Manual Vacuum Aspiration

Management of First Trimester Pregnancy Loss

TRAINEE MANUAL

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WomanCare GLOBAL academy

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CREDITS

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EngenderHealth. 2018. *REDI: A Patient-Centered Counseling Framework*. Washington D.C.

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Clinical practice handbook for safe abortion Geneva: World Health Organization; 2014

CONTENTS

INTRODUCTION

Welcome to your Management of First Trimester Early Pregnancy Loss with Manual Vacuum Aspiration training. This manual is designed to complement your training session and provides essential information for counselling for early pregnancy loss (here abbreviated as EPL) and management with manual vacuum aspiration (MVA).

This information will also be presented during the training sessions, and there will be opportunities to ask questions.

Even if you are familiar with the subject matter, please take this opportunity to use this Manual and the training itself as part of your Continuing Professional Development.

OBJECTIVES

As a provider of EPL and MVA services, you must be able to provide your patients with the highest quality service. To enable this, you should::

- Be assessed by a trainer as competent for performing the MVA procedure so that the service you provide is safe and effective.
- Take responsibility for maintaining your own competence by accessing supportive supervision opportunities.
- Provide a rights-based environment for service delivery with attention to acceptability, accessibility and availability of services thereby fostering trust with those seeking services.

Course Content

This course encompasses care related to

1. **Miscarriage**
   Spontaneous abortion and missed abortion

2. **Induced abortion**
   The deliberate interruption of an ongoing pregnancy by medical or surgical means

3. **Incomplete abortion as well as fetal death**
   Intrauterine fetal demise[1].

This training will cover one part of this - management of miscarriage less than 14 weeks gestation. This term can be used interchangeably with EPL in pregnancies in this group. Further definitions are set out in Section 2.

This training will not cover other forms of miscarriage management, namely expectant management or the "wait and see" approach, or medical management. A competent provider of EPL services should be able to counsel on these and provide treatment if they are eligible to do so.

Drugs and procedures related to conscious sedation, general anesthesia, and details of management of post-abortion complications are beyond the remit of this training.

Assessment

Objectives are for trainees to be able to demonstrate:

- Acquisition of knowledge about EPL
- Patient counseling skills that are focused on supporting the patient through decision-making and informed consent
- Competency in performing MVA and providing essential pre-and post-procedure care

Before the training, submit a Pre-Training Questionnaire to the trainers (Appendix 1). This will provide the training team with essential information on your background to ensure that the correct level of training and learning outcomes are maximized.

The training is competency-based

These competencies are outlined in Table 1 (Appendix 2) and provide the basis for ongoing supportive supervision; you can use this checklist for post-training self-assessment and with your clinical supervisor. They also provide an objective way for the trainer to assess whether you show adequate skills to provide EPL and MVA services. You will be formally assessed at the end of the day and receive feedback from the trainer. If you have fulfilled essential competencies, you will 'pass' the course and receive a certificate.

[1]https://www.who.int/news-room/fact-sheets/detail/abortion

Table 1: Competencies for EPL MVA service provision for women under 14 weeks

Competency	Achieved	Not Achieved	Plans for improvement
COUNSELING AND INFORMED CONSENT			
Knowledge of the advantages and disadvantages of all options for EPL management and explain these to the patient			
Ability to assess patient's individual situation to make informed decisions regarding treatment options			
CLINICAL ASSESSMENT			
Ability to take a medical history			
Estimate gestational age			
Ability to assess for pain options			
Assess the need for cervical preparation			
MVA PROCEDURE			
Assess the size of the uterus on bimanual examination			
Speculum examination			
Demonstrate competence in paracervical block technique			
Demonstrate competence in identifying and assembling equipment			
Demonstrate competence in gentle no touch techniques and assessing the length of the uterine cavity			
Demonstrate competence in the MVA procedure and aspiration of uterine contents			
Identification of products of conception			
Demonstrate knowledge of how to assess whether the uterus is empty			
How to monitor and manage patient for pain			
RECOVERY AND DISCHARGE			
Ability to assess whether the patient is safe for discharge			
Ability to recognize and manage complications			
Explain what is normal and abnormal (signs and symptoms) in the next few weeks			
Give discharge instructions			
Reiterate who/ how to contact for help/advice/ support			
Advice abstinence until the bleeding stopped			
Dispense antibiotics and analgesics			
Discuss analgesic needs and dispense as appropriate			

