Expansion of Comprehensive Abortion Services into the Second Trimester:

Key Programming Elements

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Acknowledgements

In 1997, Ipas expanded its technical guidance to the second trimester of pregnancy to address the urgent need for safe services in Vietnam. Since that time, we have provided training and technical guidance on second-trimester abortion in South Africa, Nepal, Cambodia and Ethiopia. In each of those countries, the providers, support staff and, especially, the women undergoing second-trimester abortion contributed significantly to the development of this guidance.

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Introduction

This guidance is designed for any health facility planning to expand its abortion services to include abortions in the second trimester of pregnancy. It provides the tools and resources necessary to successfully introduce and continue second-trimester abortion services and/or second-trimester postabortion care.

Originally developed for Ipas programs, this guidance is carefully designed to be successful in providing women with safe, high-quality and sustainable second-trimester abortion services. It seeks to standardize the expansion of comprehensive abortion services into the second trimester of pregnancy, but also can be adapted to the unique needs of your setting.

Each step of programming is covered in the guidance and related materials:

- needs assessment and garnering support for expansion of services;
- values clarification and attitude transformation training;
- provider and site selection and preparation;
- clinical training;
- identifying and managing complications;
- post-training mentoring and competency achievement;
- provider and site support (networking);
- caselog reporting;
- quality assurance measures; and
- adverse event reporting.

Because the clinical literature on abortion care continues to evolve, specific regimens generally will not be included in the tools. Please refer to the regularly updated Ipas publication *Clinical Updates in Reproductive Health* (available online at www.ipas.org/clinicalupdates), which provides Ipas's most up-to-date clinical guidance including regimens. Recommendations found in the *Clinical Updates in Reproductive Health* are more current than any clinical guidance found in Ipas print documents.

Glossary

Comprehensive program: A program focused on training and service delivery in both dilation & evacuation and medical abortion.

Second-trimester medical abortion (STMA): An abortion via medications, most commonly misoprostol-only or mifepristone with misoprostol, at 13 weeks gestation or higher.

Second-trimester dilation and evacuation (D&E): An abortion performed with a combination of suction aspiration and extraction forceps at 13 weeks gestation or higher.

Second-trimester postabortion care (PAC) treatment: Treatment of incomplete and/or unsafe abortion and abortion-related complications that are potentially life-threatening in the second trimester.

Values Clarification and Attitude Transformation (VCAT): VCAT is a process to examine personal values, attitudes and actions related to abortion and the harmful consequences of stigmatizing abortion and restricting service delivery and access to care.

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PROGRAM PREPARATION

Although the need for second-trimester abortion services may seem obvious due to the significant morbidity and mortality associated with unsafe second-trimester procedures, the reality of expanding an abortion program into the second trimester of pregnancy can be challenging. Second-trimester abortion training and service provision comes with its own set of issues above and beyond those experienced with first-trimester abortions—issues such as the technical expertise needed, unique equipment requirements, the potential for complications and heightened stigma. Recognizing these issues is the first step toward creating a receptive environment for program expansion into the second trimester of pregnancy.

I. Garnering support and creating a receptive environment

- You may need to **start within your own team.** We encourage a half- or full-day in-service training that includes education about second-trimester abortion as well as VCAT (values clarification and attitudes transformation) activities specific to second trimester abortion. (See the "VCAT Exercises" included in this toolkit.)

  These early discussions can help you better understand the concerns and potential barriers to second-trimester abortion specific to your context. Additionally, these team sessions can be used to discuss ways to facilitate and ease staff-to-staff conversations and interactions with external individuals and organizations regarding why expansion of abortion services into the second trimester is critical to the health and well-being of women.

- Next, **identify and approach key stakeholders at all levels of your health-care system,** such as the Ministry of Health, partner non-government organizations, hospital administrators and physicians. If country or region-specific outcomes data is not available, a needs assessment may be required to support programmatic expansion into the second trimester. Finally, key stakeholders may have strong preferences regarding the type of second-trimester program model to pursue (MA- or D&E-only versus a comprehensive program).

