

Appendix B

Postabortion Care Resource Materials

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Postabortion Counseling

Postabortion counseling:

- Focuses on helping individuals to make choices and to manage the emotions raised by their situation
- Goes beyond just giving facts; it enables clients to apply information to their particular circumstances and to make informed choices
- Includes a discussion of feelings and concerns, since they are relevant to the client's choices, particularly regarding sexual behavior, reproductive health, and fertility

Counseling always involves two-way communication between the client and the provider, in which each spends time talking, listening, and asking questions.

According to the World Health Organization:

“Counselling—face-to-face communication in which a counsellor assists the woman in making her own decisions and acting on them—must be a part of all abortion care.... Ideally, the same counsellor should provide support before, during, and after treatment; however, this is often difficult in a health care facility with limited staff and high caseloads. Nevertheless, a supportive and caring staff can do much to meet the psychological and emotional needs of women seeking emergency abortion care or elective abortion.

Counselling in abortion care can be provided by a variety of staff members, including nurses, midwives, physicians, social workers or nurse aides. [*Note:* This list of providers will vary, depending upon the country.] Volunteers have been used successfully in some situations. A professional counsellor is not necessary; however, training in counselling techniques should be provided for any staff functioning as counsellors.

Staff who provide counselling must be non-judgemental, extremely sensitive to and respectful of the woman's emotions and feelings, in order to adapt the session to the woman's specific needs. Counsellors should be knowledgeable, well-trained, and able to give accurate information. Counselling staff must always be aware of the need for privacy, confidentiality, and, in some cases, anonymity.... Critical elements of all good counselling include the ability of the counsellor to elicit and listen to a woman's needs, concerns, and questions, and to inform, educate, and reassure, using language and terms that the woman understands.... It is also useful to augment verbal explanations with written and pictorial materials to reinforce what has been said in the counselling sessions.”

—WHO, 1995.

Note: The materials presented here are reprinted from EngenderHealth, 2003c.

Counseling the Postabortion Client

Preprocedure

- Assess the client's ability or capacity to give or receive information
- Explore the client's needs and feelings
- Examine the client's values and life plans
- Based on the client's condition, provide information about the following, as appropriate:
 - Exams and findings
 - Treatment procedure/anesthesia
 - Possible side effects, complications, and risks
 - Human reproductive processes
 - Available contraceptive methods



During the procedure

Maintain emotional support by providing:

- Positive, empathetic verbal and nonverbal communication
- Gentleness while performing the procedure



Postprocedure

- Explore the client's feelings, questions, and concerns after the procedure—provide support and encouragement
- Remind the client of possible side effects, risks, and warning signs, and that she should return if warning signs occur
- Tell the client how to take care of herself at home
- Give her written postprocedure information
- Remind the client of the importance of follow-up
- Discuss available contraceptive methods, as appropriate
- Discuss reproductive tract infections and sexually transmitted infections
- Assess the need for additional counseling or referral for other reproductive health needs or non-medical issues

Counseling Guidelines for the Provider

Before the PAC Procedure

It is important to obtain sufficient medical information to make an accurate diagnosis and develop a treatment plan. Assure the client that these questions are being asked to get the information needed to best treat her medical condition. Examples of questions that should be asked are:

- When did the bleeding start? Is it a lot or a little?
- How did the bleeding start? Was something done to start the bleeding? (Ask these questions with sensitivity and discretion.)
- Have you passed anything from the vagina besides blood? Did it look like skin or clotted blood with tissue?
- Do you have pain? Where? When did it start? How bad is it?
- Have you had a fever? Chills?
- Have you felt weak? Fainted? Collapsed?

All women being treated for abortion complications have a *right to information* about their condition, including:

- Their overall physical condition
- Results of physical and pelvic examinations and lab tests
- The time frame for treatment
- The need for referral and transport to another facility
- Procedures to be used, as well as risks and benefits

Providers *must* have the client's consent for treatment or, if she is unable to give it, that of a family member or other responsible adult.

Be sensitive to the client's physical and emotional condition when providing information; forcing her to listen when she is not ready will just be a waste of your time and hers.

Always ask the client if she has any questions for you.

Explore her needs and feelings about her situation, and future plans, if her condition permits.

Note: Adapted from: Winkler, Oliveras, & McIntosh, 1995.

