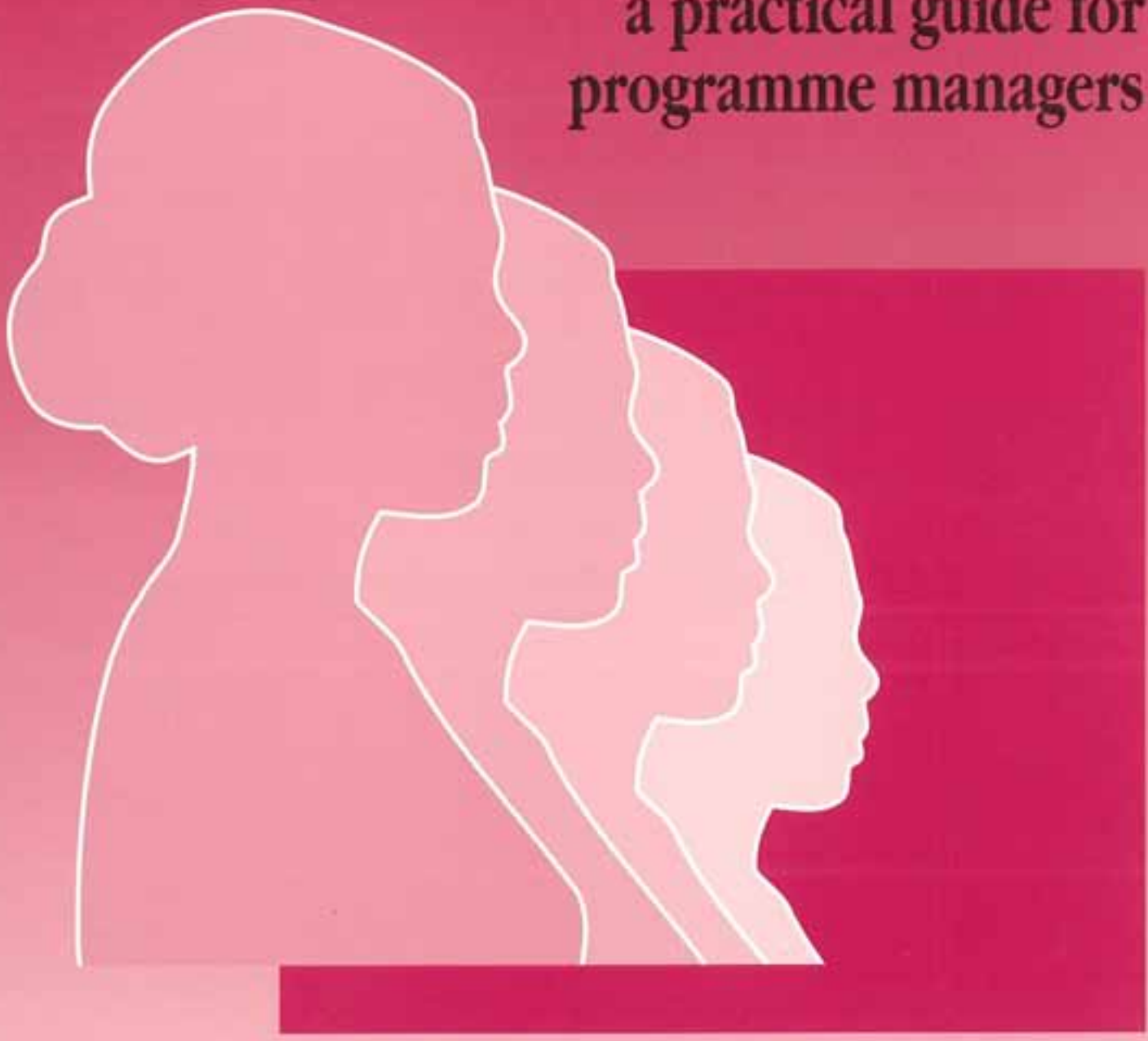
Post-abortion family planning: a practical guide for programme managers



DIVISION OF REPRODUCTIVE HEALTH (TECHNICAL SUPPORT)
FAMILY AND REPRODUCTIVE HEALTH
WORLD HEALTH ORGANIZATION
GENEVA

P r a c t i c a l G u i d e

WHO/RHT/97.20
Distr.: GENERAL

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ACKNOWLEDGEMENTS

The World Health Organization wishes to acknowledge most gratefully the Mellon Foundation and the United Nations Fund for Population Activities (UNFPA) for their financial support which made the development, production and distribution of this document possible.

The World Health Organization wishes to acknowledge the assistance of IPAS, Carrboro, NC, USA in the drafting and editing of this document.

Many country experts reviewed this document and provided valuable comments for its improvement. These included: Dr Paul Blumenthal, USA; Dr Kassam Mahomed, Zimbabwe; Dr José David Ortiz Mariscal, Mexico; Dr Alberto Rizo, Colombia; Dr SO Shittu, Nigeria; Ms Cynthia Steele Verme, USA; Ms Sudha Tewari, India and Ms Ninuk Widyantoro, Indonesia.

PREFACE

Paragraph 8.25 from the International Conference on Population and Development (ICPD) Plan of Action

In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with health impact of unsafe abortion* as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly which will also help to avoid repeat abortions.[1]

* *Unsafe abortion is defined as a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO).*

These guidelines are intended to help managers of abortion care and family planning programmes learn more about the need for post-abortion family planning, as well as to offer concrete management suggestions for ways to forge or to improve abortion care and family planning linkages. In addition, national and local policy-makers must identify post-abortion family planning as a priority and include these services in national programmes. Regardless of their personal feelings about abortion, policy-makers should: modify policies which are obstacles to the delivery of post-abortion family planning services; commit human and financial resources to programmes; and elicit political and managerial support for post-abortion family planning.

Both women who have terminated a pregnancy through unsafe, unhygienic, and often illegal abortions, and those who have utilized elective induced abortion services as allowed by the jurisdiction, are in critical need of family planning services. These women have demonstrated their determination not to bear a child, yet they face a strong possibility of future unwanted pregnancy and, for the former, of unsafe abortion. The extension of family planning services to all women who have had an abortion will have significant repercussions for preventing unsafe abortion and reducing maternal morbidity and mortality worldwide.
The goal of this manual is to provide information for policy-makers and managers that promotes understanding and coordination of services in the following areas:

the need for post-abortion family planning and the service delivery obstacles to providing care;

how design, management, and delivery of services affect the quality and acceptability of family planning services offered to women who have experienced abortion;

[1] The World Health Organization endorses this statement. These Guidelines should be interpreted and applied in accordance with this statement.

how the clinical condition of women after abortion can affect the appropriateness of methods of contraception and counselling;

how the psychological and sociological factors of abortion affect family planning counselling, choice of method and continuity of method use;

how to modify and coordinate existing services (e.g., between emergency abortion treatment and family planning services) to improve quality of care and ensure informed decision making; and

how to stimulate cooperation among groups involved in providing family planning services after abortion.

HOW TO USE THIS BOOK

These guidelines are designed for managers of abortion treatment facilities, family planning programmes and induced abortion services. General information useful for all managers is found in the first five chapters: Chapter 1 provides a rationale for post-abortion family planning programmes; Chapter 2 is an explanation of a quality-of-care framework for post-abortion family planning; clinical concerns in post-abortion contraception are explained in Chapter 3; issues that must be taken into account during post-abortion family planning counselling are covered in Chapter 4; and Chapter 5 describes organizational and logistical needs for post-abortion family planning offered in any service setting.

We recommend that managers read all of the first five chapters. Chapters 6, 7 and 8 are each tailored to the needs of particular service delivery settings. Managers of emergency abortion treatment services, for instance, may wish to focus on Chapter 6, while family planning managers may be primarily interested in Chapter 7. Information for managers of elective induced abortion services is found in Chapter 8. Chapter 9 details the role of policy-makers in the provision of family planning and discusses actions that service managers can take to encourage policy reform.

These management guidelines, while not exhaustive, cover each of the important programmatic points which managers must consider and/or implement to provide high-quality post-abortion family planning services at their respective facilities.

References for the Preface

Wolf, M. and Benson, J. Meeting Women's Needs for Post-Abortion Family Planning: Report of a Bellagio Technical Working Group. *International Journal of Gynecology and Obstetrics*, Supplement, 1994.

World Health Organization. *Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment*, Geneva: WHO, 1994.

CHAPTER 1

INTRODUCTION

1.1 Scope of the Problem

Although contraceptive prevalence rates have increased dramatically in the last thirty years, an estimated 26-53 million abortions are still performed annually worldwide (Henshaw and Morrow, 1990). Those abortions that are unsafe performed by untrained practitioners working in unhygienic conditions are responsible for between 50,000 and 100,000 preventable deaths of women each year (World Health Organization, 1993). Most of this mortality occurs in the developing world (see Table 1).

The high number of women who resort to unsafe abortion is a powerful reminder that women need access to a wide range of family planning methods to help them safely control their own fertility (Salter et al. 1996). The fact that so many women risk death, injury, and social or criminal consequences to terminate a pregnancy demonstrates clearly how desperately these women wish to delay or avoid having children. Many who have unsafe abortion procedures suffer complications and must go to a hospital or other facility for treatment. These women rarely leave the hospital armed with the knowledge and the means to avoid repeating the process of unprotected intercourse, unwanted pregnancy, and unsafe abortion that so often ends in death, injury, or long-term morbidity.

Women who have undergone abortion and are at risk of another unwanted pregnancy represent an important group with unmet family planning needs. While other high-risk groups of women have been the focus of family planning programmes, there are few examples of successful attempts to reach women treated for complications of unsafe abortion. In addition, although significant advances in the availability of family planning services have been made in recent decades, there are still many areas where services are only marginally available to the community at large. These services are often of low quality and are not designed and delivered in a way that responds to the interests and needs of the women and men who use them.

The Bellagio technical working group on meeting women's needs for post-abortion family planning stated that a range of contraceptive methods, accurate information, sensitive counselling, and referral for ongoing care should be made available and accessible to all women who have undergone abortion (Wolf and Benson, 1994). The group agreed that both providers of abortion care and family planning services have an ethical responsibility to bridge the current gap in services. Even where abortion laws and policies are restrictive, post-abortion family planning services can and should be offered; the fact that the availability of induced abortion services is restricted in a given country is not a reason to fail to provide women with post-abortion contraceptive counselling and services - quite the reverse. Family planning programmes that seek to help all women who wish to avoid additional unwanted pregnancies will help reduce needless, preventable deaths caused by unsafe abortion.

The International Conference on Population and Development (ICPD), held in Cairo in 1994, approved a plan of action which addresses the detrimental impact of unsafe abortion. Among other recommendations, the plan underscores the need for high-quality treatment of complications of abortion, and post-abortion family planning counselling and services. This recommendation was maintained by the Fourth World Conference on Women, held in Beijing in 1995.

Table 1
Global and Regional Estimated Risk of Death from Unsafe Abortion

Region	Number of unsafe abortions (1,000s)**	Number of deaths from unsafe abortion**	Case fatality per 100 unsafe abortions	Risk of death
World Total	20,000	70,000	0.4	1 in 300
More Developed Countries*	2,340	600	0.03	1 in 3,700
Less Developed Countries	17,620	69,000	0.4	1 in 250
Africa	3,740	23,000	0.6	1 in 150
Asia *	9,240	40,000	0.4	1 in 250
Europe	260	100	0.04	1 in 2,600
Latin America	4,620	6,000	0.1	1 in 800
Oceania *	20	<100	0.2	1 in 400
USSR (former)	2,080	500	0.03	1 in 3,900

Figures may not add to totals due to rounding.

* Japan, Australia and New Zealand have been excluded from the regional estimates, but are included in the total for developed countries.
** Based on 1990 United Nations projections of births.

Source: World Health Organization. *Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion,* 2nd edition. Geneva:WHO, 1993.

1.2 Definition of Terms

The term "abortion" refers to the termination of pregnancy from whatever cause before the fetus is capable of extrauterine life. "Spontaneous abortion" refers to those terminated pregnancies that occur without deliberate measures, whereas "induced abortion" refers to termination of pregnancy through a deliberate intervention intended to end the pregnancy (WHO, 1994). Induced abortion may either occur in a safe medical setting according to legal and health policy guidelines or it may occur outside the medical system. Induced abortions can be unsafe depending upon how the abortion was initiated; both spontaneous and induced abortions can be unsafe depending upon subsequent events, and the care the woman receives. Women who seek emergency treatment for complications of abortion, whether they have experienced a spontaneous abortion or have taken action to terminate a pregnancy, are most often diagnosed with incomplete abortion. "Incomplete abortion," or "retained products of conception," means that the pregnancy is no longer viable because some tissue has been expelled, but some products of conception remain in the uterus. The remaining tissue must be evacuated from the uterus to reduce the likelihood of infection and other serious complications.

1.3 Abortion and the Client Perspective

Any sexually active woman of reproductive age, regardless of marital status, age, income, education or religion, may have a spontaneous or induced abortion at some time during her lifetime. Three primary traits unite women who seek abortion (whether clandestine or legally sanctioned): 1) they are sexually active; 2) they have demonstrated their determination not to have a child at the time the pregnancy occurred; and 3) they face the distinct possibility of another unwanted pregnancy. In addition, unsafe abortion can be physically, emotionally, and psychologically traumatic. As a guiding principle, it is important to ensure that women who have experienced abortion are treated with the same respect and non-judgmental, unbiased attitude used with any other family planning client.