II. Deciding on a training and service delivery model: MA- or D&E-only, or both?

Early in the planning process, you need to decide whether the program will focus on the introduction of MA- or D&E-only, versus both. This decision has significant implications before, during and after the training.

RECOMMENDATION: Both types of programs require a substantial amount of attention, but be aware that a program including D&E is more time and resource intensive.

Rationale: A new surgical technique, like D&E, needs to be practiced almost immediately and continually. Otherwise, the proficiency and knowledge gained during the training may be lost, potentially increasing the risk of complications. If a trainee is unable to practice these new skills then re-training needs to take place prior to actual care of clients, which is both time consuming and costly. For D&E, this requires that facilities are ready both physically (available space, equipment, case load, and dedicated staff time) and emotionally (VCAT for staff and provider) immediately after the training to start providing services. This state of readiness requires a significant amount of preparation prior to the actual training, including ensuring equipment sustainability. Additionally, technical competency is not achieved with the completion of the D&E training course. Trainees should undergo a series of onsite supervisory visits to directly assess their

level of competency (See the "Trainer and Trainee Guide to Post-Training Follow Up and Achievement of Competency.") Level of experience with D&E is directly related to complication rates.

Reasons to choose an MA-only program
• Low case volume • Infrequent use of vacuum aspiration for first-trimester abortion • D&E equipment supply not sustainable • Key stakeholders and/or providers not supportive of D&E • Immediate introduction of services needed for harm reduction

III. Site selection and equipment needs

RECOMMENDATION: Start with one training site and create a core team of experts.

The first training in a country or within a system should be limited to a small group of clinicians (approximately three to five) and associated staff from ONE well-chosen facility.

Rationale: There are several challenges associated with providing second-trimester abortion services:

- Second-trimester training requires caution because of the higher level of skills and experience needed to provide second-trimester D&E, and because of the higher rates and severity of complications associated with second-trimester abortions in general.
- This type of training calls for close post-training follow-up to assess trainee competence (typically, several months of repeated site visits).
- Continued quality assurance monitoring is desirable.
- Clinicians who provide second-trimester services assume a large emotional burden because of the greater political and social stigma surrounding second- trimester abortions. They may need ongoing emotional support.

In the context of these challenges, focusing on a single site with a few experienced clinicians and support staff (e.g. nurses) makes it more likely that the training will result in sustained services (institutionalizing the service). In other words, develop depth and expertise in one limited setting before expanding to other sites. Once trained, the initial facility and group of graduates can offer a credible training site and center of excellence for other trainees, providing a foothold for expansion of high-quality, second-trimester services within a given region or country. Because of the high level of resources and close follow-up needed for second-trimester abortion training, it is not advisable to apply a model where a large number of providers from multiple sites are trained.

RECOMMENDATION: In-person facility assessments are needed to determine if a facility meets the minimum requirements for supporting second-trimester services at that site.

Rationale: In order to provide safe and high-quality second-trimester care, the appropriate infrastructure must be available at a chosen site.

RECOMMENDATION: Obtain site administrative, managerial, and leadership support/commitment before training.

Discussions with the site's leadership and, in some instances, the Ministry of Health (depending on the country) may be needed prior to finalizing site selection.

> ***Rationale:*** Success of second-trimester abortion training depends on administrative and staff support. In particular, facilities and providers must be able and willing to continue sharing information regarding their caseload and complication rates after the training and attainment of competency. This commitment often requires at least a year of ongoing communication. Additionally ongoing supportive supervision aids in strategic planning and problem-solving with sites and providers as the program grows.

Site Selection – Summary of Recommendations

- Train only a small group of providers at one facility for the initial training.
- Facilities and providers should be willing to monitor and evaluate caseloads and complications rate and share them to ensure standards achieved through benchmarking with literature and/or other sites.

IV. For sites planning D&E provision

RECOMMENDATION: Complete an inventory of D&E equipment available at the training site. Use the "Facility Assessment Form (D&E and MA)" and the "D&E Equipment List" included in this toolkit.

