examination to confirm uterine size and check for scars or other masses.

Discuss the key steps of paracervical block

Go through best practice points for cannula insertion and aspiration, and give a clear indication of when the provider can tell that the uterus is empty.

Show the video which recaps the aspiration procedure

Post Procedure

Suggested time allocated: 15 minutes Resources: Slides 62 - 67

Continue best quality care by helping the woman off the couch and into a designated recovery area.

Ask the trainees what the woman can expect after a procedure and go through the slide.

Advise that the management of complications is reliant on best techniques, and early identification. Providers and managers need to be aware of local protocols for management and transfer.

The consultation and procedure need to be documented in writing for quality and governance purposes.

Post MVA contraception

Suggested time allocated: 5 minutes Resources: Slides 68 - 69.

Provide an overview of post MVA contraception and what contraceptive methods can be started at what time after a surgical evacuation.

MVA for endometrial biopsy

Suggested time allocated: 5 minutes Resources: Slides 70 - 72.

Use the smallest cannula (3mm) to perform a blind biopsy for a limited number of indications

Indications:

- Abnormal bleeding – post coital, post-menopausal, intermenstrual

Blind biopsy alone is a limited tool, and should be used to assess abnormal symptoms as part of a suite of wider investigations including hysteroscopy and ultrasound.

Simple analgesia in the hour prior because of the small diameter cannula and short procedure may be adequate.

Evaluation and review of expectations

Suggested time allocated: 15 minutes Resources: Training evaluation sheets
'Expectations' flipchart
'Positive Actions' flipchart

Give out the *Training Evaluation Sheets* and ask participants to complete these now and to hand them to a Trainer explaining how their comments will be used. Make sure that they have all been collected before participants leave.

Then invite participants to retrieve or identify any *'expectations'* they posted on the flipchart sheet and discuss in pairs and then with the large group, about how well this has been met or not.

Ask Trainees to write down one '*positive action*' they will take back to their place of work to ensure high quality care.

Whole group review, certificates and closing

Suggested time allocated: 15 minutes Resources: Certificates, 'Ground rules' flipchart.

Give out participation and assessment *Certificates* as appropriate - or ask the person who gave the opening welcome to return to do this and reinforce the need for the work to continue.

Manage a final closing round for example, "one word to describe how you feel now at the end of the course..." and plan who to start and end with (perhaps trainers who will model using just one word) and in which direction to continue this final round so that you end with someone whom will finish with a positive comment.

Thank everyone for attending the training, highlighting the '*ground rules*' on confidentiality agreement.

General Training Techniques

Energisers

These exercises can be useful to refocus on the training, for instance after lunch break, or when the trainer feels energy is reduced in the room. They should last for approximately 2 minutes and can take the form of

- Standing up, throwing a ball to each other, and calling out an interesting fact they have heard that day,
- Look up/look down game
- Dance to a music reel

Instructions for Practical Training in classroom models

This guide is written for classroom-based training for MVA in pelvic models or e.g. papaya. For MVA training in live subjects, consult local protocols and guidance.

Essential competencies for MVA

These are summarised in Table 1 and form the minimum practical level that a provider must reach before they can practice independently.

The 4-stage approach

This training for MVA can be conducted using the 4-stage technique – demonstration, deconstruction, formulation, and performance. This is because people learn in different ways: some through observation, others though listening. You can adapt this depending on time available.

Split into groups and start demonstration with model arms using the 4-stage approach.

STAGE 1
As the trainer, start with silent demonstration in real time without any comments or explanation and then,

STAGE 2
Demonstration with commentary and explanation.

STAGE 3
Then ask each trainee to take turns to describe what the trainer is doing.

STAGE 4
Each trainee should then take turns to perform removal and provide their own commentary. This should be structured with a break halfway through the session.

Ensure that there is time to assess each provider completing a removal and giving them the chance to repeat if required.

Assess individual trainees against competency checklist during the afternoon session with the result. (Appendix 2)

A one-to-one meeting at the end of the training is crucial and provides the opportunity to discuss where improvement and support are required and to provide encouragement and motivation.

