Session 5:
Family Planning Information and Counseling for the Postabortion Client

Objectives

- To identify the essential information about family planning that all clients *must* have before they leave the service site
- To explain the importance of informed choice by the client for effective family planning services
- To describe personal and clinical factors that should be considered in family planning counseling for postabortion clients

Training Methods

- Brainstorm
- Large-group work
- Presentation/discussion
- Case study

Materials

- Flipchart paper, easel, markers, and tape
- Overhead projector (optional)
- Transparency 5-A: Minimum Essential Information about Family Planning for the Postabortion Client (page 166)
- Transparency 5-B: Family Planning Information and Counseling for the Postabortion Client (page 167)
- Handout 5-A: Simple Answers to Clients' Questions about Postabortion Family Planning (page 85)
- Handout 5-B: Statements on Contraception, Informed Choice, and Postabortion Care (page 86)
- Handout 5-C: Individual Factors for Family Planning Counseling during Postabortion Care (page 87)
- Handout 5-D: Guidelines for Contraceptive Use, by Clinical Condition (page 89)
- Handout 5-E: Guidelines for Selecting Contraception, by Method (page 91)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy for each participant. If possible, copy them on different colors of paper (especially Handouts 5-D and 5-E), to help keep them separate.

3. Prepare transparencies or flipcharts of Transparencies 5-A and 5-B.
4. Prepare a flipchart like the example shown below:

Individual Factors for Family Planning Counseling during Postabortion Care

Case-study client	Factors	Considerations
	1. If the client does not want to be pregnant soon	
	2. If the client is under stress or in pain	
	3. If the client was using a contraceptive method when she became pregnant	
	4. If the client had stopped using a contraceptive method	
	5. If the client has a partner who is unwilling to use condoms or will prevent use of another method	
	6. If the client was the victim of sexual abuse or rape	
	7. If the client wants to become pregnant soon	

5. Find out where family planning services are provided locally for each site, including location, hours, methods available, and cost.

Session Time (total): 2 hours, 15 minutes

SESSION 5 TRAINING STEPS

Part A Rationale

Time: 30 minutes

Activity 1: Large-group discussion (10 minutes)

1. Ask the participants to describe the rationale for linking family planning services to PAC services.
2. Note that regardless of the legality of induced abortion or our personal feelings about it, establishing linkages between PAC and family planning services may be the best opportunity to help people avoid further unwanted pregnancies and thus prevent the need for more abortions.
3. Ask the participants to describe *their role* as PAC providers in delivering family planning methods and services to postabortion clients.

TRAINING TIP ○○○

The role of the PAC provider in regard to family planning service delivery will vary from country to country and, possibly, from site to site. In some cases, the provider will only make referrals to services outside the PAC site. In other cases, the provider will provide initial counseling for family planning services located within the same institution. In some programs, PAC and family planning may be totally integrated, with the same staff providing both PAC and family planning services.

Regardless of the relationship between PAC and actual family planning service delivery, the PAC provider is a crucial link in terms of helping postabortion clients to recognize their need for contraception, overcoming possible misconceptions and fears regarding contraceptive methods, and building confidence and trust in the health care system, which will increase a postabortion client's likelihood of following through on a family planning referral. The rest of this session addresses the basic information about contraception needed by all PAC providers if they are to carry out these minimum essential tasks. If family planning service delivery or family planning counseling are to be provided by PAC staff, additional training in family planning is required.

Activity 2: Brainstorm/discussion (20 minutes)

1. Ask the participants to brainstorm what family planning information postabortion clients may need before they leave the service site.
2. Explain that three pieces of information *must* be provided to each postabortion client who does not want to get pregnant again soon. Display Transparency 5-A: Minimum

Essential Information about Family Planning for the Postabortion Client, and review each point:

- She will be at risk of repeat pregnancy as soon as 11 days after treatment.
- A variety of safe contraceptive methods can be used immediately to avoid pregnancy.
- She needs to know where and how to get family planning services (either at the time of treatment or after discharge).