If you do not achieve the required competencies by the end of the training, then you and the trainer can discuss whether you can practice under direct supervision in your home training environment before you can provide EPL services independently. It may be that you and the trainer will discuss repeating the training. The possible training outcomes are summarized in Table 2, and a longer version of this for you to fill in after training can be found in Appendix 3 of this manual.

Table 2: Competency Assessment for Trainees

Name of trainee: Date of training:

Area of competency	Provide independently without need for supervision?	Requires direct supervision before independent practice?	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:			

WHAT DO PROVIDERS NEED TO KNOW ABOUT EARLY PREGNANCY LOSS?

Definitions

The word miscarriage is used to define a pregnancy that is lost spontaneously before viability and up to 20 weeks gestation. This can also be described as a spontaneous abortion, but this wording may not be preferred given the association with induced abortion, which is the termination of an ongoing pregnancy using drugs or uterine aspiration.

Threatened miscarriage

Women who present with a confirmed intrauterine pregnancy and have bleeding are said to be having a threatened miscarriage. Women may experience these symptoms and go on to have a healthy pregnancy.

Missed miscarriage (silent miscarriage)

This is when the fetus has died (intrauterine fetal demise) or not developed (blighted ovum), but there has been no physical loss.

Molar and partial molar pregnancies

(Also known as hydatidiform moles) are part of a group of disorders called Gestational Trophoblastic Disease. The management of these is not covered in this training.

Incomplete miscarriage

Means that not all the pregnancy tissues have been expelled from the uterus. This can also happen after induced abortion. Diagnosing and managing incomplete miscarriage and abortion is a critical component of postabortion care.It is important to know that the majority of miscarriages are not caused by anything the woman has done and cannot be prevented. Most are 'one-off' events, and women can be reassured that they can go on to have healthy pregnancies.

FURTHER KEY FACTS ABOUT MISCARRIAGES[2]

- Estimated 23 million miscarriages every year worldwide.
- 44 pregnancy losses each minute.
- It is estimated that up to 10 to 20% of all pregnancies end in spontaneous miscarriage but the number may be much higher as many occur before pregnancy is confirmed.
- Around 10% of women have had one miscarriage , around 2% have two miscarriages and 0.7% have had three.

RISK FACTORS INCLUDE:

- Women aged under 20 and over 35 years.
- Very high or very low body mass index.
- Black ethnicity.
- Smoking, alcohol and stress.
- Recurrent miscarriage is also a markers of risk for obstetric complications.
- As well as health indicators economic costs can be high.

Ideally, EPL is diagnosed by ultrasound.

Where these services are not available or reliable, a clinical examination can diagnose incomplete miscarriage by visualizing an open cervical os on speculum examination.

Missed miscarriage should be suspected If the uterus feels smaller than the women's last menstrual period would suggest.

Complications of miscarriage

These include bleeding, which can be heavy, and infection and are discussed later in this training. Evidence is also emerging on the psychological effects of miscarriage on the mother and the father. This can cause anxiety and depression, and, in extreme cases, even post-traumatic stress disorder. It is the duty of a provider to assess the patient holistically so that any causes of concern can be managed appropriately.

[2]Miscarriage matters: the epidemiological, physical, psychological and economic costs of early pregnancy loss, Lancet, Volume 397, Issue 102285m P1685-1667m May 01 2021 Found at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00682-6/fulltext

WHAT DO PROVIDERS NEED TO KNOW ABOUT MANUAL VACUUM ASPIRATION?