1.4 The Immediacy Factor

For women who either do not wish to become pregnant soon after an abortion or who, for health reasons, should delay becoming pregnant, the need to use an effective contraceptive method is immediate, since ovulation typically occurs within two-to-four weeks of the termination of pregnancy, and 75% of women have ovulated within six weeks (Lahteenmaki, 1993; Lahteenmaki, 1980; Vorherr, 1973; Boyd and Holmstrom, 1972). Thus, a woman who has unprotected intercourse can face the possibility of unwanted pregnancy again within a few weeks after an abortion, even before her first menstrual period. In order to help these women avoid a repeat unwanted pregnancy, programmes must offer counselling and services to women either immediately at the time of treatment of complications, very soon after their abortion, or through prompt referral.

1.5 Basic Services

There are three service delivery groups with the potential to provide family planning services to women who have had an abortion: 1) providers who treat women suffering from abortion complications; 2) family planning providers; and 3) induced abortion providers. A coordinated effort among these groups is required to provide broad access to services.

Providers who treat women with abortion complications and/or offer induced abortion services play an extremely important role and must, *at a minimum*, inform the woman of basic information about the return of her fertility and the availability of safe, effective contraception.

If at all possible, family planning counselling and services should be available in conjunction with abortion procedures and emergency treatment of abortion complications so that an appropriate contraceptive method can be initiated if the woman chooses to use one. However, there are instances when initiation of a specific method should not occur at precisely the time of treatment or the induced abortion. While a referral to family planning services may be the best option in these cases, interim methods such as condoms, spermicides, injectables and oral contraceptives should also be available on site.

Essential Information for All Post-Abortion Clients

The prompt return of ovulation can lead to the possibility of unwanted pregnancy very soon after an abortion (even before the first post-abortion menses).

The availability on-site or by referral of safe, effective contraceptive methods to prevent additional unwanted pregnancies.

The availability and location of local sources of family planning services for re-supply of methods, provision of long-term and permanent methods, and related ongoing care.

Providing information and initiation of a method are only the first steps in preventing unwanted pregnancy and subsequent unsafe abortions. Family planning services in the public and private sectors play an essential role in helping women understand how to use their chosen methods correctly; in addition, these programmes offer long-term and permanent methods, follow-up care, options for method change, and re-supply of contraceptives.

In some settings where provision of induced abortion services is a lucrative practice, providers may have little incentive to promote family planning. However, providers and managers of induced abortion services have a professional responsibility to ensure that women are offered family planning services in conjunction with pregnancy termination services. On the other hand, induced abortion and family planning services must never be coercive, and provision of induced abortion services should never be contingent on the woman accepting contraception or a particular method.

1.6 The Difference Between Post-Partum and Post-Abortion Family Planning Needs

In many countries, post-abortion family planning is a part of a post-partum programme. In practical terms, however, these programmes usually concentrate their efforts on women who have just given birth and ignore women suffering from abortion complications. In addition, combining post-partum and post-abortion services often means that the differences between these two groups of women are minimized or overlooked completely, resulting in post-abortion women being treated as if they were post-partum women. While the post-partum and post-abortion periods are similar in some ways, there are a number of factors that are different and which must be considered if effective programmes are to be designed. Table 2 details the differences in characteristics of post-partum and post-abortion women.

Perhaps the most important family planning distinction between post-partum women and women suffering from abortion complications is that the latter face an immediate, acute, and possibly life-threatening medical problem: a woman suffering from abortion complications is both a "patient" in terms of her immediate medical situation, and a "client" with respect to family planning.[2] In addition, post-abortion women experience a rapid return to fertility while post-partum women's fertility return is delayed, especially for those who are breast-feeding. Furthermore, women suffering abortion complications may only enter the health care system once for treatment while new mothers may return for post-partum check-ups and/or well-baby visits. Finally, while new mothers are likely to have extensive family and community support networks, there may be little, if any, support for the woman who has had an abortion.

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[2] In this book, the term "patient" is used when referring to a woman during an induced abortion procedure or treatment of complications. When a woman seeks or receives family planning or post-abortion family planning counselling or services, the term "client" is used.

Managers need to be aware that the simple existence of a combined post-partum/post-abortion family planning programme is rarely sufficient to meet the needs of both these distinct groups.

1.7 Contraception and Unwanted Pregnancy

Many effective and safe methods of contraception have been developed; yet, even with the increasing use of modern methods, thousands of women face unwanted pregnancies every year. These unwanted pregnancies and induced abortions are symptoms of family planning failure: failure of a contraceptive method; failure of access to family planning services; or failure of a programme to assist women and couples in the use of a method that is acceptable to them.

Failure of a contraceptive method itself can result in unwanted pregnancy; no method is 100 percent effective under all circumstances, and the possibility of contraceptive failure accumulates over time (Tietze and Bongaarts, 1975; Tietze, 1974). Some couples may have discontinued contraceptive use because of lack of access to follow-up care or re-supply. Others may not understand how to correctly use a method; some women may have stopped use because a particular method was, in practice, personally unacceptable to one or both partners. These situations may be the result of a limited availability of a range of methods, and/or provider or health care system bias for or against a specific method. Unnecessary medical barriers to contraceptive use such as requiring blood tests and/or inserting intrauterine devices (IUDs) only during a menstrual period also decrease women's use of certain effective methods.

As more and more women and couples wish to control their fertility but find that effective contraceptive methods are not available to them, the incidence of unwanted pregnancy and abortion will rise. It is important that both abortion care and family planning providers recognize that unwanted pregnancy can result from a variety of contraceptive situations. In some circumstances, even those women who use contraceptive methods may be faced with an unwanted pregnancy. Post-abortion family planning programmes must assist women to identify the family planning problems that led to the unwanted pregnancy, and help them to develop strategies to prevent their re-occurrence. Programme managers need to address the lack of access to family planning, medical barriers to contraceptive use, and the need for high-quality counselling. While improved family planning services can greatly reduce the incidence of unwanted pregnancy and induced abortion, it may still be necessary for national authorities to adopt appropriate policies and develop services to address the problem of contraceptive failure in a sensitive and humane manner.

Table 2
Factors Affecting Post-Partum and Post-Abortion Family Planning

Post-Partum	Post-Abortion
Health System	
Opportunity for counselling/method delivery possibly increased by women's multiple contacts with health system	Opportunity for counselling/method delivery minimal because woman typically has only one contact with health system; few returns for follow-up
Family planning care may be available in the maternity ward	Care delivered in emergency or gynaecology ward where family planning is not offered routinely
Easy to identify women in post-partum period for follow-up family planning	Difficult to identify women in post-abortion period for follow-up family planning
Preventive approach to care	Curative, crisis-oriented approach to care
Typically supportive provider attitudes toward mother	Often insensitive and sometimes punitive provider attitudes toward women who have undergone abortion
Clinical	
Delayed resumption of menses, especially if breast-feeding	Prompt return of ovulation and menses
Breast-feeding precludes use of some hormonal methods	Complications from unsafe abortion may influence choice or timing of method
Psychosocial/Cultural	
Woman identifies herself as mother	Little known about women's perceptions of self and of the abortion experience itself
Societal support for mothers	Little societal support after abortion
Some post-partum practices postpone risk of future pregnancy	Little known about practices after abortion
Societal fertility role confirmed	Societal fertility role may not be confirmed
Women may perceive risk of subsequent pregnancy to be delayed	Women may not recognize almost immediate return to fertility

Source: Benson, J. et al. *Meeting Women's Needs for Post-Abortion Family Planning: Framing the Questions*. Carrboro, NC:IPAS, 1992.

1.8 What Providers of Emergency Abortion Treatment Can Do

The provision of family planning services at the time of emergency treatment of abortion complications has distinct advantages over referral or return appointments, but it also presents specific challenges to the service provider. For example, the woman's treatment for abortion complications may represent the only or one of the few formal contacts that she has with the health care system; therefore, the provider should take advantage of this unique opportunity to address the woman's needs. On the other hand, it is difficult to offer preventive services such as family planning in an emergency context, especially if there is a lack of coordination between emergency treatment and family planning services.

By working closely with family planning clinic staff, managers can identify the most effective and efficient use of resources for delivering family planning services in the treatment setting. This may include coordinating with family planning managers to establish services in the family planning clinic for treatment of women suffering from abortion complications or arranging for clinic staff to routinely visit abortion patients in the emergency area. Managers will also need to ensure that women are aware of family planning resources within their communities, so that they may obtain ongoing services. Chapter 6 provides detailed information and specific suggestions on how family planning services can be provided in the emergency abortion treatment setting.

1.9 What Family Planning Providers Can Do

Managers of family planning programmes are key to reaching women with post-abortion family planning counselling, methods, and follow-up care. Coordination between family planning providers and emergency abortion treatment providers is the necessary first step to ensuring that post-abortion family planning is available. In those countries with legal induced abortion programmes, family planning managers should make efforts to link their programmes with these abortion services as well.

Family planning programmes typically strive to identify and address unmet family planning needs. Given that women who have abortions are a group with demonstrated unmet family planning needs, family planning clinics themselves are one possible location to be considered for both treatment of incomplete abortion and induced abortion services. Treatment of abortion complications can be made available in family planning clinics in some countries, if skilled staff and appropriate facilities are available, if they are available on a 24 hour a day basis and if a referral system is functioning. In addition to increasing the availability of safe abortion care, where abortion is not against the law, abortion services offered by family planning clinics increase the probability that post-abortion family planning counselling, services and referrals are made available to women. Chapter 7 provides detailed information and specific suggestions on how post-abortion family planning services can be provided in a family planning setting.

1.10 What Induced Abortion Providers Can Do

The majority of women who seek an induced abortion do so to end an unplanned or unwanted pregnancy, and therefore are motivated to control their own fertility. Similarly, women who seek

menstrual regulation (MR)[3] services may be at risk of unwanted pregnancy. Women who undergo abortions for therapeutic reasons may also desire to prevent a future pregnancy that would pose a

[3] Although the definition varies by country, the term menstrual regulation is generally used to describe early evacuation of

risk to their health. Finally, some women rely on abortion because they do not find any of the locally-available methods of contraception acceptable or effective. In all of these cases, women have specific contraceptive needs that should be addressed.

Family planning counselling is widely accepted as an essential element of induced abortion services. Given the elective nature of the procedure, there are frequently more opportunities for providing family planning. However, there are needs unique to women in induced abortion or MR settings that managers need to take into consideration in order for counselling and services to be effective. Chapter 8 provides detailed information and specific suggestions on how to provide family planning in an induced abortion setting.

1.11 A Comprehensive Approach

Post-abortion family planning programmes should be offered to all women equitably, regardless of factors such as their age, marital status, or ethnicity and the programmes should be able to respond to a broad range of women's health concerns, including management of reproductive tract infections (RTIs),[4] prenatal care, or investigation and treatment of infertility. It is important that managers, policy-makers and providers take a comprehensive view of reproductive health, which includes post-abortion family planning, to reduce the toll of unsafe abortion and to improve the health of women, their partners, and the safety of motherhood. Family planning providers cannot ignore the issues of contraceptive use and failure, unwanted pregnancy, safe and unsafe abortion, and subsequent unwanted pregnancies. Emergency abortion treatment services must not only treat the complications of an unsafe abortion, but must also address these women's needs for preventive family planning services. Induced abortion and MR providers must recognize their responsibility to offer family planning counselling and services to their patients.

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the uterus, after a delayed menses, often without confirmation with a pregnancy test.

[4] Many RTIs are sexually transmitted.

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CHAPTER 2

QUALITY OF CARE

2.1 Introduction

Post-abortion family planning services should be designed, provided, managed, and evaluated in a way that recognizes the needs, interests, and perspectives of clients. The manager's goal is to provide services that help clients regulate their own fertility safely and effectively. Programme managers, policy-makers, and providers need to be aware that poor-quality family planning programmes contribute to unwanted pregnancies, for example, through limited choice of methods, inadequate counselling, or negative interactions between providers and clients. Post-abortion family planning providers should understand how an experience with abortion affects women and their partners. In addition, it is important to realize how care is perceived by the women who are served the degree to which they are satisfied or dissatisfied with services.

In recent years there has been increased interest in defining the components of quality of services, integrating a quality approach to management of services, and describing indicators and tools to measure the quality of services. Judith Bruce (1989) has described the elements of quality in offering family planning, and Leonard and Winkler (1991) have addressed the issue of quality in abortion care. *Improving Access to Quality Care in Family Planning*. WHO/FRH/FPP/96.9 provides information for revising family planning policies and practice in line with updated medical eligibility criteria supported by the latest scientific evidence. Benson and her colleagues (1992) have created a framework adapted from Bruce (1989) to address concerns specific to post-abortion family planning.

First and foremost, it is important to ensure that safe and effective post-abortion family planning services exist. Managers should then turn their attention to the care delivered through these services. This chapter contains an outline of the elements of quality of care in post-abortion family planning as follows:

timing of counselling and provision of services;

choice of methods;

information and counselling;

technical competence;

interpersonal relations; and

continuity through linkage of services.