3. If the participants do not know where family planning services are provided, provide that information, including location, hours, methods available, and cost.
4. Using Handout 5-A: Simple Answers to Clients' Questions about Postabortion Family Planning as a guide, review typical clients' questions about pregnancy and family planning, reading aloud the *questions only*. Ask the participants to provide the answers to the clients' questions, and correct any misconceptions, if necessary.
5. Note the family planning methods that clients can start to use either during or immediately after PAC, and which of these are available at their service sites.
6. Distribute Handout 5-A.

Part B Informed Choice

Time: 30 minutes

Activity 1: Large-group discussion (30 minutes)

1. Ask the participants: "What is informed choice?" After hearing several responses, read aloud the definition (the first quotation) on Handout 5-B: Statements on Contraception, Informed Choice, and Postabortion Care.
2. Ask one participant to give an example of how this definition applies to PAC services at his or her site.
3. Ask the participants to respond to the following questions:
   - If a woman has an IUD inserted against her will during postabortion treatment, what can she do about it? What if she is sterilized? How would these women feel about the health care system after this has happened?
   - If a woman is sterilized or given an IUD without adequate information, what are some of the possible results?
   - What impact would this practice have on women's willingness to seek medical care for abortion complications?

TRAINING TIP ○○○

Possible responses to these three questions are as follows:

- Providers may believe that they are acting in a client's best interest by inserting an IUD without her consent, but they must remember that a woman who does not want this contraceptive method can and will have it removed, thereby undoing the measure that the provider has taken to "protect" her from future pregnancy. Sterilization is an even more extreme example, as reversal is not feasible in most countries, so a woman who has the procedure performed against her will has no recourse afterward. At the very least, such forced use of contraception will leave clients feeling bitter toward the health care system.
- Inadequate information for contraceptive users about method use and possible side effects can have two results: The user may ignore warning signs of complications that can have a serious impact on her health or that mean the method is not working properly; or she may assume that every physical ailment that occurs after she started to use the contraceptive is somehow related to it, leading to complaints, excessive follow-up visits, and discontinuation. With the IUD, this confusion may result in a woman not recognizing warning signs, mistakenly attributing unrelated conditions to the IUD, or having the device removed unnecessarily. With sterilization, this can result in chronic complaints or in death, if a complication is over looked.
- While coercive practices may prevent further unwanted pregnancies among the individual women involved, other women who hear about these practices may be reluctant to seek medical care for abortion complications. This can result in greater morbidity or more deaths.

4. Summarize: While it is important to make family planning *available* and *accessible* to postabortion clients, women should *not* be required to choose a contraceptive method in order to receive treatment.
5. List the points below as reasons why family planning should *not* be required of all postabortion clients, and give examples of the potential negative impact that coerced contraceptive acceptance can have on women and communities.
   - A contraceptive method's effectiveness is generally related to users having enough information to be able to use the method effectively, and to their feeling good about continuing its use or about switching to another method if it is not satisfactory.
   - When a contraceptive method is provided through coercion, it may prove to be less effective, because the user received inadequate information about how to use the method properly or resented being forced to accept it, all of which can lead to discontinuation.
   - This can result in more unwanted pregnancies, and possibly to more abortions.
   - Additionally, the health care system may develop a reputation of being abusive to its clients, which will drive people away from seeking needed services, including family planning and postabortion care.

- While providers may not be aware of any short-term impact, the potential long-term effects of not allowing clients to make informed choices are reduced family planning use and greater morbidity and mortality from abortion complications that go untreated (or for which treatment is delayed).

6. Distribute Handout 5-B.

Part C Individual Factors

Time: 1 hour, 15 minutes

Activity 1: Discussion/brainstorm (30 minutes)

1. Explain that you will spend the rest of this session discussing personal and medical factors that should be considered when talking with postabortion clients about family planning.
2. Post the flipchart entitled "Individual Factors for Family Planning Counseling during Postabortion Care." For each entry in the "Factors" column, fill in the name of the case-study client from Session 3 who most closely matches the description (whenever possible—if not, make up a name for a new client to fill in on the flipchart). Ask: "How would you approach family planning counseling for this client? What would you discuss, and why?" Write the participants' responses in the "Considerations" column for each factor.