What is MVA?

- MVA is a minor surgical procedure that involves a cannula being inserted into the uterus through the cervix in to remove uterine contents with gentle suction using a handheld device (the aspirator).
- This procedure should be performed by a trained health care provider.
- It can be performed under local anesthesia in a hospital or health center.
- It has a short recovery time and is typically performed on an outpatient basis.
- It is a safe and effective method for managing EPL up to 12-14 weeks gestation and is recommended by the world's leading gynecological and obstetric organizations, including FIGO (the International Federation of Gynecology and Obstetrics), as the technique of choice for uterine evacuation.

MVA can also be used for endometrial biopsy as part of a wider suite of investigations for abnormal bleeding in non-pregnant women.

What are the advantages of managing EPL with surgical evacuation of the uterus?

Surgical evacuation has the advantage that it is highly likely to be a one-off intervention that may suit a woman who does not want to keep returning for check-ups or if she wishes to avoid medication. It also avoids the uncertainty of when the miscarriage may occur, which may better suit her personal circumstances. It can be provided in the comfort of a regular exam room, and no loud machines are required with an Ipas Manual Vacuum Aspirator.

Women who wish to avoid surgery can choose expectant management or medical management after consultation with their provider.

Medical management is an option for managing missed miscarriages under 14 weeks. It is a quicker process than expectant management, the "wait and see" approach, and women may be willing to accept side effects for the advantages of miscarrying at a time and location of their choosing.

For both expectant and medical management, she would need to return for assessment over a period of time to ensure that the miscarriage has occurred.

Note dilatation and curettage (D&C) as a method of surgical evacuation of the uterus and as a sharp curettage 'cavity check' post MVA should be replaced by vacuum aspiration alone, which is associated with fewer complications.

D&C also causes "painand suffering to women and is not recommended for use; its use is incompatible with numerous human rights, including the right to health."[3]

What are the risks of MVA?

For any MVA procedure **performed at less than 14 weeks gestation**, the risks are small.[4]

- Failure of procedure 1 in 1000
- Incomplete evacuation 35 in 1000
- Infection less than one in 100
- Severe bleeding requiring transfusion less than one in 1000
- Cervical injury from dilation less than one in 100
- Uterine perforation 1-4 in 1000

It should be noted that infection after miscarriage is unlikely and is usually associated with pre-existing infection.

[3]Abortion care guideline. Geneva: World Health Organization; 2022.
[4]Best Practices in abortion care, Royal College of Obstetricians and Gynaecologists, 2022

MVA COUNSELING

Essential information that should be discussed with the patient during the counseling process is set out in the checklist in Table 3. Documenting that counseling has taken place with details of what has been discussed should be entered into the patient records.

Table 3: Counselling checklist for MVA for EPL

COUNSELLING CHECKLIST FOR MVA FOR EPL	
Benefits of MVA v medical management v expectant management	
Risks and complications	
Pain management options and methods of anesthesia	
Explanation of the MVA procedure itself	
What to expect after the procedure	
Taking verbal and written consent	

The procedure involves a tube being inserted into the uterus through the cervix to remove the pregnancy with a suction device.

- She may experience crampy period type pain during the procedure and for several days afterward
- She may bleed for up to two weeks.

RIGHTS-BASED APPROACH TO HIGH-QUALITY EPL SERVICES

Ultimately it is the women's choice which method she chooses to manage her miscarriage. This is part of the principle of a rights-based approach to service delivery. Patients must not only have access to safe, effective, acceptable care – there should be an effort to increase access, equity, and availability in a healthcare environment that is acceptable. Examples of how to promote a rights-based service for EPL services:

1. Promote acceptability of services by providing an environment where there is visual and auditory privacy, confidentiality, dignity and respect.

2. Use active listening and communication skills effectively to identify the decisions the patient needs to make or confirm and help the patient consider the benefits, disadvantages, and consequences of available options. Confirm that any decision the patient makes is informed, well-considered, and voluntary.