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After the PAC Procedure

Once the surgical procedure has been completed:

- Approach the client when she is already calm and recovering from the procedure. Be sensitive to her physical and emotional condition; forcing her to listen when she is not ready will just be a waste of your time and hers.
- Be flexible about where you conduct counseling. Sometimes clients may feel strong enough to get up and talk to the provider in a separate room; others may prefer to remain in bed and be counseled while still in the recovery room.
- Be aware that the important thing is to provide the client with useful information that is suitable to her needs.
- If others have accompanied the client to the service site, ask if she would like to include them in the discussion.
- Start the counseling by exploring the client's feelings, questions, and concerns after the postabortion procedure.
- Follow the postabortion counseling diagram (page 192) to check what information may be given to the client.
- Explore the client's postprocedure plans.
- Provide the client with the Postprocedure Information Sheet (page 195) and review it with her (and with others, as appropriate).
- Offer to help her with whatever she needs, as appropriate, before saying good-bye.

Postprocedure Information Sheet

How to Take Care of Yourself

- Resume normal activities only when you feel comfortable enough to do so.
- Take the medications you have been given *correctly and completely*:

- _____ is an antibiotic to prevent or treat infection.
Take _____ pills _____ times a day for _____ days until all pills are gone.
- _____ is for discomfort.
Take _____ pills every _____ hours, as needed.
- Iron tablets will make your blood normal and healthy again.
Take _____ tablets _____ times a day.

- Keep your follow-up appointment as scheduled on _____. Return at any time if you have concerns.
- If you are interested in using a family planning method, talk to a provider about starting one *right away*. It is possible to become pregnant as soon as you resume sexual relations.

Avoid:

- Strenuous activity for two to three days
- Sexual relations until the bleeding has stopped

What Is Normal:

- Bleeding and cramping similar to a normal period for up to one week
- Mild fatigue for a few days
- Mild depression or sadness for several days

What Is Abnormal:

- Fever
- Dizziness, lightheadedness, or fainting
- Abdominal pain
- Severe cramping
- Nausea or vomiting
- Bleeding that is twice as heavy as a normal period
- Vaginal discharge that smells bad

Return *immediately* if you experience any of these symptoms!

Special Instructions:

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Simple Answers to Clients' Questions about Postabortion Family Planning

Q: When can I resume sexual activity?

A: After your bleeding has stopped.

Q: How soon can I become pregnant?

A: Almost immediately—even before your next period.

Q: How can I avoid becoming pregnant again?

A: Start using a family planning method now.

Q: Which methods can I use right away?

A: Ask your family planning counselor which methods may be right for you. The family planning methods that can be safely used immediately after abortion include:

- Condoms
- Oral contraceptives (the pill)
- Injectables (DMPA, NET-EN)
- Norplant implants
- Spermicidal foams, jellies, tablets, sponge, or film
- Diaphragm or cervical cap
- IUD (The IUD should not be inserted following possible infection, injury to the genital tract, or severe bleeding with anemia.)
- Female or male sterilization

Q: Which methods protect against STIs and HIV?

A: Only *condoms* and *abstinence* offer protection against STIs and HIV.

Note: If you have intercourse without using a family planning method, ask your provider about emergency contraception. If you take a special dose of birth control pills within 72 hours (three days) after intercourse, you have a much lower chance of becoming pregnant.

Note: Adapted from: Winkler, Oliveras, & McIntosh, 1995.

Statements on Contraception, Informed Choice, and Postabortion Care

“Free and informed choice means that the patient/family planning client chooses a contraceptive method voluntarily, and without pressure or coercion. It is based on a clear understanding of the benefits and limitations of the methods that are available. The patient/client should understand that almost all methods can be used safely and effectively immediately after treatment of an incomplete abortion and that she can choose another method later if she wishes to change [except in the case of sterilization].”

—Winkler, Oliveras, & McIntosh, 1995.

“Remember: Acceptance of contraception or of a particular contraceptive method should never be a prerequisite for obtaining emergency postabortion care.”

—Winkler, Oliveras, & McIntosh, 1995.

“The provision of emergency abortion care or elective abortion procedures must not be made conditional on the acceptance of family planning in general, or of a specific method of contraception. Women need information on a wide range of contraceptive methods in order to make their own selection, in consultation with clinic staff. Managers can ensure that coercion is not being used in method selection by monitoring trends in contraceptive distribution to women after abortion.”

—WHO, 1995.

“Service providers should establish mechanisms to assure women the opportunity to make informed, voluntary choices about post-abortion family planning use. Provision of abortion care should never be contingent on acceptance of a family planning method, and a woman should never be given a method to which she does not consent. Furthermore, no woman should leave a service setting without all the information necessary to enable her to continue or discontinue use of the method she has chosen. Adherence to these principles is particularly important where long-term or provider-dependent methods are concerned and in the crisis context of emergency care settings.”

—Wolf & Benson, 1994.