2.2 Timing of Counselling and Provision of Services

There is much debate about the best time to offer family planning to women after abortion. Should services be offered when the woman is treated for abortion complications, or is it better to provide a referral appointment for a later time? A woman who has had an unwanted pregnancy, sought means to terminate the pregnancy, and received treatment for complications is likely to be stressed

and in pain, and she will more than likely be treated in a crowded, busy emergency room where there is no private space for counselling. This is clearly not the ideal time and place for the woman to be counselled or for informed decisions about family planning to be made. Yet, if the woman leaves the hospital without receiving counselling and services, she is faced with the reality of the prompt return of fertility and the possibility of a subsequent unwanted pregnancy.

Consideration of the best time to offer post-abortion family planning counselling and services requires balancing three concerns:

the provision of contraceptive protection in the face of the immediate possibility of unwanted pregnancy. For a woman who does not want to become pregnant, she or her partner should use a contraceptive that will be effective as soon as they begin intercourse again.

the provision of good counselling that will assist the woman in making her own decisions about family planning and selecting a method that she can use effectively for as long as she wishes not to become pregnant. A decision to use a contraceptive method, particularly a long-term or permanent method, should be made at a time when the woman is neither under stress nor in pain.

the ability to take advantage of the available opportunity. Even though the time of treatment may not be optimal for counselling, will the woman have other opportunities to receive counselling or services? Will she have access to family planning counselling and services or the method of her choice if she leaves the hospital without them? Will someone or some circumstance prevent her from using services that are available?

The answer to the question of when it is best to offer contraceptive counselling and services varies for each woman and according to the capabilities of the facility. It is clear that no facility that offers adequate treatment to women suffering from abortion complications can ignore the need to offer family planning care. In many facilities a full range of family planning services can be made available to women suffering from abortion complications, while other settings may be more limited and unable to fully counsel women at the time treatment is offered. Before they are discharged, at a minimum, women in all settings must understand the following information:

the prompt return of ovulation can lead to the possibility of unwanted pregnancy very soon after abortion, even before the first post-abortion menses;

the availability on-site or by referral of safe, effective contraceptive methods to prevent additional unwanted pregnancies; and

the availability and location of local sources of family planning services for re-supply of methods, provision of long-term and permanent methods, and related ongoing care.

Facilities providing elective abortion must always offer post-abortion family planning counselling and methods on site as part of a unified approach to treatment and avoidance of repeat unwanted pregnancy; however, acceptance of contraception or a particular method of contraception should not be a prerequisite to obtaining an abortion.

If the woman does not wish to become pregnant again immediately, but elects not to accept a family planning method at the time of treatment, she should feel welcome to return and she should be

provided with a referral appointment or told where contraceptive services are available in her community.

2.3 Choice of Methods

Research has shown that when women are given a choice of method, their own method choices are often markedly different from the selections made for them by health care providers (Piotrow, 1993). In addition, women "are most likely to use a contraceptive method effectively and safely when they have a choice among methods, are well informed about those methods, and choose a method freely based on their own needs" (Piotrow, 1993). Furthermore, a limited choice of methods can lead to unwanted pregnancy because women may discontinue use if the method is unacceptable to them and/or their partners. Thus, family planning programmes, and specifically those for post-abortion family planning, should offer a range of methods in order to meet the variety of needs and the changing needs of the individuals they serve.

There is no medical reason to limit the number of contraceptive choices women have either after treatment of abortion complications or after an elective induced abortion. All methods can be considered for use after abortion as long as attention is paid to the particular clinical condition of each woman, appropriate screening is provided for the contraindications to each method, and good counselling is offered (see Chapter 3). The particular medical condition of an individual woman, her preferences, ability to use a method, and access to follow-up determine the appropriateness of each method for any woman.

In many locations, women's choice of contraceptives after abortion is limited because providers do not know about the appropriate use of certain methods after abortion or because of bias against a method or its use after abortion. The health care system can also impose barriers on the availability of a range of methods following abortion. These barriers may be based on many factors, including misinformation, quotas or irrelevant medical protocols. For example, if protocols on post-partum contraception are applied to a post-abortion situation, a woman could potentially be denied her choice of method following an abortion because of a recommendation based upon lactation or post-partum uterine size. These practices needlessly restrict the options that women have in their attempts to avoid a repeat unwanted pregnancy.

The principle of informed choice means that it is the client of her own free will, not the provider, who must ultimately choose whether or not to use contraception in her situation, and which method to use, based on her correct understanding of relevant information.[5] The provider's role is to objectively inform the woman about the risks, benefits, side effects, and correct use of all available methods or those methods which interest her, and to help her identify the factors in her life that may influence successful contraceptive use.

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[5] "Informed consent is a client's agreement to use a contraceptive or to undergo a medical procedure ... voluntarily, in full possession and understanding of the relevant facts. The concept is often associated with an informed consent form, commonly used to document the client's agreement, though a signed informed consent form does not guarantee informed consent. Documented informed consent is no assurance that consent has been given freely, with full knowledge and understanding, as it is possible for clients to sign a form out of ignorance, under pressure, or when they have been misinformed. ... Because the informed consent form serves to document the client's understanding and free choice once a decision has been made, completing the form should therefore be one of the last steps of a counselling session, after the client's needs, options, and feelings have been examined and the client has made a choice. Simply meeting informed consent documentation requirements does not substitute for counselling." (Neamatalla and Harper, 1990).

2.4 Information and Counselling

Family planning information and counselling delivered after an abortion needs to include all of the attributes of good family planning services (Table 3). In addition, post-abortion family planning counselling must enable the woman to identify and resolve those factors which led to the unwanted pregnancy. The goal is to provide the woman with the information that she needs to make her own informed decisions about family planning and to select a method that is best for her particular interests. Women treated for abortion complications or who have had an induced abortion need to fully understand the minimum information for all abortion patients (see Chapter 1, Section 1.5). Women treated for abortion complications also need to be aware of any implications for their future reproductive ability.

Women who wish to avoid or delay childbearing should have information about a range of methods. This does not necessarily mean that every woman needs detailed information about each method, but it does mean that she should understand that a variety of methods are available for her and her partner (including short-term, long-term, and permanent methods, as well as those that protect against sexually-transmitted diseases including HIV infection [STD/HIV]) as well. For example, if a woman says that she is interested in using injectables perhaps because she knows someone who uses this method it may be helpful for her to learn about other hormonal methods. This level of specialized information in response to a woman's stated interests should be provided in addition to standard counselling.

Table 3
Elements of High-Quality Family Planning Counselling Services

The client's needs are put first.
The goal is for clients to make informed, voluntary, well-considered decisions.
Responsibilities of the various staff members involved in counselling are clearly delineated.
Counsellors and counselling supervisors are well trained.
Counselling is conducted in comfortable settings that protect the client's privacy and confidentiality.
Counsellors have the support materials they need and have been trained to use them.
Records are simple and easy to keep, yet provide the programme the information it needs to monitor the quality of counselling.
Counsellors are regularly supervised, with the purpose being to improve counselling, rather than to criticize staff members.
Counsellors have the full support of family planning programme managers and policy-makers, as indicated by an adequate commitment of resources for personnel training, supervision, space, and materials.
To gauge whether the system is working properly, the programme conducts periodic special studies related to counselling (for instance, to assess client knowledge and satisfaction).

Source: Neamatalla, G.S. and Harper, P.B. *Family Planning Counselling and Voluntary Sterilization*. New York:Association for Voluntary Surgical Contraception, 1990.

The health care worker providing counselling should ask the woman about contraceptive methods that she may have used in the past. This is especially important for women who have had abortions. Particular attention should be paid to any woman who was using a method at the time she became pregnant. If the woman selects the same method following the abortion, the counsellor should identify potential problem areas and provide information on how to use the method correctly or

suggest another method. If the woman was not using any contraceptive method at the time she became pregnant, it is important to find out why. While some unwanted pregnancies are the result of failure of a method itself, other women may have become pregnant because they used a particular method incorrectly. Still other women may have discontinued a method because of unacceptable side effects, or the unavailability of commodities for re-supply. A woman's past experience with contraception *must* be considered in helping her select a method that she can use correctly.

Most health care workers with training can provide some counselling, and managers can arrange training in counselling for a variety of staff likely to have contact with post-abortion women. All counsellors must be knowledgeable of family planning resources in the patients' communities. For some health care facilities, most patients live in nearby areas. In others, women travel long distances to seek care and are unlikely to return for follow-up visits. Up-to-date knowledge of public and private sector family planning services available in local and more distant communities is important so that counsellors can offer accurate referrals to all the clients seen in their facility.

2.5 Technical Competence

The term "technical competence" is used in this book to describe the collective proficiency with which all members of the health care team perform the tasks of counselling and delivering family planning services to women after abortion. Technical competence is an integral part of the quality of services because it is the most basic requirement for the safety of services.

The cornerstone of technical competence is the skill and knowledge of individual providers; however, skill alone does not guarantee technical competence. Training and supervising staff, monitoring and reviewing service statistics, developing and adhering to relevant protocols, and providing feedback to personnel are mechanisms that foster technical competence of the entire team. Delivery of family planning services to women who have had abortions usually involves both staff who treat emergency abortion complications and family planning providers. Family planning providers must understand the basics of treatment services and the implications of abortion-related complications for method use, in addition to being skilled in the provision of family planning services. Emergency abortion treatment providers often have a curative focus to care and must learn to take a more preventive approach to enable them to offer effective post-abortion family planning; in addition, training in family planning counselling, methods and referral will need to be given to treatment staff.

Up-to-date service delivery protocols are necessary to ensure that women are not needlessly denied methods that are appropriate, as well as to ensure that they are not given methods that are inappropriate. Guidelines on post-abortion family planning must take into account the specific clinical and physiological situation of women who have had abortions. Providers are likely to require initial and ongoing training in the use of contraceptive methods post-abortion. Managers can improve the level of technical competence by making sure that protocols are relevant, that staff understand and follow them, and that they monitor the competence with which services are delivered.

2.6 Interpersonal Relations

All people seeking health care services, curative and preventative, should be treated professionally and non-judgmentally. Provider attitudes profoundly affect interaction with patients, counselling and selection of methods. Providers sometimes express judgmental attitudes toward women who have had an abortion, for example, because of the providers' own feelings or beliefs about abortion or women who seek abortion. Punitive treatment of women who have induced abortions can be widespread in jurisdictions where abortion is legally restricted, but also exists in areas where induced abortions are more liberally allowed by law. It is important that providers keep in mind that these women need and are entitled to abortion care and to family planning as a health concern. Providers must not allow their personal views to impair their ability to provide services non-judgmentally. Providers must strive for non-judgmental interactions with all patients, regardless of the patient's age, marital status, or ethnicity, or whether the patient is receiving a first-time or repeat abortion. Family planning counselling requires an open exchange of information in order to help women select methods that are appropriate for their individual situations. This communication is not possible if providers treat patients in a judgmental manner.

2.7 Continuity through Linkage of Services

Continuity of care should be a focus of all family planning services. The term refers to women having access to a range of services in order to meet their particular reproductive health and family planning needs. A continuity of care focus requires that health care providers and systems treat the woman as an individual, addressing both her physical and emotional reproductive health needs. It requires that providers and managers know what services are available in the community and what barriers to access exist so that these obstacles can be reduced.

The job of providing post-abortion family planning services does not end when a woman has selected and begun to use a method. Continuity of family planning care means that women need access to the services and supplies that will enable them to continue to use a chosen method, to receive follow-up treatment in case of complications, to address any concerns about the method that arise, to change methods, and to discontinue use. In order to set a pattern of continuity into place, it is important that the woman be given a referral to a family planning clinic or other source near her home.

It is important that providers are also able to provide or refer women for a broad range of services. These services may include diagnosis or treatment of RTIs and STD/HIV, cancer screening, prenatal care, treatment of infertility, and appropriate social services.

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CHAPTER 3

CLINICAL CONCERNS

3.1 Introduction

The clinical issues in post-abortion family planning services share many similarities with family planning provided to women at other times. All of the standards of general family planning care must be in place for post-abortion family planning as well. These include:

informed choice;

assessment of risk factors;

choice of methods;

counselling; and

back-up for long-term and permanent methods and follow-up care.

Likewise, eligibility criteria for use of methods should be followed. Linking family planning with abortion care in no way removes the obligation of providers to provide high-quality family planning services.

In addition to meeting the standards of general family planning, managers must understand that women who have experienced abortion have some family planning needs that differ from those of other women, and service providers must strive to meet those needs. This chapter will discuss those factors which are unique or central for post-abortion family planning, and it will provide detailed information on the factors to consider in assessing each woman's individual needs and situation.

3.2 Clinical and Individual Concerns

Women suffering from abortion complications are different from most family planning clients in the specific medical conditions that they may be confronting. The majority of abortion patients will be diagnosed with incomplete abortion. Some will have additional serious or life-threatening abortion-related complications. The most important of these are:

infection ranging from localized pelvic infection to generalized sepsis (and the possibility of a developing infection that is not yet symptomatic and thus cannot be ruled out);

injuries including minor lacerations, uterine perforation, and intra-abdominal injury requiring immediate surgical attention;

haemorrhage or severe vaginal bleeding; and

shock.