3. Increase access by changing appointment times or having walk-in clinics to suit local populations.

Ensure safety and effectiveness by ensuring that all provider skills and knowledge are up-to-date and there is a steady supply of high-quality equipment

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Manual Vacuum Aspiration Procedures

PRE-PROCEDURE CARE

Patient assessment

Patient assessment consists of taking a medical history and performing a physical examination

Medical history

For the medical history, it is important to establish the first day of her last menstrual period to assess pregnancy gestation.

Obstetric history

Obstetric history, including the numbers of vaginal deliveries, Caesarean sections, ectopic pregnancies, or any other pregnancy losses, should be documented.

Gynecology history

A gynecology history should document if there have been any previous abdominal or uterine surgery symptoms of genital tract infection. It is critical to establish and treat any infection prior to instrumenting the uterus.

Medical conditions

Ask about any medical conditions and document if she is on any medications, including any herbal medications. It is important to ask if she has any allergies.

Ultrasound scan

If the woman has had an ultrasound scan, note the pregnancy gestation, size of the uterus, and whether it is anteverted or retroverted. If there is no access to ultrasound, a bimanual examination will determine the size and position of the uterus. It is critical to establish the gestational age at this clinical assessment to ensure that a first-trimester MVA procedure will be appropriate and safe.

Ectopic pregnancy

If there is any suspicion of ectopic pregnancy, either with a definitive diagnosis on ultrasound scan or an empty uterus, or the size of the uterus being incompatible with dates on physical examination, refer for further assessment.

Check with your local guidelines for the use of anti-D rhesus prophylaxis, oral antibiotics, and measuring hemoglobin or hematocrit levels.

Pain management

There are several options for anesthesia or sedation for MVA, which should be discussed as part of the patient assessment. The method should be based on the woman's wishes and any relevant findings during the clinical assessment.

MEDICAL OPTIONS FOR PAIN MANAGEMENT:

Nonsteroidal anti-inflammatory drugs

All women should be offered nonsteroidal anti-inflammatory drugs 20 minutes before the procedure.

Local anesthetic injection

A local anesthetic injection to numb the cervix and paracervical block, or an injection to the neck of the womb. This does not require sedation or general anesthesia and will not delay discharge, but it does mean that the patient will be awake during the procedure.

Monitored anesthetic care (MAC)

Monitored anesthetic care (MAC) or deep sedation ('conscious sedation'), or general anesthesia. These are not routinely recommended for vacuum aspiration for women 12-14 weeks gestation, but this depends on the circumstances of the woman and whether she would prefer to be awake during the procedure. She will need to be given nil-by-mouth instructions and arrange for someone to accompany her home. Her recovery time in the clinic will be longer compared to having a local anesthetic. It should be noted that sedation and general anesthesia require specialist equipment and supplies with skilled staff who are competent to administer drugs and monitor the patient during and after the procedure.

VOCAL LOCAL TECHNIQUES

It is important to understand that pain relief is not just pharmacological.

'Vocal local' or distraction techniques such as controlled breathing and listening can reduce perceptions of pain and of anxiety, and when effective, there is an increased likelihood that the patient will require less pharmacological interventions.

CERVICAL PREPARATION

The cervix can be 'primed' with agents such as misoprostol before the procedure, which act to soften the cervix making dilation easier. This can be useful for women who are nulliparous or have had cervical surgery, but this is not routinely required for first-trimester surgical procedures because of the side effects of misoprostol, such as shivering and fever and the risk of bleeding while waiting for the MVA.

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MVA PROCEDURE

- The procedure room must conform to local standards and should be clean, well ventilated, and adequately equipped.

- A proper bed and fittings suitable for minor gynecological procedures to put the patient in a dorsal lithotomy position are highly desirable so that the patient is comfortable.