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Individual Factors for Family Planning Counseling during Postabortion Care

Factors	Recommendations	Rationales
1. If the woman does not want to be pregnant soon	Consider all temporary methods.	Her seeking treatment for abortion complications suggests that she does not want to be pregnant.
2. If the woman is under stress or is in pain	Consider all temporary methods. Do not encourage use of permanent methods at this time. Provide referral for continued contraceptive care.	Stress and pain interfere with making free, informed decisions. The time of treatment for abortion complications is not a good time for a woman to make a permanent decision.
3. If the woman was using a contraceptive method when she became pregnant	Assess why contraception failed and what problems the woman might have had using the method effectively. Help the woman choose a method that she will be able to use effectively. Make sure she understands how to use the method, get follow-up care and resupply, discontinue use, and change methods.	Method failure, unacceptability, ineffective use, or lack of access to supplies may have led to the unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.
4. If the woman had stopped using a contraceptive method	Assess why the woman stopped using contraception (e.g., side effects, lack of access to resupply). Help the woman choose a method that she will be able to use effectively. Make sure she understands how to use the method, get follow-up care and resupply, discontinue use, and change methods.	Unacceptability or lack of access may have led to the unwanted pregnancy. These factors may still be present and may lead to another unwanted pregnancy.
5. If the woman has a partner who is unwilling to use condoms or will prevent use of another method	If the woman wishes, include her partner in counseling. Protect the woman's confidentiality (even if she does not involve her partner). Discuss methods that the woman can use without her partner's knowledge (e.g., injectables). Do not recommend methods that the woman will not be able to use effectively.	In some instances, involving the partner in counseling will lead to his use of and support for contraception; however, if the woman, for whatever reasons, does not want to involve her partner, her wishes should be respected.
6. If the woman was the victim of sexual abuse or rape	Inform her about emergency contraception (or other contraception, if appropriate).	The woman may be at risk for repeat assault or rape, and may have continuing need for emergency or other contraception.
7. If the woman wants to become pregnant soon	Do not try to persuade her to accept a method. Provide information or a referral if the woman needs other reproductive health services.	If the woman has had repeated spontaneous abortions, she may need to be referred for infertility treatment.

Note: Adapted from: Winkler, Oliveras, & McIntosh, 1995.

Guidelines for Contraceptive Use, by Clinical Condition

Clinical Condition	Recommendations	Precautions
<p>No complications after treatment of incomplete abortion</p>	<p>Consider all temporary methods.</p> <p><i>Norplant implants</i>: Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN)</i>: Can be used immediately.</p> <p><i>IUD</i>: Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only)</i>: Can be used immediately.</p> <p><i>Condoms (male/female)</i>: Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Can be used when sexual activity is resumed.</p> <p><i>Diaphragm or cervical cap</i>: Can be used when sexual activity is resumed.</p>	<p><i>Natural family planning</i>: Do not recommend until a regular menstrual pattern returns.</p> <p><i>Female sterilization</i>: The time of treatment for abortion complications usually is not the best time for clients to make decisions about methods that are permanent.</p> <p><i>Diaphragm or cervical cap</i>: Should be refit after a second-trimester abortion.</p>
<p>Confirmed or presumptive diagnosis of infection:</p> <ul style="list-style-type: none"> • Signs and symptoms of sepsis/infection • Signs of unsafe or unclean induced abortion • Unable to rule out infection 	<p><i>Norplant implants</i>: Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN)</i>: Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only)</i>: Can be used immediately.</p> <p><i>Condoms (male/female)</i>: Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Can be used when sexual activity is resumed.</p> <p><i>Diaphragm or cervical cap</i>: Can be used when sexual activity is resumed.</p>	<p><i>Female sterilization</i>: Do not perform until infection is fully resolved (approximately three months) or until risk of infection is ruled out.</p> <p><i>IUD</i>: Do not insert until infection is fully resolved (approximately three months) or until risk of infection is ruled out.</p>
<p>Injury to genital tract:</p> <ul style="list-style-type: none"> • Uterine perforation (with or without bowel injury) • Serious vaginal or cervical injury, including chemical burns 	<p><i>Norplant implants</i>: Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN)</i>: Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only)</i>: Can be used immediately.</p> <p><i>Condoms (male/female)</i>: Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Can be used when sexual activity is resumed (can be used following uncomplicated uterine perforation).</p> <p><i>Diaphragm or cervical cap</i>: Can be used when sexual activity is resumed (can be used following uncomplicated uterine perforation).</p>	<p><i>Female voluntary sterilization</i>: Do not perform until serious injury is healed.</p> <p><i>IUD</i>: Do not insert until serious injury is healed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film</i>: Do not begin use until vaginal or cervical injury is healed.</p> <p><i>Diaphragm or cervical cap</i>: Do not begin use until vaginal or cervical injury is healed.</p>