At the end of the training, you may also decide that some trainees need more practice to become proficient under supervision in their home training environment. This feedback can be part of their individual post training debrief.

Additionally, you may make the decision that some trainees should have to repeat training to attain competency. These expectations and possible outcomes should be communicated at the start of training.

Suggestions for trainers who are assessing competencies

Prepare yourself and other trainers by going through the training materials and become familiar with the components, especially the 4-stage training technique and competency assessments. Liaise with any other trainers and discuss the format and methods with them, especially if the organisers are providing trainers. This is the time to ask if they have the necessary experience to train alongside you.

Select trainees. Communication with training site focal persons should be done in advance of the training so that there is adequate time to obtain information on the trainees. Each trainee should receive the MVA CAC Reference Guide in advance and should return the completed Pre-Training Questionnaire to document their competencies and suitability for training. You can review this as part of the trainee selection and should be done in advance with enough time to allow trainers and organisers to decide who is eligible for training, which modules are required and adequately prepare so enough time is allocated for the required modules. It may be that some potential candidates are not suitable to come to training for example they will not have adequate case load in their practice. It is important to manage the organisers expectations about the training and who is eligible to attend.

Ideally the trainees should be of the same cadre. Trainees should reflect on who will support and supervise them when they go back to their practice so that they can maintain skills. They can consider how they will procure or access implants to ensure consistent supplies for provision adequate method mix. Their review of the subject matter in advance will also maximise impact of training.

Numbers of trainers. You must ensure there is a realistic trainer to trainee ratio; in an ideal scenario, this should be 1:4. This is to ensure that each trainee has enough exposure to practice during training and that the trainer has enough time to provide high quality input so that competencies can be achieved.

Follow up activities. See if there are any opportunities for training follow up or how you as the trainers can provide support after training in the way of supervision or repeat training if required. You can contribute to decisions about who could be suitable to return for a training the trainer course in future and who will be eligible to train other providers based on competencies achieved.

Copies of training materials. Ensure that there are enough copies of role play, knowledge tests.

Certificates can be given to trainees who pass the training. This should be reserved to trainees assessed as competent in MVA for CAC. It is not recommended that certificates are given to all attendees.

- Leave plenty of time in advance of training to organise logistics such as dates times accommodation and travel plans. This will reduce the pressure on the day of training.
- Confirm that the site will be large enough for the number of trainees and accessible for any trainees with disabilities.
- Ensure that the trainees receive the MVA CAC Reference Guide in advance.
- Review the training schedule to ensure that breaks are planned. Sometimes, when there is a fall in energy of the trainees, for example after lunch, consider activities that get people up and moving around – 'energisers'

APPENDIX 1
Role Plays for Counselling and Eligibility for MVA

Scenario A:

Maryam is a 38-year-old woman, and she attends your clinic requesting induced abortion.

She is confirmed to be 9 weeks and 5 days pregnant. Mary has had 4 previous vaginal deliveries and her partner refused to use a condom. She has a full-time job and cannot afford to take too much time off work.

Points for discussion

- Counsel for MA v MVA as options for the procedure. However, the irregular and unpredictable bleeding patterns may not suit her lifestyle.

- Mary sounds eligible for MVA and may not need cervical preparation.

- She can be counselled on having an IUD inserted after the procedure to protect from future pregnancies

- Be sensitive to the possibility of gender-based violence and signpost to support services

Scenario B:

June is a 16-year-old woman attends your clinic requesting information on unplanned pregnancy. She was sexually assaulted 6 weeks ago and has a positive pregnancy test; this was the only time she had has sex. June does not wish to keep the pregnancy and does not want her family to know. Her periods are always heavy.

Points for discussion

- Reassure her that the consultation and treatment are confidential.

- Counsel for MA v MVA as options for the procedure. She may wish to have a one off MVA procedure or take MA tablets and bleed at home. Either are suitable especially if she lives near a facility in case the MA procedure requires follow up, although if she is used to having heavy periods, she may be better prepared

- Offer STI screening and signpost for appropriate GBV services

- If she has overt signs of infection, consider counselling for MA.