Checking the equipment

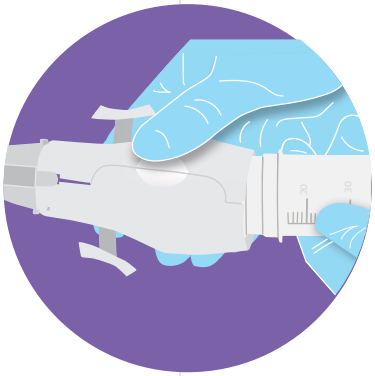
Before starting the procedure, ensure that all necessary equipment and supplies are ready and laid out before the patient enters the room to reduce the risk of anxiety.

A key part of this is assembling the equipment to check that it is functioning. The essential equipment and supplies checklist is listed in Table 5.

Table 5: Essential Supplies and Equipment for MVA under 14 weeks

INSTRUMENT	QUANTITY PER SET
Sponge holding forceps	
Bivalve speculum	
Tenaculum	
MVA sets with cannula	
Gauze	
Kidney dish for tissue	
Gallipot for antiseptic solution	
Sponge forceps	
Sterile and disposable gloves	
Needles and syringes	
Personal protective equipment: aprons goggles	
Sanitary napkins	
Waste disposal: (fetal remains)	
Waste disposal dry waste	
Sharps disposal	
Decontamination solution	

DRUGS	QUANTITY PER SET
Lidocaine 1% without adrenaline for paracervical block	
Misoprostol for cervical preparation	
Oral analgesia, nonsteroidal anti-inflammatory drugs	
Drugs for sedation as per local protocol (not covered in this training)	
Emergency drugs box containing, e.g., drugs for management of anaphylaxis. See local protocols and requirements	



Step 1

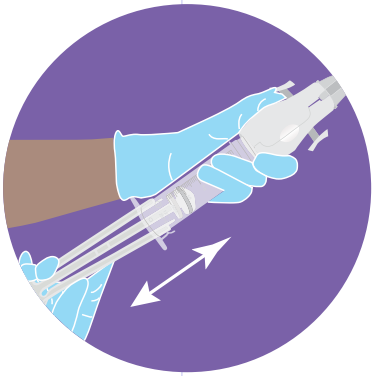
Before the procedure begins, assemble and ready the equipment. Begin with the valve button or buttons open (that are not depressed) with the plunger inserted all the way inside the cylinder and the collar stop locked in place (with the tabs pushed down into the holes in the cylinder).

- Push the button or buttons down and forward until you feel them lock.

Step 2

- Create a vacuum by pulling the plunger back until the plunger arms snap out and catch on the wide sides of the cylinder base.

- The plunger arms must be fully extended to the sides and secured over the edges of the cylinder. Incorrect positioning of the arms could allow them to slip back inside the cylinder, which raises the risk of injecting the contents of the aspirator back into the uterus. Never grasp the aspirator by the plunger arms.



Step 3

- Check for vacuum retention by releasing the buttons. This should be done before each use. A rush of air into the aspirator should be heard, indicating that a vacuum was retained.

- If the rush of air is not heard, remove the collar stop, withdraw the plunger and check that the plunger O-ring is free of damage and foreign bodies and that it is properly lubricated and positioned in the groove. Also, make sure the cylinder is firmly placed in the valve. Then create a vacuum and test it again; if the vacuum is still not retained, the aspirator should be discarded and replaced with a new one.

- The Ipas Manual Valve Aspirators are compatible with Semi-rigid and Flexible cannulae sizes 4-10mm and 12mm.

- They should all have lines or dots marked on the length, which are used to assess the size of the uterus during the procedure.

Preparing the patient

When the patient enters the room, ensure that instruments are covered.

Confirm her identity and check whether a consent form has been signed, review the medical history.

Introduce yourself and any other staff in the room and briefly outline what their roles are.

Ensure that the patient has been helped onto the exam or operating Table and that she is covered with a sheet.

Palpate the abdomen and check for scars, masses, and uterine size.