After uncomplicated abortion in the first trimester all methods except natural family planning (rhythm, withdrawal), can be considered immediately. Even if they have complications, most women can choose from a range of methods. Providers and managers need to understand how clinical conditions relate to the use of various methods of contraception and that protocols on

post-abortion family planning do not unnecessarily restrict women's access to their method of choice.

3.3 Rapid Return to Fertility

A woman can become pregnant almost immediately after an abortion. Family planning therefore represents an immediate concern. In the case of spontaneous abortion, a woman may wish to become pregnant again quickly, and unless there are any medical problems (e.g., multiple spontaneous abortions, nutritional anaemia, or irregular uterine bleeding that may signal the provider to refer the patient for infertility counselling or other tests), there is no reason for providers to discourage her from doing so. For most women, however, an induced abortion represents a desire not to become pregnant again in the near future. Although many women do not wish to become pregnant again immediately, some may not want to make a family planning decision at the time of abortion care. Others may choose methods that cannot be used immediately because of clinical or other factors. These women should be offered an interim method, as well as a referral to a service for re-supply or provision of a long-term or permanent method.

Post-Abortion Physiological Return to Fertility

Research on the levels of hormones associated with pregnancy and ovulation shows that the hormones associated with pregnancy disappear quickly, and the cycle of hormone production that enables ovulation to occur resumes promptly after an abortion. Seventy-five percent of women will ovulate within six weeks following an abortion. Often ovulation occurs within two weeks after a first-trimester abortion and within four weeks after a second-trimester abortion (Boyd & Holstrom, 1972; Vorherr, 1973; Lahteenmaki, 1980; and Lahteenmaki, 1993).

Specifically, after a first trimester termination, the levels of oestrogen and progesterone decrease to non-pregnant levels within a few days of the abortion (Lahteenmaki, 1993). Likewise, other hormonal levels re-equilibrate very soon after abortion: ovarian response to follicle stimulating hormone (FSH) occurs within 4-9 days, while human chorionic gonadotropin (HCG) takes longer, disappearing within 38 days. These equilibrations enable ovulation to take place as soon as 2-3 weeks following the termination (Lahteenmaki, 1993; Vorherr, 1973). In contrast, the return to fertility post-partum takes an average of 4-6 months if the woman is breast-feeding (Vorherr, 1973).

3.4 Post-Abortion Clinical Recommendations

Providers should familiarize themselves with the precautions applicable to all women who are treated for abortion complications or who have an abortion:

treatment of acute, serious conditions is the first priority for providers caring for women with abortion complications;
consideration of contraception can occur once the patient's medical condition has stabilized;

sexual intercourse is not recommended until bleeding stops, and signs of infection (if present) and other complications are resolved;

the woman should seek immediate medical help if certain warning signs appear: foul smelling discharge, severe abdominal pain, continued bleeding, or high fever. Early diagnosis and treatment of a complication will instill general confidence in post-abortion care;

eligibility criteria for individual contraceptive methods should be followed;

the full range of contraceptive methods can be considered for use after an abortion, as long as the client is appropriately screened and able to make an informed choice;

If natural family planning (NFP) is the woman's choice, it should not be relied upon until a regular menstrual pattern returns.

3.5 Contraceptive Use in Presence of Clinical Complications

Clinical issues related to the abortion or to complications of an unsafe abortion will need to be considered in assessing what methods may be most appropriate for each individual. Unless clinical decision-making is based upon each woman's individual needs, the services delivered will not be effective in helping her prevent future unwanted pregnancies (Leonard and Ladipo, 1994). The individual clinical characteristics of the woman who has received emergency abortion treatment (see sections 3.5.1-3.5.3) should be considered by all providers. Annex 1 contains a chart of contraceptive methods and recommendations for their use in post-abortion situations (Leonard and Winkler, [in press]). A chart describing clinical, personal and service delivery factors associated with post-abortion contraceptive use is found in Annex 2. The method failure rates for individual methods are found in Annex 3.

3.5.1 Confirmed or Presumptive Infection Related to the Abortion

For many women seeking treatment for incomplete abortion, the provider may be unable to determine if or how the abortion was induced, and the woman may be unwilling or unable to provide further details. Similarly, the provider may be unable to rule out the existence of RTIs or STDs if there are no symptoms.

The potential of infection developing must be weighed against the woman's desire for immediate contraceptive protection and her ability to return to the system for additional contraceptive services. The situation of each woman must be considered individually, and often a interim method may be the most appropriate choice until any uncertainties about infection are resolved.

The presence of infection is an important consideration in the use of some methods, because any infection, whether from retained products of conception, unclean/unhygienic abortion, or other causes, affects the usefulness of some contraceptive methods. The provider must keep in mind that even if an infection is not apparent at the time of treatment it may subsequently develop quickly if the woman has undergone an unclean abortion. In cases where an infection is evident or presumed:

delay female sterilization until infection is either ruled out or fully resolved;

do not insert IUDs until infection is either ruled out or fully resolved.

any other method can be considered immediately.

In all cases of confirmed or suspected infection, the provider should advise the patient to avoid intercourse until the infection is resolved. If complete abstinence is not a realistic option, the woman can consider use of the following methods of contraception when infection is present:

NORPLANT implants[6];

injectables;

oral contraceptives;

condoms (male/female);

spermicidal foam, jelly, tablets or film; and

vasectomy (for her partner).

3.5.2 Trauma to the Genital Tract

Some women seeking emergency treatment may have evidence of trauma to the genital tract, including burns, perforations, cervical tears or lacerations. In these situations:

delay female sterilization until trauma is healed, however, if abdominal surgery is required, sterilization can be done concurrently if no additional risk is involved;

do not insert an IUD until uterine perforation or other serious trauma is healed;

the use of female barriers and spermicides may be limited according to the extent and placement of the injury;

any other method can be considered immediately.

3.5.3 Haemorrhage/Severe Anaemia

Some women who undergo unsafe abortion suffer haemorrhage which may result in severe anaemia. When haemorrhage is present, stabilization of the patient is the primary concern and, therefore, a method should not be initiated until the condition is resolved. In the case of severe anaemia, any method which might increase or continue blood loss should be avoided until the condition is resolved. Methods that should not be used in this situation include:

female sterilization; and

inert or copper-bearing IUDs.

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[6] At the time of publication of this document, NORPLANT was the only commercially available contraceptive implant.

The following methods are considered appropriate for women with severe abortion-related anaemia:

NORPLANT implants;

injectables;

progestin-releasing IUD;

oral contraceptives (beneficial when haemoglobin is low);

diaphragm, cervical cap, sponge;

condoms (male/female);

spermicidal foam, jelly, tablets or film; and

vasectomy (for her partner).

3.6 Timing of Contraceptive Initiation

In addition to ensuring that specific contraceptives are appropriate for a woman's individual clinical condition, providers must be aware of when these methods should be initiated. Many providers mistakenly apply existing contraceptive guidelines that may be inappropriate for post-abortion women. Guidelines that advise delay of initiation of oral contraceptives for post-partum women based on breast-feeding, for example, are sometimes used when advising post-abortion women. In fact, if a woman selects oral contraceptives following an induced abortion procedure or treatment of complications, she should start this method immediately. Annexes 1 and 2 provide recommendations on when to begin use of specific methods.

3.7 Second Trimester Abortion

Women's clinical and physiological situation after an abortion in the second trimester is similar to that of the first trimester, but there are certain differences that will affect initiation or use of particular methods. The most significant difference that affects contraceptive use is that after a second trimester abortion the uterine size is larger and uterine involution (return to normal size) is slower than in a first trimester abortion, usually taking 4-6 weeks. This factor is significant in fitting female barrier methods, ensuring proper fundal placement of IUDs, and in locating the fallopian tubes for female sterilization.

Protocols for post-partum contraception are not appropriate for first or second trimester abortions because of differences in physiological and clinical characteristics. For example, some guidelines on post-partum contraception are based on factors such as lactation, which is not relevant to post-abortion practices, and post-partum hypercoagulability, which is not significant in the second trimester of pregnancy. Post-partum family planning guidelines, therefore, should not be used to limit the range of methods available to women after abortion.

For the woman who has experienced a second trimester abortion:

providers of female sterilization must take into account the changed uterine size and position of the fallopian tubes;

delay fitting diaphragm or cervical cap for six weeks;

an IUD inserted immediately following treatment requires the skills of an experienced provider, since correct fundal placement is critical to reduce the risk of expulsion or perforation.

If excessive clotting disorder is present, special measures may be required before surgery. This may be an issue after missed abortion. If a previous history of coagulopathy or current indications of risk for coagulopathy are present, any surgical procedures are contraindicated. The risk of coagulopathy is rare in the second trimester and oral contraceptives, while not the best choice, can generally be used.

Assuming no complications, however, the following methods may be used following a second trimester abortion:

NORPLANT implants;

injectables;

IUDs (assuming a skilled, experienced provider is available since correct fundal placement is critical to reduce risk of expulsion or perforation);

oral contraceptives;

condoms (male/female);

spermicidal foam, jelly, tablets or film; and

vasectomy (for her partner).

In addition, if the patient has any of the complications previously described in this chapter, the recommendations for method use for those complications should be followed.

3.8 Post-Abortion Contraceptive Use and STD/HIV

The risk of contracting STD/HIV must be assessed for each woman receiving post-abortion family planning information and methods. All women should be advised that the only contraceptive methods that provide some protection against STD/HIV are male and female condoms and to a lesser extent, spermicides. Male and female condoms are the only methods known to provide some protection against the transmission of Human Immunodeficiency Virus/Acquired Immunodeficiency Disease (HIV/AIDs). Condoms and spermicides can significantly reduce the risk of both unintended pregnancy and STD/HIV. In some cases, women may choose to use a condom for protection from STD/HIV in addition to another, more effective method for contraception.

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CHAPTER 4

COUNSELLING ISSUES FOR SERVICE MANAGERS

4.1 Introduction

An essential part of high-quality post-abortion family planning services is counselling of patients. Whether working in an emergency setting for treatment of abortion complications or in induced abortion services, managers have the responsibility to see that counselling is provided so that all women are able to make voluntary, well-informed decisions about family planning use. Counselling abortion patients presents special challenges because of the physical and emotional stress associated with unwanted pregnancy and abortion. Furthermore, staff in busy clinics or hospitals often believe that they do not have the time to counsel patients. Managers in these settings have a duty to ensure that patients receive high-quality counselling. Without this opportunity, women who have experienced an abortion remain at risk of a repeat unwanted pregnancy and unsafe abortion.

Counselling consists of two-way communication between the counsellor and the client. Both the client and counsellor talk and listen during a counselling session. Counselling is more than stating information about contraceptive methods, although provision of information is a part of counselling (Subcommittee on Quality Indicators in Family Planning Service Delivery, 1990). The focus of counselling should be problem-solving, that is, helping the woman to resolve the obstacles to family planning use. As an expert in abortion counselling notes, "More attention to selecting and personalizing information and more assistance in application of that information to decision-making may be of greater help to her than more comprehensive information-giving" (Beresford, 1979). Managers must recognize the important content areas to include in counselling sessions, train staff in how to counsel women, and monitor the quality of counselling offered.

4.2 Key Elements of a Counselling Session

Post-abortion counselling should address the same topics as any other family planning counselling session. There are, however, additional points which are unique to the abortion situation which must also be covered. High-quality post-abortion family planning counselling should include the following:

consideration of the patient's physical and emotional state, as detailed in section 4.4.1;

discussion of the woman's return to fertility and causes of the unwanted pregnancy (e.g., fear of side effects, unavailability of services, partner opposition) are of particular importance for women who have had an abortion. As with any family planning counselling, the woman's reproductive desires for the future and her particular needs for a family planning method (e.g., desire to wait a certain amount of time for a subsequent pregnancy, partner cannot or refuses to use a method correctly) should be discussed. Counselling should also address any concerns the woman may have about her own sexuality and fertility, as well as cultural, social or religious issues related to family planning use. Sections 4.4.2, 4.4.3 and Annex 2 provide more information on these topics (Leonard and Ladipo, 1994);

provision of information on methods, taking into account the woman's current clinical and personal situation, and her individual preferences. This information should include how to

use the method, its effectiveness, risks and benefits, management of side-effects, and referral for re-supply or follow-up (Fisher, 1992). If the client chooses an interim method such as oral contraceptives or condoms she should receive information about where in her community she can obtain re-supplies and other services. Referrals to local sources are also required for provision of and ongoing care for long-term and permanent methods (Chapter 3 and section 4.5 contain additional information on methods and family planning follow-up.); and

provision of referral information about other reproductive health services. Counsellors should be alert to signs of other reproductive health problems, such as high risk of STD/HIV, and should be able to offer referrals for diagnosis and treatment.

How a counsellor interacts with a patient has a significant effect on the quality of counselling. Women are more likely to feel that their individual needs have been addressed if the counsellor provides a supportive counselling environment. Specifically, counsellors should demonstrate the following skills:

establishment of rapport between the counsellor and the client, so that clients feel comfortable asking questions and discussing their concerns;

utilization of appropriate communication skills, such as listening to clients, asking questions, giving examples, confirming clients' feelings, and using clear, understandable language; and

provision of opportunities for questions, answers and decision-making. The counsellor's role is to assist the woman in making a decision that is most appropriate for her clinical and personal situation. Clients should be allowed to decide themselves if they wish to include their partners or other individuals in the counselling session (see section 4.4.4).