TRAINING TIP ○○○

If participants overlook key points during this discussion, you can refer to Handout 5-C: Individual Factors for Family Planning Counseling during Postabortion Care to guide the discussion. However, to help the participants think this through for themselves, do not distribute the handout until they have finished discussing all of the factors. Then, briefly review each factor, noting any differences between the participants' discussion and what is written on the handout.

Reminder: Factors 3, 4, 5, and 7 on the flipchart entitled "Individual Factors…" involve sexuality and gender issues that were identified in Session 3 (Parts D and E). Work with the participants to fill in the columns in the handout for this important point.

3. Distribute Handout 5-C and discuss any points that were not mentioned during the activity (see Training Tip, above). Then summarize by noting the importance of considering the individual's personal situation and history of contraceptive use before trying to give information about family planning methods.

Activity 2: Discussion (45 minutes)

1. Explain that another important factor in the use of contraception after postabortion treatment is the client's clinical condition. Distribute Handout 5-D: Guidelines for Contraceptive Use, by Clinical Condition, and *briefly* review. *(30 minutes)*

TRAINING TIP ❍❍❍

It may be difficult to complete this discussion in 30 minutes. Given the participants' medical background, they may be curious and may have many questions about specific clinical conditions and the family planning precautions and recommendations related to those conditions. Remind the participants that the purpose of this workshop is to enable PAC providers to give basic information and answer clients' questions, to ensure that clients will follow up as necessary to get family planning and other reproductive health services. This discussion is meant to familiarize them with the category of clinical condition that a family planning provider would need to consider for each client and which methods would be suitable. If the participants will be providing family planning services on-site, they will need more in-depth training to cover both the clinical and counseling aspects.

2. Distribute Handout 5-E: Guidelines for Selecting Contraception, by Method, and explain that it is useful as a counseling reference, because clients often have a particular method in mind when they ask about family planning. Tell the participants that they can look over the handout on their own and can use it to prepare for their counseling role plays later in the workshop. *(5 minutes)*
3. Summarize by reminding the participants that all of these factors—the family planning service-delivery structure at their sites, informed choice, the individual client's situation, her clinical condition, and characteristics of the contraceptive methods—should be considered for their individual case-study clients (from Session 3) when they practice counseling through role plays later in the workshop. Some clients may want or need family planning information before treatment or after, and some may not be interested at all. One of the provider's tasks is to determine the best time to give this information and to ensure that at least the three key points are covered with every client. *(10 minutes)*
4. Display Transparency 5-B: Family Planning Information and Counseling for the Postabortion Client. Ask for a volunteer to read the quotation aloud.

Session 5

Handouts

Handout 5-A

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.

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 5-B
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, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium, p. 9-4.

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

—Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium, p. 9-4.

"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."

—World Health Organization. 1995. Information and counselling for the patient. *Complications of abortion: Technical and managerial guidelines for prevention and treatment*. Geneva, p. 76.

"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, M., and Benson, J. 1994. Meeting women's needs for post-abortion family planning: Report of a Bellagio Technical Working Group, Bellagio, Italy, February 1–5, 1993. *International Journal of Gynecology and Obstetrics* 45 (Suppl.):S18.

Handout 5-C
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.	Seeking treatment for abortion complications suggests that the woman 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.

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Handout 5-C (continued)
Individual Factors for Family Planning Counseling during Postabortion Care

Factors	Recommendations	Rationales
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.

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 5-D
Guidelines for Contraceptive Use, by Clinical Condition