When the woman is comfortably in lithotomy, assess the size and position of the uterus by bimanual examination. Where available, ultrasound may be helpful for accurate dating where there is a discrepancy between the examination and last menstrual period date. Also, assess whether there is any pelvic tenderness or masses.

Insert a bivalve speculum, check the genital tract and cervix for signs of infection such as abnormal vaginal discharge and pain, and discuss treatment if required. Clean the cervix with antiseptic solution twice from the os to the edge of the cervix.

Performing a paracervical block

If the patient has chosen a paracervical block as part of her analgesia plan, this should be performed as follows:

Inject 1 -2 ml of local anesthetic at the cervical site where the tenaculum will be placed (either at 12 o'clock or 6 o'clock, depending on your preference or the presentation of the cervix).

Stabilize the cervix with the tenaculum at the anesthetized site.

Use slight traction to move the cervix and define the transition of the smooth cervical epithelium to vaginal tissue. This delineates the sites for additional injections.

Slowly inject 2 – 5 ml lidocaine into a depth of 1.5 – 3 cm at 4 points at the cervical/vaginal junction 2 and 10 o'clock and 4 and 8 o clock.

Move the needle while injecting OR aspirate before injecting to avoid intravascular injection.

The maximum dose of lidocaine in a paracervical block is 4.5mg/kg/dose or generally 200!!! -300mg (approximately 20ml of 1% or 40 ml of 0.5%)

Uterine Aspiration Procedure

With the speculum still in place and after the paracervical block, apply the tenaculum to the cervix to gently apply traction to straighten the cervical canal.

Introduce a dilator that has a diameter smaller than the estimated gestation of the pregnancy gently through the cervical os into the uterine cavity. Rotating the dilator with gentle pressure can ease insertion.

Repeat this with progressively larger dilators until you reach the cannula size that is appropriate for the patient's gestation.

Once appropriate dilation has been achieved, advance the cannula slowly until it touches the uterine fundus, then withdraw it slightly. ***Do not touch the cannulae.***

Use the following Table as a guide to the appropriate size cannulae:

Throughout the procedure, ensure that the patient is comfortable and remain open to offer additional forms of pain relief.

If the patient is moving, there is a risk of the procedure being unsuccessful.

If the patient is not tolerating the procedure despite additional pain control, consideration should be given to abandoning the procedure.

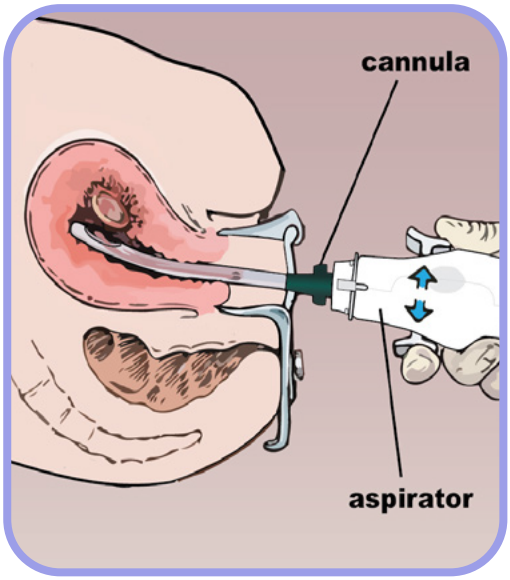
UTERINE SIZE (weeks since LMP*)	SUGGESTED CANNUAL SIZE (mm)
4 - 6	4 - 7
7 - 9	5 - 10
9 - 12	8 - 12
12 - 14	10 - 14

It is critical to insert the cannula gently through the cervix. A forceful movement of the cannula increases the risk of trauma to the cervix and the uterus or to the surrounding pelvic organs.

Attach the prepared aspirator to the cannula with care that the cannula does not advance further into the uterus.

Release the buttons on the aspirator to transfer the vacuum through the cannula into the uterus. Blood, tissues, and bubbles should begin to flow through the cannula into the aspirator.