4.3 Manager's Tasks

To establish high-quality post-abortion family planning counselling, managers have the responsibility to ensure that the following requirements are met (Benson, Gringle and Winkler, 1996):

Counselling should be conducted in a private location, preferably a room with a closed door. If the woman is not able to move from the recovery area or if a private room is not available, a curtain should be used to at least provide visual privacy.

Managers also need to determine the most opportune time to offer counselling. Counselling can be provided before and/or after treatment of complications or induced abortion procedures. Timing should depend on the physical and emotional condition of patients, the efficiency of services, and the non-counselling duties of the staff. Group counselling sessions can be an effective way to provide basic family planning information to several women simultaneously. This approach standardizes the information given and can reduce the amount of time needed for individual counselling, particularly in induced abortion settings. However, private, individual sessions will also be necessary to assist women in assessing their personal situations.

Materials such as brochures, contraceptive samples and flip charts should be available for clients and counsellors. Managers of emergency treatment services where family planning has not traditionally been offered can usually obtain educational materials from local Family

Planning Associations (FPAs), Ministry of Health family planning programmes, or hospital-based family planning clinics.

At a minimum, a basic stock of contraceptives such as pills and condoms should be easily accessible to the counsellor so that clients may leave with a method if they choose. A wider array of methods should also be available to meet the reproductive needs of individual women, and to foster client satisfaction and continued use. As with educational materials, managers of emergency abortion services can seek a supply of methods from their hospital family planning clinic, local family planning agencies or others.

Managers are responsible for selecting the staff who will have counselling duties. The selection process involves preparing a job description, interviewing candidates, and observing their interactions with patients. Counsellors can be nurses, social workers, and/or non-medical personnel with special counselling skills. Managers must ensure that the staff selected offer counselling to all abortion patients and that trained back-up staff are available to cover times when those with counselling responsibilities are not present.

Training is necessary for all staff who have contact with patients. An orientation should be provided for all of these staff, even for personnel who do not have primary counselling responsibilities. The orientation should cover the basics of counselling, such as how to establish respectful interpersonal communication with clients and how to discuss the use of contraceptives post-abortion. Counselling staff will require additional skills training. This training should include both theoretical information, role plays and, under supervision, actual counselling. A video on postabortion family planning counselling, *Put Yourself In Her Shoes*, produced by the Johns Hopkins Center for Communication Programs is a useful training resource. Managers will need to identify those organizations that could recommend trainers to conduct staff training. These may include local Family Planning Associations or other family planning non-governmental organizations, Ministry of Health family planning programmes, hospital family planning clinics, local women's organizations or others.

Once counsellors are selected and trained, and services are ongoing, managers have the responsibility to monitor the quality of counselling through ongoing supervision. A variety of supervisory techniques should be utilized to obtain a comprehensive view of counselling activities. Chapter 5 provides additional information on supervision.

Managers should establish a simple record-keeping system to assist in monitoring counselling activities. Records can include information about the patient's clinical condition, personal situation, method accepted and referrals made. The type of record may vary from cards containing information about the client and the health-care facility to a patient chart. Managers must implement mechanisms to ensure that all records are kept confidential and are accessible only to a limited number of staff who have valid reasons for reviewing them. In some locations, record-keeping has become more important and time-consuming than counselling itself. Managers should ask staff to record only the minimum amount of information necessary to monitor the programme and help maintain counselling as the priority activity.

4.4 High-Quality, Individually-Focused Counselling

The mistaken assumption that women lack knowledge about how to use contraceptive methods correctly or that they lack motivation to use family planning oversimplifies the problem of unwanted pregnancy. Many of the factors that contribute to unwanted pregnancy are socio-medical in nature. A woman's decision to seek an abortion can result from a complex set of factors, including timing of the pregnancy, economic stresses on the family, an uncertain relationship with the partner, and/or pressure from others.

High-quality counselling helps a woman to identify what led to the unwanted pregnancy and enables her to make decisions and develop plans that work for her situation. Counsellors should take the following factors into account in order to tailor their counselling to each woman's individual needs.

4.4.1 Is the Woman under Stress or in Pain?

A woman may experience a variety of emotions during the decision to seek an abortion, the abortion itself, and/or treatment of complications. These may include fear, anxiety, guilt, and ultimately, relief that she has resolved a crisis situation. Women may also be in physical pain. These conditions may interfere with informed, voluntary decision-making, influence her interest in receiving counselling, and her ability to choose a contraceptive and use it correctly. Decisions about long-term and permanent methods are of particular concern (see section 4.6). Additionally, the process of abortion care may not offer adequate time to make a fully informed decision. The counsellor should assess a woman's readiness for counselling, so that if she expresses any hesitancy, the counsellor can schedule a follow-up appointment or refer her to a local family planning source; if the patient is referred, the counsellor should provide an interim method. The counsellor should be aware of the following when talking with a woman who is under emotional stress and/or in pain:

selection of a interim method (such as oral contraceptives, female barrier methods, injectables, and male/female condoms and spermicides) may be most appropriate;

discussion of long-term methods (such as IUDs and NORPLANT implants), and permanent methods (such as female sterilization), including cost and referral to community providers, can occur if the woman is interested. Long-term or permanent methods, however, require that the woman has ample opportunity to consider her options and receives full counselling; and

decisions about long-term or permanent methods should be made only when the woman has received complete information about her contraceptive options, has ample time to make a decision, and is relieved from stress and pain.

4.4.2 Does the Woman Want to Become Pregnant Again, and If So, When?

It is essential that the counsellor understand the woman's desire for future pregnancies, both for the short and long term. Women may or may not want to use contraceptive methods after an abortion. For instance, women who have had a spontaneous abortion may want to become pregnant again soon. Other women may want to delay the next pregnancy or avoid future pregnancies altogether. Whatever the woman's choice, the counsellor must understand her reproductive intentions andperspective before making any contraceptive recommendations. Counsellors must consider the following:

a woman should be well-informed of options, of risks of pregnancy versus risks of contraception, as well as of timing of her return to fertility;

a woman who does not desire to use contraceptive methods should never be pressured to do so;

if a woman is unsure about her desire to use contraceptive methods, helping the woman to clarify and define her reproductive intentions must precede discussion and selection of a method;

if a woman desires to become pregnant but her medical condition requires her to wait, she should be provided an interim method of contraception; and

a woman who wants to delay or avoid future pregnancies should be offered the full range of contraceptives available.

4.4.3 Has the Woman Used Contraception Previously?

Unwanted pregnancy may occur because a woman was not using any contraceptive method. On the other hand, many women who undergo abortion will have had an unwanted pregnancy as a result of contraceptive failure. This contraceptive failure may have been the direct result of a method failure or it may have been a failure of the system to provide a method which works well for that particular woman. Whatever the situation, those same conditions which brought about the unwanted pregnancy may still exist. Unless the counsellor understands those factors, the same problem may occur again. The counsellor must consider the following when a woman's unwanted pregnancy resulted from contraceptive failure:

a full range of contraceptives should be considered;

previous contraceptive failure should be fully discussed in order to understand possible reasons for failure;

any method that has proven troublesome or ineffective in the past should be cautioned against or should be provided again only after careful counselling;

emotional conflict, societal pressure, relationship to her sex partner, and feelings about sexuality may influence appropriate use of a method;

a woman should receive her contraceptive of choice, barring any clinical contraindications; and

instructions on method use should be provided in a clear, concise manner, and comprehension of the instructions should be confirmed by having the woman repeat the instructions in her own words.

4.4.4 Should the Partner or Another Family Member Be Involved in Counselling?

An abortion situation requires special attention to confidentiality issues. The woman's confidentiality is paramount, about the abortion itself and any subsequent family planning decisions. During counselling, the woman may indicate that her partner is unwilling to use condoms or that he will prevent her from using some or all methods. The counsellor will need to understand the nature of the partner's reluctance in order to be of assistance in the woman's decision-making process. The counsellor needs to consider the following:

involving the male partner in choosing an appropriate contraceptive method, if the woman wishes;

counselling on method selection that addresses the woman's concerns for confidentiality; and

protecting the woman's confidentiality even if she selects a method without involving her partner or other family member.

4.5 Family Planning Resources in the Community

A woman's ability to use a method correctly and continuously is based in part on the resources of the community where she lives. Women may travel far from home seeking treatment of abortion complications. To ensure continuity of care, health care providers must consider a woman's abortion-related and family planning needs within the context of accessible overall health care services. Therefore, family planning providers must know what services a woman will have access to when she returns home in order to provide an appropriate method.

Long-term or permanent methods may not be appropriate for women with no access to the care necessary to manage complications that might arise. On the other hand, women with little access to re-supply of condoms or pills may find long-term or permanent methods (IUD, NORPLANT implants, contraceptive sterilization) their only workable option. Cost is also a principal factor in accessibility of services: it can inhibit women's initial access to contraceptives, it can be a factor in women's decisions to discontinue contraceptive use, and it dramatically influences women's ability and willingness to obtain safe induced abortion services or care for abortion complications. Providers must be aware of the lowest-cost alternatives for services and methods within each woman's local community.

4.6 Special Counselling Situations

4.6.1 Contraceptive Sterilization in an Abortion Care Setting

The issue of sterilization as a permanent contraceptive method for abortion patients requires careful consideration. Managers must understand the need for true informed consent from women who are considering sterilization. Informed consent is necessary to assure that the stress immediately preceding and following an abortion and/or treatment of complications does not influence the patient's decision to be sterilized. In some situations, therefore, consent and sterilization at the time of an induced abortion may not be recommended because the physical and/or emotional stress of the unwanted pregnancy are likely to pressure the woman's decision in favour of sterilization. In other situations, however, counselling and informed consent for sterilization prior to the abortion allows the sterilization to be performed at the same time, avoiding the risk of anaesthesia for two different procedures and virtually eliminating the risk of a subsequent unwanted pregnancy. True informed consent is particularly difficult to obtain in an emergency setting for treatment of complications; women's desires and the need for informed consent must be weighed against the possibility of a subsequent unwanted pregnancy and abortion. Providers must be sure that true, voluntary, informed consent occurs in all situations.

While general rules will not apply to every situation, managers must ensure that counselling, services and referral allow for an appropriate process of informed choice for sterilization, as well as for other methods. Each woman should receive thorough counselling, tailored to her individual situation. For further information, managers are encouraged to read "Family Planning Counselling and Voluntary Sterilization" (Neamatalla and Harper, 1990).

If a woman expresses a desire to have a sterilization procedure at the time of an induced abortion or treatment of complications, her clinical condition must first be considered. If there are no medical contraindications (e.g., infection) present, the counsellor should answer the questions presented in Table 4 as part of the counselling process in order to assess the appropriateness of a permanent contraceptive method.

Table 4
Counselling Questions for Permanent Contraception Post-Abortion

Question	Recommendation	Rationale
Is the woman sedated or recovering from anaesthesia?	Sterilization is unlikely to be appropriate. The counsellor should provide an interim method and instructions for use along with information on where and when to return for the sterilization procedure.	Legitimate informed consent cannot be obtained if the woman is sedated or recovering from anaesthesia. This may rule out sterilization performed during treatment of abortion complications.
Is the woman in physical pain?	Sterilization is unlikely to be appropriate. The counsellor should provide an interim method and instructions for use along with information on where and when to return for the sterilization procedure.	Legitimate informed consent cannot be obtained if the woman is in physical pain. This may rule out sterilization performed during treatment of abortion complications.
Is the woman under emotional stress?	Sterilization is unlikely to be appropriate. The counsellor should provide an interim method and instructions for use along with information on where and when to return for the sterilization procedure.	Legitimate informed consent cannot be obtained if the woman is under emotional stress. This usually rules out sterilization performed during treatment of abortion complications.
Has the woman decided prior to the abortion that she wants no more children?	Sterilization may be appropriate at the time of the abortion if the woman is fully informed and is making a voluntary choice, especially if she and her partner jointly made the decision.	Women who have had ample time and opportunity to consider permanent contraception well before the stress of an abortion can often give informed consent at the time of induced abortion services or treatment of complications. If the timing of the woman's decision for sterilization is too close to the abortion, the counsellor should provide an interim method and instructions for use along with information on where and when to return for the sterilization procedure.
Will the woman have access to sterilization services upon her return home?	Sterilization may be appropriate at the time of induced abortion or treatment of complications if the woman is unlikely to be able to obtain services near her home, and she is fully informed and makes a voluntary choice.	Women sometimes travel great distances to seek abortion services. Counsellors should be knowledgeable of sterilization and other family planning services accessible to abortion patients. Sterilization services may not be readily available to abortion patients near their homes. In this situation, the woman's desire for a permanent contraceptive at the time of abortion care and her ability to provide informed consent must be balanced against the risk of a subsequent unwanted pregnancy.

Source: Adapted from Neamatalla, G.S. and Harper, P.B. *Family Planning Counselling and Voluntary Sterilization*. New York:Association for Voluntary Surgical Contraception, 1990.