Scenario C:

Rekha is 29-year-old woman attends with a confirmed pregnancy of 7 weeks and 3 days, having had two previous caesarean sections. She has morbidly obese and is known to have uterine fibroids. Rekha's blood pressure is normal.

Points for discussion

- Counsel for MA v MVA as options for the procedure.

- Bear in mind that an MVA procedure risks being technically difficult with uterine fibroids and previous pelvic surgery, so she needs to be counselled about surgical (and possible anaesthetic) risk.

- Discuss contraception.
She may be eligible for contraceptive implants which can be given on the day of the MVA or the day the MA tablets are taken.

APPENDIX 2

Competency assessment sheet

Name of trainee:		Date of training:	

Area of competency	Provide independently without need for supervision?	Requires direct supervision before	Not able provide service independently?
Counselling	Yes / No	Yes / No	Yes / No
Insertion	Yes / No	Yes / No	Yes / No
Removal	Yes / No	Yes / No	Yes / No

○ Follow up actions agreed with timeframe:			
○ Who will support trainee in their setting?			
○ Is the trainee competent to train others?	Yes	No	Further numbers of insertions required first:
○ Is the trainee suitable to return for a training of trainers?	Yes	No	Unable to comment
○ Other reflections about the training:			

Competencies for first trimester MVA

Competency	Achieved	Not Achieved	Plans for improvement
ASSESSMENT AND INITIAL MANAGEMENT			
Ability to take a complete medical, obstetric, and gynaecological history including gestational age			
Ability to carry out bimanual pelvic and speculum examinations			
Ability to assess for sexually transmitted diseases and treat as indicated			
Knowledge of all contraindications to medical and surgical abortion			
CLIENT COUNSELLING AND INFORMATION PROVISION			
Comprehensive knowledge of all CAC management options available, including post abortion family planning, and ability to present them in a language the client understands			
INFORMED CONSENT			
Ability to assess client's capacity to understand, retain, and use information provided to make informed decisions			
CERVICAL PREPARATION FOR SURGICAL ABORTION < 12 WEEKS			
Competent cervical preparation using accepted medical or physical preparation methods			
Ability to assess condition/state of cervix (ripeness – soft to allow ease of dilatation with dilators)			
MANUAL VACUUM ASPIRATION			
Ability to administer appropriate analgesia and prophylactic antibiotics			
Ability to monitor and manage clients for pain, bleeding, and vital signs			
Ability to accurately assess uterine depth			
Competent technique for evacuation of uterus using Manual Vacuum Aspiration			
Ability to assess completeness of procedure			
POST PROCEDURE			
Ability to recognise and manage complications and side effects arising from the above			
Ability to administer appropriate FP methods			
CLIENT DISCHARGE			
Ability to make discharge decision based on assessment of pain, bleeding, and vital signs			
Able to give discharge instructions, advice on warning signs and how to contact for follow up			
Ability to prescribe correct medication			

APPENDIX 3

Pre and Post Course Knowledge Test

Name of trainee: Date of training:

Only 5% of all pregnancies end in induced abortion	TRUE	FALSE
Only 5% of first trimester pregnancies are estimated to end in miscarriage	TRUE	FALSE
It is for the health care professional to decide what is the best method of managing any type of abortion	TRUE	FALSE
Miscarriage less than 12 weeks is never associated with any long term physical risks to health	TRUE	FALSE
Post abortion care includes managing haemorrhage after a spontaneous pregnancy loss	TRUE	FALSE
The syringe plunger arms must be fully extended to the sides and secured over the edges of the cylinder before starting the procedure	TRUE	FALSE
The vacuum retention of the syringe only needs to be checked at the beginning of the day	TRUE	FALSE
All women should be offered a non steroidal anti inflammatory drug 30-60 minutes pre procedure (if they have no contraindications)	TRUE	FALSE
Paracervical block should only be used as a last resort	TRUE	FALSE
If there is difficulty dilating the cervix, try a larger cannula with some increased pressure	TRUE	FALSE

Contact

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