Evacuate the contents of the uterus by rotating the cannula 180 degrees in each direction while using a gentle in and out motion to cover all surfaces of the uterine cavity.



WHAT TO DO IF THE FOLLOWING HAPPENS:

1

If the aspirator fills up 2/3 and causes the suction to stop or when the syringe is full, depress the valve button or buttons and disconnect the cannula from the aspirator. If there are signs the uterus is not empty, leave the cannula in place in the uterus. Then use either a new aspirator or the current aspirator (after you have emptied the contents), create a new vacuum, and re-attach it to the cannula to remove the remaining contents.

2

If the cannula becomes clogged, ease it back toward but not through the external os of the cervix. This movement will often unclog the cannula. Alternatively, withdraw the cannula and aspirator together with depressing the button or buttons. Remove the tissue with sterile forceps. Re-establish vacuum in the aspirator, reinsert the cannula using the no-touch technique and continue the procedure if required. Never try to unclog the cannula by pushing the plunger back into the cylinder.

3

The signs that the uterus is empty include red or pink foam without tissue that is seen passing through the cannula and a gritty sensation that is felt as the cannula part is over the surface of the evacuated uterus and if the uterus contract around the cannula. When you have established that the uterus is empty, depress the valve button or buttons and remove the cannula from the uterus; If the uterus feels empty and there are minimal products aspirated, consider whether the patient has an ectopic pregnancy and refer as appropriate.

Empty the contents of the aspirator into the appropriate container by releasing the buttons, squeezing the plunger arms, and pushing the plunger fully into the cylinder. Follow local protocols for sensitive disposal of fetal remains.

Instrument processing

!

It is important to establish what equipment you have in your clinic and read the instructions to understand infection control procedures. Check whether the equipment is sterile on arrival or if any part of it needs processing. All instruments designed for multiple uses must be high-level dis-infected or sterilized prior to first use and after each procedure. See document (TBD) for detailed procedures.

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POST - PROCEDURE

Patient support and counseling

- Immediately post-procedure, reassure the woman that the procedure is finished and help her off the couch or operating table and support her to a recovery area.
- Assess the patient for any further analgesic requirements and ensure these are administered.
- Ensure that there are supplies and equipment available to perform routine observations and manage any complications as for any other surgical procedure.

BEFORE DISCHARGE:

Assess the patient to ensure that bleeding has settled and that she is not in pain and that her pulse and blood pressure are normal.

Ensure that the patient has passed urine before she leaves.

Ensure that the patient is safe to leave and that she has the correct follow-up information if she should experience any complications or have any questions.

Patients may not require routine follow-up, but this will depend on your local protocols. Dispense any analgesia which can be taken for a few days after discharge.

Advise her that it is normal to have some vaginal bleeding, and it is usually heavier than a normal period. Bleeding can last for up to a week, but the key point is that it should get lighter over this time.

Discuss post-procedure recommendations such as avoiding sexual intercourse, douching, or placing anything in the vagina until heavy bleeding stops. Post MVA pain can cause some cramping pains like period pain which can come and go for 5-7 days after the procedure.

If the pain or bleeding persists or worsens or if she has any fever above 99.5 degrees F, chills, abnormal or offensive discharge, she should seek medical advice. Clarify when and how to seek help if existing symptoms worsen or new symptoms develop, including a 24-hour contact telephone number.

Offer to address any emotional needs the woman might have immediately following her procedure. Ensure that sufficient time is available to discuss these issues with women during the course of her care and arrange an additional appointment if more time is needed.

After early pregnancy loss, offer the woman the option of a follow-up appointment with a health-care professional of her choice.

When advising the patient about conceiving again, counsel that she can try for another pregnancy as soon as she feels ready.

Complications of pregnancy loss

Women may present to your service with complications from a spontaneous miscarriage that has already occurred or from an unsafe uterine evacuation performed elsewhere.