During the initial site assessment, the equipment available at the site should be compared against the "D&E Equipment List." A clear determination then can be made regarding equipment needs.

> ***Rationale:*** The use of correct instruments is an important part of safely providing second-trimester abortion care; D&E should not be performed without the proper equipment. In many cases, large forceps, dilators and cannula will not be available at the site and will need to be purchased. In addition, instruments initially supplied to perform safe D&E procedures may become lost or broken with repetitive use (e.g., cannulas), so sites will need to have a resupply plan in place prior to beginning training.

RECOMMENDATION: Discuss options for obtaining supplies and replacing lost or broken equipment.

> ***Rationale:*** Becoming familiar with various supply options can help staff decide how to budget for the purchase of necessary equipment. Options include government budget and procurement systems and donor budgets.

D&E Equipment – Summary of Recommendations

- During the initial site assessment, the equipment at the site should be compared against the "D&E Equipment List" and the "Facility Assessment Form (D&E and MA)" to identify needed instruments.
- The appropriate equipment for the training and for the trainee post-training must be budgeted for and purchased before the training course begins.
- A resupply plan must be in place.

V. Trainee selection

RECOMMENDATION: Focus on training providers who have dedicated time to provide services.

- Trainees must allow post-training follow-up visits and commit to sharing case log information, including SAEs .
- Trainees should have undergone a prior training with exposure to MVA and women-centered care.
- Obstetric experience is desirable, but not required.

Specific to D&E:

- Trainees must possess excellent skills in late first-trimester MVA (10 to 12 weeks); their proficiency should be directly observed and assessed by a trainer, as trainee self-reporting is not a good predictor of actual skills.

Rationale: MVA skills are used for both types of second-trimester abortion, D&E and MA. For D&E, trainees must already have expertise in MVA as they are building on these skills in order to perform D&E. For MA, MVA is used to manage retained placenta, thus experience with MVA is helpful but the skills can be introduced during the training if necessary.

It is certainly possible to train clinicians who have no previous obstetric experience, but this creates challenges during the training intervention. Some second-trimester abortion complications are quite similar to postpartum complications (e.g. retained placenta, hemorrhage). Providers with obstetrical experience will have familiarity and experience with managing these situations.

RECOMMENDATION: Training should include lead clinicians and support staff from the selected site.

Rationale: Because trainees should support each other over time, a team approach facilitates implementation of new services at a site. The reinforcement that trainees provide to one another may be especially important in decentralized or restrictive settings—training a team from a single site makes the service delivery context more supportive, decreasing the likelihood of isolation, burnout and trainee attrition. Team training also makes it more likely that the program will continue if staff transitions occur, and more likely that team members will pass on their new skills to others. In contrast, if only one or two clinicians are trained and the doctor leaves the job, the program is in jeopardy.

Additionally, the inclusion of lead or highly respected clinicians provides greater legitimacy to this highly stigmatized care.

RECOMMENDATION: Before the actual training, conduct a values clarification and attitudes transformation (VCAT) workshop (sensitivity training) for potential trainees and their support staff, representative staff (such as administrators) who are instrumental in supporting second-trimester abortion services at a facility, and any staff who have contact with women receiving services. Use the "VCAT Exercises" included in this toolkit.

Rationale: Initially interested trainees sometimes discontinue providing services for a variety of reasons—including lack of support, change in interest or difficult feelings. This attrition is expensive and creates wasted effort. A VCAT workshop can help ensure that trainees who chose to

be trained will continue to provide services. Additionally, VCAT activities at a potential training site prior to the training may help to identify a hostile environment that may make service introduction difficult (i.e. an administrator or other staff who are not supportive of second-trimester abortion). Although some potential trainees may already be involved in second-trimester abortion and/or postabortion care, they may not have had hands-on experience seeing, extracting and/or disposing of fetal parts to the extent that occurs with second-trimester surgical procedures (D&E).

RECOMMENDATION: Trainees should be prepared to invest significant time.

Train only those providers who actually have the time to dedicate to training, clinical practice and follow-up. Create an action plan for the follow-up.