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Guidelines for Contraceptive Use, by Clinical Condition (*continued*)

Clinical Condition	Recommendations	Precautions
<p>Severe bleeding (hemorrhage) and related severe anemia (Hb <7 g/dL or Hct <20)</p>	<p><i>IUD (progestin-releasing):</i> Can be used with severe anemia (decreases menstrual blood loss).</p> <p><i>Combined oral contraceptives:</i> Can be used immediately (beneficial when hemoglobin is low).</p> <p><i>Condoms (male/female):</i> Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film:</i> Can be used when sexual activity is resumed.</p> <p><i>Diaphragm or cervical cap:</i> Can be used when sexual activity is resumed.</p>	<p><i>Female sterilization:</i> Do not perform procedure until the cause of hemorrhage or anemia is resolved.</p> <p><i>Progestin-only pills:</i> Use with caution until acute anemia improves.</p> <p><i>Norplant implants:</i> Delay insertion until acute anemia improves.</p> <p><i>Injectables (DMPA, NET-EN):</i> Delay starting until acute anemia improves.</p> <p><i>IUD (inert or copper-bearing):</i> Delay insertion until acute anemia improves.</p>
<p>Second-trimester abortion</p>	<p><i>Norplant implants:</i> Can be used immediately.</p> <p><i>Injectables (DMPA, NET-EN):</i> Can be used immediately.</p> <p><i>Oral contraceptives (combined or progestin-only):</i> Can be used immediately.</p> <p><i>Condoms (male/female):</i> Can be used when sexual activity is resumed.</p> <p><i>Spermicidal foams, jellies, tablets, sponge, or film:</i> Can be used when sexual activity is resumed.</p>	<p><i>Female sterilization:</i> Use postpartum minilaparotomy. If this technique is not possible, delay procedure until uterus returns to prepregnancy size (four to six weeks).</p> <p><i>IUD:</i> Use postpartum insertion technique with high fundal placement. If an experienced provider is not available, delay insertion four to six weeks.</p> <p><i>Diaphragm or cervical cap:</i> Should be refit when uterus returns to prepregnancy size (four to six weeks).</p>

Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
<i>Nonfitted barrier methods:</i> latex and vinyl male/female condoms; and vaginal sponge and suppositories (foaming tablets, jelly, or film)	These methods may be used as soon as sexual intercourse is resumed.	<ul style="list-style-type: none"> • Are inexpensive • Are good interim method if use of another method must be postponed • Require no medical supervision • In the case of condoms (latex and vinyl), provide protection against sexually transmitted infections (STIs), including HIV • Are easily discontinued • Are effective immediately 	<ul style="list-style-type: none"> • Are less effective than IUD or hormonal methods • Require use with each episode of intercourse • Require continued motivation • Require resupply to be available • May interfere with intercourse
<i>Fitted barriers used with spermicides:</i> diaphragm or cervical cap with foam or jelly	<p>The diaphragm can be fitted immediately after first-trimester abortion; after second-trimester abortion, fitting should be delayed until uterus returns to prepregnancy size (four to six weeks).</p> <p>Fitting the cervical cap should be delayed until bleeding has stopped and the uterus has returned to its prepregnancy size (four to six weeks).</p>	<ul style="list-style-type: none"> • Are inexpensive • Require no medical supervision for use • Provide some protection against STIs, including HIV • Are easily discontinued • Are effective immediately 	<ul style="list-style-type: none"> • Are less effective than IUD or hormonal methods • Require use with each episode of intercourse • Require continued motivation • Require resupply to be available • Are associated with urinary tract infections in some users • Require fitting by trained service provider
<i>Oral contraceptives:</i> combined and progestin-only	Pill use may begin immediately, preferably on the day of treatment.	<ul style="list-style-type: none"> • Are highly effective • Can be started immediately, even if infection is present • Can be provided by nonphysicians • Do not interfere with intercourse 	<ul style="list-style-type: none"> • Require continued motivation and daily use • Require resupply to be available • May have reduced effectiveness if client has used certain medications (e.g., rifampin, dilantin, or griseofulvin) long-term • Necessitate condom use if client is at risk for STIs, including HIV

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Guidelines for Selecting Contraception, by Method *(continued)*