If this is suspected either through the medical history or by assessment of clinical status, ensure that protocols are followed to identify and manage them with all the necessary equipment and supplies that are regularly checked, functioning, and accessible.

Interventions may include:

1. Intravenous fluid replacement,
2. Blood transfusion,
3. Oral or intravenous antibiotics, and
4. Uterine evacuation with antibiotic cover if required.

Every facility providing MVA services must be able to stabilize and treat or refer women with hemorrhage immediately.

Complications such as severe bleeding, uterine injury, or infection are rare with first-trimester MVA itself but can occur at the time of procedure or present after the patient has been discharged.

Documentation

Robust documentation is critical to high-quality patient care. It should include contemporaneous accounts of patient assessment, investigations, and documentation of results. All decisions and the rationale for interventions should also be accurately documented together with any drugs administered and procedures carried out. This process not only supports safe and effective care for the patient on the day but contains essential information if she returns with any complications and provides data for quality audit

APPENDICES

1

Pre training questionnaire to submit prior to training

2

Competencies for EPL MVA service provision for women under 14 weeks

3

Competency assessment for trainees

APPENDIX 1

Pre-training questionnaire to submit prior to training

Name of trainee:

Date of training:

- What is your role?
- Are you eligible to provide counseling for women who are experiencing early pregnancy loss?
- Are you eligible to provide MVA?
- Are you going to have enough case load to maintain your skills after training?
- Is there anyone who will assist you with ongoing educational support?
- What is your motivation to provide high quality MVA services?

APPENDIX 2

Table 1:

Competencies for EPL MVA service provision for women under 14 weeks 1/2

COUNSELING AND INFORMED CONSENT			
Competency	Achieved	Not Achieved	Plans for improvement
Knowledge of the advantages and disadvantages of all options for EPL management and explain these to the patient			
Ability to assess patient's individual situation to make informed decisions regarding treatment options			

CLINICAL ASSESSMENT			
Competency	Achieved	Not Achieved	Plans for improvement
Ability to take a medical history			
Estimate gestational age			
Ability to assess for pain options			
Assess the need for cervical preparation			

MVA PROCEDURE			
Competency	Achieved	Not Achieved	Plans for improvement
Assess the size of the uterus on bimanual examination			
Speculum examination			
Demonstrate competence in paracervical block technique			
Demonstrate competence in identifying and assembling equipment			
Demonstrate competence in gentle no touch techniques and assessing the length of the uterine cavity			
Demonstrate competence in the MVA procedure and aspiration of uterine contents			

APPENDIX 2 cont.

Competencies for EPL MVA service provision for women under 14 weeks 2/2

MVA PROCEDURE (CONTINUED)			
Competency	Achieved	Not Achieved	Plans for improvement
Identification of products of conception			
Demonstrate knowledge of how to assess whether the uterus is empty			
How to monitor and manage patient for pain			

RECOVERY AND DISCHARGE			
Competency	Achieved	Not Achieved	Plans for improvement
Ability to assess whether the patient is safe for discharge			
Ability to recognize and manage complications			
Explain what is normal and abnormal (signs and symptoms) in the next few weeks			
Give discharge instructions			
Reiterate who/ how to contact for help/ advice/ support			
Advice abstinence until the bleeding stopped			
Dispense antibiotics and analgesics			
Discuss analgesic needs and dispense as appropriate			

If you do not achieve the required competencies by the end of the training, then you and the trainer can discuss whether you can practice under direct supervision in your home training environment before you can provide EPL services independently. It may be that you and the trainer will discuss repeating the training. The possible training outcomes are summarized in Table 2, and a longer version of this for you to fill in after training can be found in Appendix 3 of this manual.

Name of trainee: Date of training:

APPENDIX 3

Competency assessment for trainees

Name of trainee:		Date of training:	

Area of competency	Provide independently without need for supervision?	Requires direct supervision before independent practice?	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:			

Contact

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