Clinical condition	Recommendations	Precautions
No complications after treatment of incomplete abortion	Consider all temporary methods. *Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN):* Can be used immediately. *IUD:* Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed. *Diaphragm or cervical cap:* Can be used when sexual activity is resumed.	*Natural family planning:* Do not recommend until a regular menstrual pattern returns. *Female sterilization:* The time of treatment for abortion complications usually is not the best time for clients to make decisions about methods that are permanent. *Diaphragm or cervical cap:* Should be refit after a second-trimester abortion.
Confirmed or presumptive diagnosis of infection: ■ Signs and symptoms of sepsis/infection ■ Signs of unsafe or unclean induced abortion ■ Unable to rule out infection	*Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN)*: Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed. *Diaphragm or cervical cap:* Can be used when sexual activity is resumed.	*Female sterilization:* Do not perform until infection is fully resolved (approximately three months) or until risk of infection is ruled out. *IUD:* Do not insert until infection is fully resolved (approximately three months) or until risk of infection is ruled out.
Injury to genital tract: ■ Uterine perforation (with or without bowel injury) ■ Serious vaginal or cervical injury, including chemical burns	*Norplant implants:* Can be used immediately. *Injectables (DMPA, NET-EN):* Can be used immediately. *Oral contraceptives (combined or progestin-only):* Can be used immediately. *Condoms (male/female):* Can be used when sexual activity is resumed. *Spermicidal foams, jellies, tablets, sponge, or film:* Can be used when sexual activity is resumed (can be used with uncomplicated uterine perforation). *Diaphragm or cervical cap:* Can be used when sexual activity is resumed (can be used with uncomplicated uterine perforation).	*Female voluntary sterilization:* Do not perform until serious injury is healed. *IUD:* Do not insert until serious injury is healed. *Spermicidal foams, jellies, tablets, sponge, or film:* Do not begin use until vaginal or cervical injury is healed. *Diaphragm or cervical cap:* Do not begin use until vaginal or cervical injury is healed.

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Handout 5-D (continued)
Guidelines for Contraceptive Use, by Clinical Condition

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

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.

Handout 5-E
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Nonfitted barrier methods: 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.	■ 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	■ 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
Fitted barriers used with spermicides: diaphragm or cervical cap with foam or jelly	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). Fitting the cervical cap should be delayed until bleeding has stopped and the uterus has returned to its prepregnancy size (four to six weeks).	■ Are inexpensive ■ Require no medical supervision for use ■ Provide some protection against STIs, including HIV ■ Are easily discontinued ■ Are effective immediately	■ 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
Oral contraceptives: combined and progestin-only	Pill use may begin immediately, preferably on the day of treatment.	■ Are highly effective ■ Can be started immediately, even if infection is present ■ Can be provided by nonphysicians ■ Do not interfere with intercourse	■ 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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Handout 5-E (continued)
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Injectables: DMPA and NET-EN	Injection may be given immediately after first- or second-trimester abortion. Method may be appropriate for use if a woman wants to delay choice of long-term method.	■ Are highly effective ■ Can be started immediately, even if infection is present ■ Can be provided by nonphysicians ■ Do not interfere with intercourse ■ Are not user-dependent (except for injection every two or three months ■ Do not require client to obtain supplies	■ 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
Progestin-only implants: Norplant implants	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.	■ Are highly effective ■ Provide long-term contraceptive protection (effective for at least five years) ■ Allow immediate return to fertility upon removal ■ Do not interfere with intercourse ■ Do not require client to obtain supplies	■ 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
IUD	Insertion should be delayed until serious injury is healed, hemorrhage is controlled, or acute anemia improves. Insertion should be delayed until infection has been resolved (three months). *First-trimester abortion:* IUD can be inserted if risk or presence of infection can be ruled out. *Second-trimester abortion:* Insertion should be delayed for six weeks *unless* equipment and expertise for immediate postabortal insertion are available.	■ 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	■ 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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Handout 5-E (continued)
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Female sterilization	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. Technically, sterilization procedures usually can be performed immediately after treatment of postabortion complications, unless infection or severe blood loss are present. Sterilization should not be performed until an infection is fully resolved (three months) or an injury healed.	■ 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	■ 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
Natural family planning	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.	■ Is associated with no cost ■ Produces no change in sexual function ■ Has no long-term side effects	■ 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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Handout 5-E (continued)
Guidelines for Selecting Contraception, by Method

Method	Timing postabortion	Advantages	Remarks
Vasectomy	Vasectomy may be performed at any time.	■ 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	■ 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

Adapted from: Winkler, J., Oliveras, E., and McIntosh, N. (eds.) 1995. *Postabortion care: A reference manual for improving quality of care*. Postabortion Care Consortium.