Method	Timing postabortion	Advantages	Remarks
<i>Injectables:</i> DMPA and NET-EN	<p>Injection may be given immediately after first- or second-trimester abortion.</p> <p>Method may be appropriate for use if a woman wants to delay choice of long-term method.</p>	<ul style="list-style-type: none"> • Are highly effective • Can be started immediately, even if infection is present • Can be provided by non-physicians • Do not interfere with intercourse • Are not user-dependent (except for injection every two or three months) • Do not require client to obtain supplies 	<ul style="list-style-type: none"> • May cause irregular bleeding, especially amenorrhea (excessive bleeding may occur in rare instances) • May cause delayed return to fertility • Require injections every two or three months • Necessitate condom use if client is at risk for STIs, including HIV
<i>Progestin-only implants:</i> Norplant implants	<p>Implants may be inserted immediately after abortion. If adequate counseling and informed decision making cannot be guaranteed, insertion must be delayed and an interim method provided.</p>	<ul style="list-style-type: none"> • Are highly effective • Provide long-term contraceptive protection (effective for at least seven years) • Allow immediate return to fertility upon removal • Do not interfere with intercourse • Do not require client to obtain supplies 	<ul style="list-style-type: none"> • May cause irregular bleeding (especially spotting) or amenorrhea • Require a trained provider to insert and remove • Are cost-effective only if used long-term • Necessitate condom use if client is at risk for STIs, including HIV
<i>IUD</i>	<p>Insertion should be delayed until serious injury is healed, hemorrhage is controlled, or acute anemia improves.</p> <p>Insertion should be delayed until infection has been resolved (three months).</p> <p><i>First-trimester abortion:</i> IUD can be inserted if risk or presence of infection can be ruled out.</p> <p><i>Second-trimester abortion:</i> Insertion should be delayed for six weeks <i>unless</i> equipment and expertise for immediate postabortal insertion are available.</p>	<ul style="list-style-type: none"> • Is highly effective • Provides long-term contraceptive protection • Allows immediate return to fertility upon removal • Does not interfere with intercourse • Does not require client to obtain supplies • Requires only monthly checking for strings (by client) • Requires only one follow-up visit, unless there are problems 	<ul style="list-style-type: none"> • May increase menstrual bleeding and cramping during the first few months • Can result in uterine perforation during insertion • May increase risk of PID and subsequent infertility for women who have chlamydia or gonorrhea infection at the time of insertion • Necessitates condom use if client is at risk for STIs, including HIV • Requires a trained provider to insert and remove

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Guidelines for Selecting Contraception, by Method (*continued*)

Method	Timing postabortion	Advantages	Remarks
<i>Female sterilization</i>	<p>Sterilization after a first-trimester abortion is similar to an interval procedure; sterilization after a second-trimester abortion is more similar to a postpartum procedure.</p> <p>Technically, sterilization procedures usually can be performed immediately after treatment of postabortion complications, unless infection or severe blood loss are present.</p> <p>Sterilization should not be performed until an infection is fully resolved (three months) or an injury healed.</p>	<ul style="list-style-type: none"> • Is a permanent method • Is the most effective female method • Requires no further action once completed • Does not interfere with intercourse • Produces no change in sexual functioning • Causes no long-term side effects • Is immediately effective 	<ul style="list-style-type: none"> • Requires adequate counseling and fully informed consent before being performed, which often is not possible at the time of emergency care • Has slight possibility of surgical complications • Requires trained staff and appropriate equipment • Necessitates condom use if client is at risk for STIs, including HIV
<i>Natural family planning</i>	<p>Natural family planning is not recommended for immediate postabortion use. The first ovulation after an abortion will be difficult to predict, and the method is unreliable until after a regular menstrual pattern has returned.</p>	<ul style="list-style-type: none"> • Is associated with no cost • Produces no change in sexual function • Has no long-term side effects 	<ul style="list-style-type: none"> • Is difficult to use immediately after abortion • Necessitates use of alternative methods until normal cycles have resumed • Requires extensive instruction and counseling • Necessitates condom use if client is at risk for STIs, including HIV • Requires the woman and her partner to have continued motivation and a thorough understanding of how to use the method

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Guidelines for Selecting Contraception, by Method (*continued*)

Method	Timing postabortion	Advantages	Remarks
<i>Vasectomy</i>	Vasectomy may be performed at any time.	<ul style="list-style-type: none"> • Is a permanent method • Is the most effective male method • Requires no further action once completed • Does not interfere with intercourse • Produces no change in sexual functioning • Causes no long-term side effects • Is effective after 12 weeks following the procedure 	<ul style="list-style-type: none"> • Requires adequate counseling and fully informed consent before being performed • Has slight possibility of surgical complications • Requires trained staff and appropriate equipment • Necessitates condom use if client is at risk for STIs, including HIV • Is not effective until after 12 weeks following the procedure

Note: Adapted from: Winkler, Oliveras, & McIntosh, 1995.