4.6.2 Post-Abortion Family Planning for HIV Positive Women

HIV infection and AIDS pose a significant threat to the health and longevity of women of childbearing age. Perinatal transmission of HIV is well documented, averaging 30-35 percent of births to HIV positive women in the developing world (World Health Organization, 1992). Whether or not women who know they are HIV positive seek abortion more frequently than other pregnant women is largely unknown, but it is reasonable to assume that a post-abortion woman who knows her HIV positive status will experience physical, emotional, social and psychological stress differently from other post-abortion clients:

the physical recovery of HIV positive women may be difficult, prolonged, or unattainable especially if treatment is required following an unsafe abortion;

providers may be hesitant to provide health care services because of fears of HIV transmission;

the woman may face additional stigmatization if her condition is known within her family or community; and

if the decision to abort was made primarily because the woman feared perinatal HIV transmission, her sense of self-worth may be severely undermined.

Staff providing services to post-abortion family planning clients known to be HIV positive need to be aware of these additional factors, and must be prepared to offer either HIV-specific information, counselling and/or other services, or appropriate referrals. If HIV-specific referral resources are not available and counselling services are limited, the client must at an absolute minimum understand that:

sexual intercourse with an uninfected partner will forever pose a risk of HIV transmission, and the contraceptive options for providing some protection against potential spread of infection are currently limited to condoms (male or female), preferably used with spermicide;

condoms must be correctly used every time intercourse occurs;

the use of condoms with spermicides to prevent infection does not preclude the simultaneous use of another method to provide additional protection from unwanted pregnancy; and

any future pregnancies carried to term may result in HIV positive infants.

4.6.3 Post-Abortion Family Planning for Women Who Have Had Repeat Abortions

Counselling tailored to a woman's individual needs is especially important in this situation. In most instances, providers will not know the client's abortion history unless the woman chooses to disclose this information. If this occurs, the counsellor should be aware that varying circumstances over a woman's reproductive life may have prompted her to seek an abortion. For example, a woman who has an abortion as an adolescent and again when she is 35 years old is likely to have faced very different situations. Furthermore, women who are consistent contraceptive users may experience failure of the method itself, or may discontinue use for a brief time because of personal circumstances or problems in access to services.

Identifying any common difficulties in family planning use over time and working with the woman to resolve them is essential. The woman, for example, may be unable to obtain a reliable supply of oral contraceptives, which has led to discontinuation of the method and resulting unintended pregnancy. The counsellor and client should discuss other contraceptive options which are potentially more satisfactory and reliable for the woman. Referral to affordable local services is especially important so that the woman can obtain follow-up for any concerns she may have.

4.6.4 The Special Needs of Adolescents

Issues related to unsafe abortion are among the most important and neglected in adolescent sexuality and reproductive health. Pregnant adolescents are particularly likely to experience spontaneous abortion if they are young adolescents; and seek induced abortion more often than adult women for the following reasons:

The pregnant adolescent may not be married, and may be more likely than adult women to fear the stigma associated with a pregnancy outside of marriage.

Adolescent girls often have difficulty resisting pressure and/or coercion from adult or adolescent males to engage in unwanted sexual activity.

An adolescent whose pregnancy outside of marriage results in the birth of a child may be forced to abandon her formal education.

Adolescents are less likely than adults to receive information and access to contraception and family planning services from service providers for reasons of law, regulations, cultural mores and fear of negative reaction to their active sexuality.

Adolescents are less likely to have information about abortion, or material resources to seek safe abortion where access is restricted; where access is less restrictive, adolescents remain more likely to attempt self-abortion or seek out unsafe methods offered by unreliable providers.

Adolescent females who do seek clinically-based medical abortions are more likely to present later in pregnancy, increasing the potential for health complications.

Because of the often clandestine nature of procuring an abortion procedure and the frequent lack of support from the sex partner or parents, adolescent females are likely to experience isolation and emotional stress.

Table 5
Actions Promoting Adolescent Reproductive Health

1. Providing adolescent access to information and reproductive health services, including counselling and abortion where it is legal.

2. Training health providers in adolescent sexuality and developmental needs to help prevent abortion and enable adolescents to protect themselves from unwanted sexual relations and pregnancy. *(See Counselling skills training in adolescent sexuality and reproductive health: a facilitator s guide, WHO/ADH/93.3, Geneva, 1993 [E, F and S])*

3. Providing effective and accessible services to adolescents that take into account special needs such as privacy and confidentiality.

4. Providing counselling and access to contraceptive options that maximize protection against unwanted pregnancy and STD/HIV infection.

5. Promoting policy, legislation and regulation that permit access by sexually active unmarried adolescents to the provision of contraceptives, family planning services and protection against STD/HIV infection.

6. Establishing linkages between health services that address the reproductive needs of adolescents, such as: family planning, maternal care, and STD/HIV services.

7. Establishing linkages between reproductive health services and community-based information, education, and communication (IEC) programmes.

8. Involving knowledgeable adolescents (including trained and supervised peer counsellors) in the planning, implementation and evaluation of beneficial health services.

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CHAPTER 5

COMMONALITIES OF SERVICE APPROACH

5.1 Areas of Commonality

Separate chapters within this book focus in detail on each of three abortion and post-abortion related services: emergency abortion treatment services (Chapter 6); family planning services (Chapter 7); and induced abortion and menstrual regulation services (Chapter 8). Managers of each type of programme must implement and oversee several interconnected components of service delivery, including:

facilities;

equipment;

supplies;

commodities;

client flow;

staffing (including staffing patterns, attitudes, and supervision);

training;

monitoring and evaluation;

linkage and referral; and

cost.

While each of these areas entails unique and specific issues depending on the services offered, there are commonalities on approach of importance to all managers. This chapter presents information on these commonalities. Subsequent chapters expand on the specifics relevant to each of the three types of services.

5.1.1 Types of Treatment Programmes

Access to safe induced abortion treatment is limited by law and by practice in much of the developing world. Therefore, most women who present at hospitals for abortion-related care are experiencing complications of an unsafely induced procedure. Treatment for incomplete abortion usually requires removal of retained tissue from the uterus to prevent continued bleeding and infection; treatment for other complications may also be required. This emergency medical care can be offered in a variety of settings. These range from tertiary/first referral level hospitals to primary health care and family planning clinics, and on an inpatient or outpatient basis, depending on the organization of the health care system and the delivery of services within the facility. Care for abortion complications and post-abortion family planning should be integrated throughout the health care system, with each level providing treatment appropriate to the skills and resources available.

Table 6 details the type of care, and the staff and equipment needed to provide services at each level of the health care system. For detailed guidance on the clinical management of abortion complications at various levels of the health care system, see *Clinical management of abortion complications: a practical guide*. WHO/FHE/MSM/94.1.

Table 6
Emergency abortion care activities by level of health care facility

Level	Possible staff	Care activities
Community	Community residents with basic health training, traditional birth attendants, traditional healers	Recognition of signs and symptoms of abortion and complications Timely referral to the formal health care system
Primary	Health workers, nurses, trained midwives, general practitioners	All of the above activities plus: simple physical and pelvic examination diagnosis of the stages of abortion resuscitation and preparation for treatment or transfer haematocrit/haemoglobin testing referral, if needed *If trained staff and appropriate equipment are available, the following additional activities can be performed at this level:* initiation of essential treatments including antibiotic therapy, intravenous fluid replacement, and oxytocics uterine evacuation during the first trimester basic pain control (paracervical block, simple analgesia and sedation)
First referral	Nurses, trained midwives, general practitioners, specialists with training in obstetrics and gynecology	All of the above activities plus: emergency uterine evacuation in the second trimester treatment of most complications of abortion blood cross-matching and transfusion local and general anaesthesia laparotomy and indicated surgery (including for ectopic pregnancy if skilled staff are available) diagnosis and referral for severe complications such as septicemia, peritonitis or renal failure
Secondary and tertiary	Nurses, trained midwives, general practitioners, obstetrics and gynecology specialists	All of the above activities plus: uterine evacuation as indicated treatment of severe complications (including bowel injury, tetanus, renal failure, gas gangrene, severe sepsis) treatment of coagulopathy

Source: World Health Organization. *Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment.* Geneva: WHO, 1994.

5.1.2 Types of Family Planning Programmes

Family planning services are offered in a variety of ways, and each type of programme can incorporate post-abortion family planning. While not all-inclusive, the list below covers the major categories of family planning services seen around the world:

hospital-based family planning clinics;

primary health care centres;

non-governmental organization (NGO) family planning clinics;

community-based services (CBS);

social marketing programmes; and

private providers, including physicians, nurses and others.

5.1.3 Induced Abortion and MR Programmes

While legal access to abortion is commonly restricted, in almost every country there are some legal indications for induced abortion. These indications vary widely, ranging from those countries restricting legally induced abortion to situations where it is necessary to save the life of the woman, to induced abortions legally available upon request of the woman. Where abortion is not against the law such abortion should be provided in the safest possible conditions.

Induced abortion services are provided in a wide variety of settings, both public and private. Hospitals, clinics specializing in abortion care, family planning clinics, or centres that provide comprehensive reproductive and/or general health services are all locations in which induced abortion services and/or MR services may be offered. Because in many instances induced abortion and MR are elective, non-emergency procedures, the services are usually provided on an outpatient basis. Induced abortions that are performed at later gestations or for therapeutic purposes (e.g., to save the life of the mother) may require an inpatient stay.

5.2 Facilities

The manager who wishes to establish post-abortion family planning services must make sure that the following facilities are provided:

an area where contraceptive commodities and educational materials can be securely stored;

space where counsellors can talk privately with women about their family planning needs; and

if contraceptive methods are provided on site, a space where the method can be delivered (e.g., where an IUD can be inserted).

While an elaborate counselling room or office is not necessary, privacy is essential to ensure that patients will feel free to ask questions and to talk openly. Possible areas are an office that is rarely used, a corner of an examination room not in use, or even a hallway or an outside bench, if it is out of hearing range of other patients. Managers should emphasize the importance of privacy and confidentiality to their staff, and they should provide staff with several options for counselling locations from which they can choose. In this way, if one area is occupied, the staff member doing the counselling can find another available area.

A space for storage of contraceptive commodities and educational materials must be identified, and an inventory system implemented, to make sure that resources are not lost and are available at all hours. Guidelines for appropriate storage of contraceptive methods are available in other publications (Management Sciences for Health, 1992a).

5.3 Equipment, Supplies and Commodities

For family planning facilities, community-based services, and private contraceptive providers, few changes in equipment and supplies are needed in order to offer post-abortion family planning services. For family planning clinics and centres that plan to add induced abortion services and/or treatment of complications, some additions in equipment and supplies will have to be made. The World Health Organization's *Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment* provides managers with complete, specific lists of equipment and supplies necessary for the treatment of abortion complications (WHO, 1994).

At a minimum, managers must stock some temporary methods, such as condoms, combined oral contraceptives (COCs), spermicides and injectables in sufficient supply in the area where women are treated. This will enable women who are not ready to make a long-term decision to have contraceptive protection when they leave the facility. These methods should be available whenever abortion care is offered.

Facilities that plan to offer IUDs, and/or NORPLANT implants will need to add supplies and equipment appropriate to these methods. Managers are urged to consult the WHO contraceptive method series and eligibility criteria for guidance (WHO, [in press] [a]; WHO, [in press] [b]; WHO, 1993; WHO, 1990a; WHO, 1990b; WHO, 1988a; WHO, 1988b; WHO, 1987, WHO 1996).

5.4 Client Flow

It is important that patients/clients move efficiently through the hospital/clinic so as to prevent unnecessarily long waiting times or congestion in a given area. Managers will need to assess at what point in the overall process of post-abortion family planning counselling, services, and referral should be offered.

Managers should conduct a simple client flow analysis (CFA) to determine how clients move through the facility, and systematically follow a small sample of patients to identify the most effective point for contraceptive counselling and the provision of methods. It is advisable for managers to conduct a CFA prior to the initiation of post-abortion family planning services; once services are underway, managers should identify any resulting congestion in patient flow. *The Family Planning Manager* guides managers through a simple CFA (Management Sciences for Health, 1992b). *A Guide to Assessing Resource Use for the Treatment of Incomplete Abortion* provides instructions on how to carry out a simple tracking of abortion patients (Abernathy et al., 1993). Following a small number of patients both before and after the addition of contraceptive counselling and services will give managers a good idea of how long patients spend at various

points during the treatment process. Family planning counselling offered during times when patients have to wait anyway (e.g., during recovery from an evacuation procedure) is often an efficient way to provide information via print materials, visual materials, and videotape players. Interactive group presentations can also be used, followed by individual counselling sessions.

5.5 Staffing

5.5.1 Staffing Patterns

Managers need to make decisions about which staff members will provide post-abortion family planning. To effectively reach post-abortion clients, managers should identify ways of making post-abortion family planning counselling and services available at all times. Managers should be aware that the provision of counselling, contraceptive methods, and referral will increase the work load of the staff members involved. Managers may have to develop creative solutions to these challenges. Strategies include: 1) shifting other responsibilities among several staff members; 2) hiring additional staff; and 3) looking for the most efficient ways to reach women (e.g., group information sessions).