Rationale: Follow-up is much more time-intensive for second-trimester services than for first-trimester training.

Trainee Selection – Summary of Recommendations

- Trainees must be experienced and facile with the provision of late first-trimester MVA procedures (10-12 weeks). Direct observation of these skills must occur prior to undergoing D&E training.
- Prior obstetric experience helps.
- Train a team from one site with the initial introduction of services.
- Conduct a values clarification workshop specific to second-trimester abortion prior to training.
- Select trainees who have time to provide second-trimester abortion care.

VI. Trainer selection

RECOMMENDATION: Select skilled and experienced trainers (local and international) who have undergone a training-of-trainer course and are experienced in second- trimester abortion.

Trainer Selection – Summary of Recommendations

- Second-trimester abortion trainers must have participated in a training-of-trainer course, be familiar with second-trimester abortion protocols, and be experienced second-trimester abortion providers.

VII. Training

This section will review strategies regarding planning a training schedule, ensuring an optimal trainer-to-trainee ratio, clarifying training expectations, reviewing case logs and adverse event reporting, and discussing patient care ground rules.

Training schedule

RECOMMENDATION: The length of the training is dependent on the type of program (MA- or D&E-only or both) and the case volume. The didactic portion for both types of programs takes approximately five to six days. For MA-only training, a total of six to seven days is typically sufficient as the hands-on portion of the training can start on Day 2. For a D&E-only or a combined program, plan for at least 10 days of training. In some instances, the course may need to be longer than 10 days (particularly if the site's caseload is low).

Rationale: The second-trimester training course incorporates adult learning techniques with a combination of structured didactic sessions, case studies and hands-on training (models and actual patients).

Training Schedule – Summary of Recommendations
• The length of a second-trimester training course is dependent on the type of program chosen, ranging from 6-7 days for an MA-only course to 10 days or longer for a D&E-only or comprehensive course. • See sample training agendas.

Trainee-to-trainer ratio

RECOMMENDATION: This training focuses on training teams which typically include two to three physicians and two to three support staff (nurses) from each site. The training should be limited to five to seven trainees (physicians plus nurses) per trainer in the classroom, and three physician trainees per trainer in the procedure room.

Rationale: Second-trimester training, especially in D&E, requires intensive oversight and support. In the procedure room, smaller hands-on groups allow trainees to rotate through different roles, including clinician, support person, and assistant (who also provides feedback and helps the clinician with the Standardized D&E Procedure Checklist.).

Trainer-to-Trainee Ratio – Summary of Recommendations
• For classroom training, there should be no more than 5-7 trainees per trainer. • For hands-on procedures, have 3 physician trainees per trainer.

VIII. Training expectations

RECOMMENDATION:

- Award a certificate of D&E competency only after the trainee has completed supervised, ongoing service provision.

- Track and report all second-trimester D&E and MA procedures during and after the training period until at least competency is achieved, but ideally sites/providers will continue collection indefinitely to aid in internal ongoing quality improvement.
- Serious adverse events should reported and reviewed as part of a site's or program's quality improvement system. Creation of a safety culture may need to be discussed and trialed in order for providers to feel comfortable reporting adverse events. Use of root-cause analysis to analyze adverse events can help to improve the safety and quality of services.

Rationale: Upon completion of training, participants will be considered competent to deliver second-trimester medical abortion services. However, completion of training does NOT imply competency for D&E procedures (although trainees do receive a certificate of participation at the end of the hands-on training). In most instances, approval to perform D&E should be granted incrementally, by allowing training graduates to perform earlier second-trimester D&E before carrying out the procedure at later gestational ages. In rare cases, trainers may consider it appropriate to approve trainees only for second-trimester medical abortion services and not D&E services.

Ongoing review of cases after the attainment of competency will provide information that can be used internally for quality improvement purposes, and to guide decisions about the viability of future training sessions and/or the need for "refresher" courses.