Providing post-abortion family planning should be viewed as a routine part of abortion care that is the responsibility of the staff, not as an "extra" activity that may or may not be offered. The advantages and disadvantages of various staff configurations in specific settings are discussed in subsequent chapters.

5.5.2 Staff Attitudes

The attitudes of personnel toward women who have had an abortion are important to the delivery of high-quality care. Women who are treated punitively or disrespectfully are less likely to seek subsequent care. Managers should be aware that their own personal beliefs about abortion and sexuality , as well as the beliefs of their staff, can affect interactions with patients. Managers should take the following steps to encourage staff to have positive interactions with patients/clients:

provide leadership in implementing a preventive approach to health care;

provide training and supervision which emphasizes respect for patients/clients;

inform staff about the role of unsafe abortion in maternal mortality and the need for post-abortion family planning to save women's lives;

organize activities to heighten staff awareness so that post-abortion family planning services are provided in a professional way;

provide opportunities for staff to discuss their feelings about abortion; and

gather information on how clients feel about services and share results with staff to raise awareness of patient/client perspectives.

5.5.3 Staff Supervision

Supervision of staff is one of the most important tasks for service managers. The process of supervision should be supportive, ongoing, constructive and not perceived as "policing." Once a plan is developed for how and by whom post-abortion family planning services will be provided, managers must take the following steps for adequate supervision of staff:

ensure that the roles and responsibilities of staff are clearly written, and are understood and followed;

schedule initial and refresher training sessions as needed;

organize staff development workshops to help staff members deal with job-related stress;

rotate responsibilities among staff to guarantee that they receive periodic breaks from the stresses of their work;

share both successes and problems identified with staff; and

use a variety of supervisory approaches.

These supervisory techniques include:

Observation of counselling sessions. Annex 4 contains a checklist for assessing the interpersonal skills of the counsellor, while Annex 5 offers suggestions on how to conduct an observation.

Client interviews immediately after a counselling session. Managers can administer brief interviews with clients, using a standard set of questions, to obtain women's opinions on the quality of counselling and other services offered. These interviews should be anonymous, without identification of the woman. Sample questions can be obtained from several sources (Otsea et al. [in press]; AVSC International, 1995). It is advisable to include several open-ended questions (e.g., How would you recommend that services be changed? or What would you tell a friend or relative about these services?) along with questions requiring a "closed" response (e.g., yes/no; very good/fair/poor). Open-ended questions give women the opportunity to express their concerns about issues that are not otherwise covered in the questionnaire. Results from interviews should be shared with staff, and used to focus on problem areas and develop solutions.

Self-assessment by counsellors. Managers can convene counsellors in a group for problem-solving and discussion of sessions that went well or were especially difficult. Counsellors themselves are often valuable sources of solutions to problems they or the manager have identified.

Review of records. Managers can examine records to determine their completeness, appropriateness of methods provided and patient statistics.

5.6 Training

Because post-abortion family planning is rarely integrated into ongoing contraceptive or abortion services, managers will need to train their staff, including those not directly involved in post-abortion family planning activities. In some cases, staff working in emergency abortion treatment services have had little or no training in basic family planning methods and counselling. Family planning staff are often unfamiliar with the needs of abortion patients. Managers must ensure that:

staff working on all shifts attend an informational session about the rationale for post-abortion family planning, information on methods, and counselling techniques;

mechanisms are available for providing training to new staff in the event of staff turnover; and

ongoing training and update sessions are provided to all staff as needed.

More in-depth training for counsellors and those actually providing methods should include:

interpersonal communication skills;

the reasons women seek abortion and need post-abortion family planning;

counselling women in an emergency or other clinic setting;

the necessity of and how to ensure that women give voluntary, informed consent;

minimum information for all abortion patients;

appropriate post-abortion contraceptive technology;

referral information for follow-up family planning and other reproductive health needs;

counselling role plays appropriate to the setting where post-abortion family planning will be offered; and
counselling actual patients/clients under supervision.

Managers can contact the Ministry of Health or local family planning association for recommendations on local trainers who could conduct training. For family planning staff who are unfamiliar with the clinical and socio-medical situation of abortion patients, representatives from medical school or hospital obstetrics-gynecology departments, medical or nursing societies or other organizations can participate in training. In addition, IPAS has developed counselling-relevant postabortion family planning materials into a printed curriculum guide format that may be helpful (*Postabortion Family Planning: A Curriculum Guide for Improving Counselling and Services*, IPAS, 1996).

5.7 Monitoring and Evaluation

Monitoring and evaluation need not be a series of complex, time-consuming tasks. Existing records such as log books, service statistics, patient records and charts, and routine checklists can be used

directly or modified to provide information. Managers who wish to implement a simple monitoring system for their post-abortion family planning services should do the following:

decide what routine or basic information is needed to assess quality and/or make management decisions;

set up a simple method to routinely collect the basic information on services provided; and

involve all staff by sharing information obtained during monitoring and evaluation activities.

Monitoring activities should address the following questions:

Counselling: is counselling appropriate for abortion patients at this time? (e.g., patients may be physically and/or emotionally distressed and unable or unwilling to talk about family planning information).

Contraceptive Methods: are protocols and practices appropriate for contraceptive use post-abortion?

Patient-Provider Interactions: Is the confidentiality, privacy and modesty of patients protected?

Organization of Services: is post-abortion family planning efficiently integrated into abortion or routine family planning services?

Provider Training: are providers trained and routinely updated in post-abortion family planning counselling, methods and referral?

It is important that monitoring activities occur frequently and routinely. The collection of information should never be perceived as an end in itself, e.g., the collection of information just to collect and store information. The amount and type of information obtained should be used to help improve services, and this point should be clear to everyone involved in information gathering. Patient interviews need to be well thought out in advance, and carefully worded. Likewise, staff interviews should be focused and precise. Staff must be involved in all steps of the process from modifying a family planning checklist, to monitoring various components of services, to using monitoring results to resolve problem areas. Top medical or programme officials should, of course, participate in the monitoring process. However, nurses, social workers, clerks and door-keepers all interact with patients and can provide insight into how services are offered and might be improved.

The WHO document *Studying Unsafe Abortion: A Practical Guide* presents further guidance on the monitoring and evaluation of services. Numerous publications exist that offer guidelines on how to conduct an overall evaluation or one focused on specific components of service delivery. (Aga Khan Health Services and University Research Corporation Center for Human Services, 1993; Dwyer et al., 1991; Garcia-Núñez, 1992; Jain, 1992; Management Sciences for Health, 1993a; Management Sciences for Health, 1993b; Management Sciences for Health, 1992a; Management Sciences for Health, 1992b; Management Sciences for Health, 1992c; Management Sciences for Health, 1992d).

5.8 Linkage and Referral

Managers must ensure that referrals to resources within the community for re-supply of methods and ongoing family planning care are established and maintained. If family planning is not a component of services offered, it is the responsibility of the manager to make sure women understand the minimum information about fertility return and the availability of safe, effective contraception, and are referred to a specific place or person within the health facility or in her community.

This responsibility can be met in a variety of ways. For example, an up-to-date address list of local institutions and sources for family planning services should be kept and displayed. Providers should give the woman the name and location of family planning services near her home. Referrals to other reproductive health services are important because of the comprehensive nature of women's health; abortion services, in isolation, are rarely sufficient to fully address women's overall health care needs.

An important issue when referring abortion patients is maintaining confidentiality. Public sector programmes and funders in some countries require the names of patients in order to document the number of referrals made. This practice destroys confidentiality and the trust that accompanies it, and ultimately damages service delivery programmes. Managers should emphasize the necessity of confidentiality to their staff, and should work to ensure that each patient's privacy is protected.

Women who are referred to another provider for family planning services should receive verbal and/or written medical information that is relevant to the use of certain methods or to the woman's ability to follow up on complications that should be resolved. Staff should convey to the client that a complete understanding of her reproductive history and current clinical situation is important to the selection of an appropriate contraceptive method. The woman may then decide whether or not to convey this information to the provider at the referral site.

Managers should identify other sources in the community that offer reproductive health care. These include:

General health services to treat women for diseases such as malaria or tuberculosis. Sources may include primary health care centres, public sector maternal-child health/family planning (MCH/FP) clinics, NGO clinics, and private physicians.

Outlets for re-supply of temporary contraceptive methods. Available sources may include primary health care centres, public sector MCH/FP clinics, NGO clinics, community-based services, and/or commercial outlets.

Provision of long-term and permanent methods and on-going contraceptive care. Available sources may include primary health care centres, public sector MCH/FP clinics, NGO clinics, and/or private physicians.

Gynaecological services, such as STD/RTI diagnosis and treatment, cancer screening, diagnosis and treatment of menstrual disorders, and others. Available sources may include MCH/FP or NGO clinics, and/or private physicians.

Assessment of repeat spontaneous abortion, and infertility diagnosis and treatment. Available sources may include hospital-based obstetrics-gynecology services, NGO clinics, and/or private physicians.

Obstetrics services for prenatal care. These services may be needed by women who plan to become pregnant again immediately. Prenatal care is usually available at primary health care centres, MCH/FP clinics, and through private physicians.

Domestic violence. Providers should be aware that unwanted pregnancy may result from domestic violence. Women's centres, social services, legal advocacy or public sector counselling services are possible sources for referral.

In order to offer high-quality referrals, managers should learn about the types of services offered by neighbouring and distant facilities. This information should include the kinds of services available, cost of services, and location. It is helpful to have written information on referrals for patients to take home.

5.9 Cost

Incorporating family planning counselling and services into any existing setting will have cost implications for both the facility and for the patient. Some of the costs associated with instituting new post-abortion family planning services might include:

training existing staff in family planning counselling and service delivery;

hiring staff specifically to provide post-abortion contraceptive counselling and/or services;

purchasing contraceptive supplies, adding new reporting forms and educational materials to give to patients; and

equipping a space for private counselling.

Providing family planning services that prevent unwanted pregnancies is more cost-effective than treating emergency, obstetric complications at a centralized, urban level (Maine, 1991). Although family planning will not totally eliminate unwanted pregnancy and abortion, programmes that ensure women the opportunity to obtain family planning counselling and methods following abortion services will have a substantial positive impact. However, many countries are facing severe economic difficulties, resulting in increasing costs of health services and contraceptive commodities. Even in some public sector facilities, which traditionally have offered free care, fees for services have been implemented.

Managers of public sector services may find they have little control over costs of services. However, managers should be aware that the rising cost of contraceptives may have contributed to unwanted pregnancy in the first place. The role of managers is to do the following:

identify conveniently-located outlets where women can be referred to obtain affordable contraceptive services;

train staff in making those referrals; and

monitor the information given to patients.

Offering comprehensive reproductive health services in some locations has attracted clients, and has enabled facilities to offer family planning services at lower cost than would otherwise be possible.

In general, however, managers will need to emphasize the cost savings and improvements in quality that can result from a post-abortion family planning programme

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CHAPTER 6

EMERGENCY ABORTION TREATMENT SERVICES

6.1 Types of Treatment Programmes

Treatment of incomplete abortion and other complications is offered by virtually all public sector health care systems. Other facilities such as private or mission hospitals may also provide emergency abortion treatment services. This chapter provides information on how managers of these services can incorporate post-abortion family planning into their programmes (Greenslade et al., 1994).

6.1.1 Tertiary/First Referral Level Hospitals

Many lower level hospitals or health centres do not offer treatment of abortion complications, and instead refer women to tertiary care hospitals. This practice may be due to lack of trained staff or to the perception that women with incomplete abortion require the skills and facilities of a tertiary care centre. Many of the women treated at tertiary levels, however, would more appropriately receive care at the first referral level, or even at primary health care centres. Women seeking abortion care in tertiary care facilities usually go first to the emergency area of a hospital, where they are admitted and later treated in major or minor operating rooms and recuperate in the gynaecology wards or recovery areas.

Although the safest method of first-trimester uterine evacuation is vacuum aspiration, many hospitals still employ the use of sharp curettage, or dilation and curettage (D&C) for treatment of incomplete abortion. Use of sharp curettage often involves general anaesthesia or heavy sedation and carries a greater risk of complications than does vacuum aspiration, thereby reinforcing women's dependence upon tertiary care hospitals for the treatment of abortion complications (Greenslade et al., 1993); however, vacuum aspiration can safely be offered at lower levels of the health care system because the procedure can be performed in non-operating room settings with minimal levels of pain control medications needed (WHO, 1994).

Admissions for treatment of abortion complications represent a large percentage of gynecology admissions in many major hospitals; this often overwhelming caseload results in overcrowding and contributes to negative attitudes among staff. Treatment of abortion complications can utilize up to 60% of an obstetrics-gynecology department's resources (Bolivian Ministry of Social and Public Health, 1976; Liskin, 1980). When treatment of abortion complications is provided on an inpatient basis, there may be opportunities for providing family planning counselling and services while the woman recovers and before she is discharged. Unfortunately, the staff in the emergency abortion treatment area are often not equipped or trained to provide family planning services; in addition, contraceptive commodities are often not available in the treatment area.