Training Expectations – Summary of Recommendations

- A certificate of participation will be achieved if a trainee successfully completes the second-trimester training course.
- To achieve competency in D&E, trainees will need to be observed performing additional cases after the actual training.
- An incremental approach is recommended for approval of D&E services (for example, the trainee may be approved initially to provide D&E services up to 13 to 14 weeks, then 15 to 16 weeks, then 17 to 18).
- Prior to the end of the training course, trainers and trainees should discuss how to track second-trimester abortion cases (medical and D&E) during and after the training.
- A protocol for reporting serious adverse events (SAEs) should be established.

IX. Post-training

This section addresses issues regarding trainee follow-up, ensuring trainees' emotional well-being, obtaining necessary instruments and monitoring adherence.

D&E trainee follow-up

RECOMMENDATION: Limit lag time between the training course and the observation of supervised cases.

Trainers should devise a follow-up action plan with trainee. The action plan should include the actual personnel (local or international) who will complete the follow-up, along with a time line.

Rationale: A new technique (D&E) needs to be practiced almost immediately and continually. Otherwise, the proficiency and knowledge gained during the training and model practice may be lost, potentially increasing the risk of complications. If the trainer is unable to supervise procedures within six weeks of the training, then at the time of follow-up the trainer and trainee must review the Standardized D&E Procedure Checklist and perform several procedures on a model prior to performing procedures on actual clients.

Post-Training Follow-Up – Summary of Recommendations

- The training team must prepare a follow-up action plan with the trainees
- If the trainer is unable to supervise procedures within six weeks of the training, then at the time of follow-up the trainer and trainee must review the Standardized D&E Procedure Checklist and perform several procedures on a model prior to performing procedures on actual clients.

Trainee emotional well-being and support

RECOMMENDATION: Establish a supportive network for participants after they complete training.

The training team can help trainees set up an email listserve, phone tree or some other mechanism to foster mutual support.

Rationale: Providing second-trimester abortion services can be stressful for both physicians and support staff. Complication rates are slightly higher than first-trimester abortions, and issues surrounding second-trimester abortion are often harder to share with a provider's regular support network. Establishing a forum where providers and staff can find support for their challenges and successes can help with these issues.

Emotional Well-being and Support – Summary of Recommendations

- Set up an appropriate support network for providers that you train.

Competency and supportive supervision follow-up for D&E providers

RECOMMENDATION: Supervision should include an assessment of trainees' adherence to the Standardized D&E Procedure Checklist.

Rationale: As providers become more facile and experienced with D&E, they sometimes slightly change how they perform the procedure, either performing it incorrectly or skipping a step entirely. Although some changes do not affect safety, other modifications to the protocol possibly can have a serious impact. Deviations in D&E protocol that we know to affect safety include inadequate dilation, not using the appropriate cannula size (14mm cannulas for most second-trimester procedures involving MVA), and not inspecting tissue thoroughly.

Competency and Supportive Supervision Follow-Up for D&E Providers–Summary of Recommendations

- During post-training follow-up, pay particular attention to the trainee's D&E technique.
- Verify that the appropriate D&E steps are being followed (Standardized D&E Procedure Checklist) and that the correct instruments (e.g., size 14mm cannulas) are being used.

X. Appendix

Tools/Job Aids included in this toolkit:

Pre-training/Assessment

- Program needs assessment
- Facility assessment form (D&E and MA)
- Trainee assessment form (D&E and MA)
- Facility and trainee assessment form (MA only)
- D&E equipment list
- Client evaluation form
- VCAT exercises

Training

- Standardized D&E Procedure Checklist
- Competency Checklist (MA only)
- Job Aid (MA only)
- Nursing Job Aid (MA only)
- Complications Job Aid/Flowchart (MA only)
- Job Aid (D&E)
- Client Monitoring (MA only – for use at client's bedside)
- Sample agenda: MA training
- Sample agenda: MA nurse/midwife training
- Sample agenda: Assistant/support staff orientation

Post-training

- Facility and trainee follow-up assessment (MA only)
- Trainee follow-up assessment: Case logbook summary (MA only)
- Severe Adverse Event (SAE) reporting (MA only)
- Trainer and trainee guide to post-training follow up and achievement of competency

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