Emergency abortion treatment can be provided on an outpatient basis as well. The resulting shorter hospital stay has advantages for the woman and for the health care system, but it may present challenges in providing post-abortion family planning services. Although first referral hospitals may not have separate departments for obstetrics or gynecology, most will have an operating room where minor procedures are performed. Women seeking abortion care from these facilities usually enter the hospital through an outpatient admissions area and are treated as soon as possible in the operating room. Many hospitals are short-staffed, which causes some women to wait for treatment. Generally, however, treatment is faster in smaller hospitals because the number of abortion patients is much lower than in tertiary care facilities.

In all of these settings, the major disadvantage is that the emergency abortion treatment area is often physically and administratively separate from the family planning services, making it difficult to link the two. Additionally, emergency treatment and family planning clinic staff may not perceive post-abortion family planning as part of their responsibilities. In order to successfully provide post-abortion family planning, managers will need to take a leadership role in coordinating these two services or will need to establish an effective referral system between the service delivery sites. As there is no single ideal location for providing family planning after treatment of abortion complications, managers should consider offering both abortion treatment and family planning in multiple locations within a single institution to increase access to both types of services. For instance, this may be accomplished through introducing abortion treatment services into the family planning clinic or by training gynaecological staff to offer family planning services.

6.1.2 Primary Care Level

Few health care systems offer treatment of abortion complications at the primary care level. In those centres where services are available, trained staff offer treatment of incomplete abortion without additional serious complications, and refer other cases to higher-level facilities. Many of these primary care settings use vacuum aspiration for uterine evacuation because it can be done quickly and safely with minimal pain control measures. These centres often also provide family planning services and thereby strengthen the link to post-abortion family planning, while establishing a mechanism for ongoing service provision. Decentralization of emergency treatment to the lowest level where trained staff, supplies and equipment are available not only improves women's access to abortion care, but also increases the likelihood that they will receive post-abortion family planning services.

6.2 Facilities

The same area used for emergency abortion treatment can usually be used for contraceptive service delivery. Managers must also arrange for appropriate storage of contraceptives and educational materials. A number of opportunities exist for providing family planning information in facilities with limited space. For instance, posters can be placed on the walls in the waiting, treatment and recovery areas as a simple way of educating patients about the benefits of family planning or providing information about contraceptive options. Another option is to have staff offer informational talks about family planning to women waiting for or recovering from treatment. If this approach is tried, managers should consider the need to expand waiting areas to allow the woman's partner or family members to join her if she wishes, and to provide flipcharts for the staff to use as well as printed and audio-visual materials to enhance the availability of information.

Another step toward improving the post-abortion family planning services offered to women is to post clearly marked signs or instructions indicating where the women should go after they are discharged. In hospitals that physically separate the abortion treatment and family planning service areas, this task will greatly improve the woman's ability to find the care she wants. In abortion treatment settings that do not offer family planning services on-site, it can help clients locate their referral.

6.3 Equipment, Supplies and Commodities

The equipment and supplies needed to provide family planning services in an emergency abortion treatment area are the same as those required for providing family planning services in any setting. The issues specific to the emergency treatment setting are related to the availability, re-supply, and storage of family planning commodities and educational materials. As family planning services have not traditionally been provided in an emergency abortion treatment context, these settings do not usually stock contraceptive commodities. Nevertheless, managers should identify a way in which a supply of some temporary methods can be kept on hand at all times, even if a wider selection of methods is kept elsewhere. For example, if the woman is unable to make a decision about which contraceptive method is most appropriate for her, the provider can offer her condoms, spermicides, oral contraceptives or injectables as an interim method and provide a referral for follow-up services. Managers of emergency abortion treatment settings must take the following steps to ensure that the necessary equipment and supplies are available to provide post-abortion family planning:

coordinate with family planning clinics within the hospital or health facility to establish supply/re-supply mechanisms for commodities;

provide written or visual materials about contraception for both literate and low-literacy patients that can be taken home;

stock all available methods, as women are more likely to use contraception safely and correctly when they have a choice of methods; and

develop and implement clinical and managerial protocols for contraceptives and educational materials.

Some women may choose to use long-term contraceptive methods after their abortion care, such as NORPLANT implants and IUDs. These services can be provided immediately following treatment for abortion complications, as long as:

the necessary equipment and supplies are stocked in the treatment area;

the client has been counselled and made an informed decision; and

a trained provider has ruled out any medical contraindications.

Abortion treatment areas that do not stock these commodities should consider doing so, since only minor changes would be required to offer these additional services, yet they would greatly expand a woman's choices for immediate contraception. In cases where this is not possible, managers should develop protocols that allow immediate referral to providers who can offer these services.

6.4 Client Flow

In emergency treatment service areas in hospitals, providers often attend large caseloads and multiple problems in a congested, busy atmosphere. Although women seeking care for abortion complications should receive prompt emergency care, this does not always happen (Abernathy et al., 1993). In some hospitals, a woman may spend several hours waiting for care before she is treated. Some health care professionals harbour negative attitudes towards the issue of abortion which they

may transfer to the women suffering from complications. There are other reasons for delay, however: except for women who are severely ill and need immediate treatment, many emergency facilities schedule abortion patients for treatment at designated times during the day rather than treating women as they present at the hospital. Some hospitals may only have one doctor on staff who can provide treatment. If the woman arrives when the doctor is away or attending another patient, she will have to wait until the physician becomes available before she can be treated. The practice of keeping women waiting several hours for treatment can disrupt patient flow, cause overcrowding in admissions areas or inpatient wards, and increase the risk of further medical complications.

The manager's first responsibility is to try to facilitate client flow and to ease the congestion (see section 5.4). Figure 1 provides a sample flowchart of the route a patient may take through the hospital before family planning services are added; after family planning services are added, another flowchart should be prepared and the amount of time that patients spend at each stage in the treatment and counselling process compared.

If there are waiting periods for women before and following treatment for abortion complications, providers should consider using that time to offer family planning information for those individuals whose conditions are not severe enough to preclude their participation in a group. However, women who are suffering from serious complications will obviously need to wait until their health status has improved; those who are experiencing emotional stress and less serious but significant medical problems may be unable to absorb new information. In any event, group information sessions do not replace the need for one-on-one counselling with patients to assess their needs individually and to allow them to raise any questions or concerns.

Specific examples of ways in which the manager can take advantage of these waiting or recovery periods include:

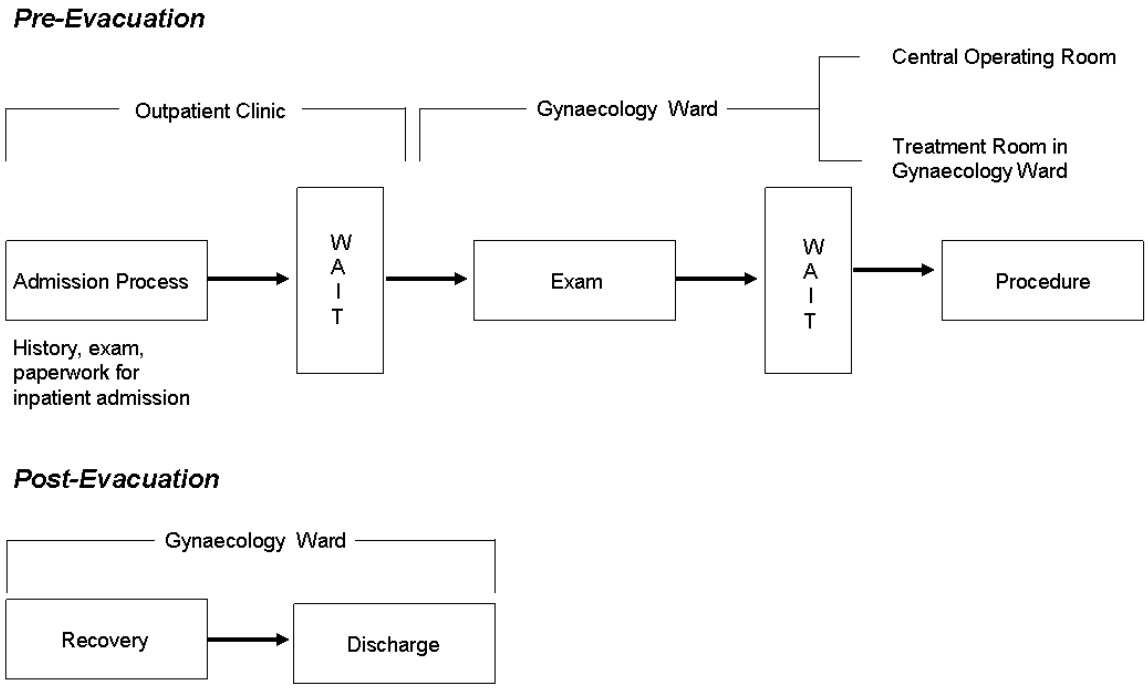
placing audio-visual materials (e.g., a videotape player) in the waiting or recovery areas containing information which describes the range of contraceptive methods available, and characteristics of specific methods;

making informational brochures available for patients to review

scheduling a counsellor from a family planning clinic to make a group presentation for women who are waiting; or

scheduling family planning counsellors or a gynaecological nurse to visit the emergency abortion treatment area to counsel individual patients who are recovering from treatment before they are discharged.

Figure 1
Sample Patient Management Flowchart for Treatment of Incomplete Abortion



Source: Adapted from Abernathy, M. et al. *A Guide to Assessing Resource Use for the Treatment of Incomplete Abortion*. Carrboro, NC: IPAS, 1993

Abortion treatment services provided in outpatient settings are typically more efficient than inpatient treatment, due to reduced waiting times and consequent shorter lengths of stay. In addition, a woman treated with lower dosages of pain control on an outpatient basis is more likely to be able to discuss her needs and desires regarding contraception; a woman who has had general anaesthesia or heavy sedation should not be asked to consider family planning until she is fully free of the effects of medication.

A range of additional approaches exist to improve patient flow and to link family planning and abortion services. One solution is to add abortion care services to the family planning clinic, where trained family planning staff, materials, and commodities are available during clinic hours and on condition that they are linked to a hospital and operate as outpatient clinics. Outside clinic hours, continuity of care should be assured by back-up facilities on a 24 hour a day basis at the hospital. The manager could also establish and implement protocols for effective referral between the treatment area and the family planning clinic in the hospital. Another innovative approach to providing linkages is to distribute referral cards to women treated for abortion complications, which would allow a visit to the family planning clinic at no charge.

Women referred for family planning services may have an impact on client flow in the clinic to which they are referred. For example, if incomplete abortion patients are treated at specific times during the day and then immediately referred to the family planning clinic within the health facility, the clinic may not be able to accommodate the sudden increased workload. Managers of abortion care services will need to coordinate with the family planning clinic managers to make sure staff know when to expect the additional patients so that they may receive services as quickly as possible.

6.5 Staffing

6.5.1 Staffing Patterns

To ensure that post-abortion family planning is adequately addressed at the time of emergency abortion treatment, managers must decide who should provide the post-abortion family planning:

existing staff who provide emergency abortion care;

additional staff who will dedicate their time exclusively to post-abortion family planning;

staff who provide counselling services at the family planning clinic in the health facility; or

trained volunteers willing to contribute their time to serve abortion patients.

Staff who work in the abortion treatment area may be able to address the woman's post-abortion family planning needs. These staff will already be familiar with the medical circumstances and will have had an opportunity to develop rapport with the woman. However, the following must be considered when using existing staff in the abortion treatment area to provide family planning counselling and services:

staff may be unable or unwilling to take on additional tasks;

high staff turnover may be an obstacle to training a few specific people to be responsible for providing the family planning counselling;

settings that provide 24-hour emergency treatment of abortion complications will need to orient and train more staff in providing family planning counselling or referral; and

emergency room staff have a curative approach to their work and may require orientation to the preventive aspects of post-abortion family planning.

Managers can also investigate the possibility of "borrowing" staff who provide family planning services at other locations within or outside of the health facility. For example, some hospitals have family planning counsellors who provide services to post-partum women on the obstetrics ward. These counsellors could also visit abortion patients during their recovery. Counsellors who are skilled in post-partum counselling need to be aware that patients who have undergone treatment for abortion complications will not have the same clinical and emotional needs as post-partum patients, and should tailor their counselling accordingly (see section 1.6 and Table 2).

Managers of emergency abortion treatment services who arrange to have family planning clinic staff provide post-abortion contraceptive services must consider how abortion patients will receive counselling during hours when the clinic is not open, or during weekends and holidays.

6.5.2 Staff Attitudes

Providers of emergency abortion treatment services may not view post-abortion family planning as a priority, impeding the communication necessary for good counselling. Managers should take the steps outlined in section 5.5.2 to address these concerns.

6.5.3 Staff Supervision

The person supervising emergency abortion treatment services can help ensure that abortion patients are able to receive the best family planning services possible given the resources available by developing a plan for how and by whom post-abortion contraceptive services will be provided. Managers may

consider instituting a quality assurance system to aid in supervision. In addition to the suggestions noted in section 5.5.3, managers may decide to conduct periodic review of patient records and procedure logbooks to determine if post-abortion family planning services are being provided consistently.

6.6 Training

Staff of emergency abortion treatment services, in many cases, have never received training in family planning methods and counselling. It is important that these providers learn about family planning in general and about post-abortion contraception and counselling techniques. Staff who do counselling and/or will actually provide contraceptive methods will require specialized training to develop their knowledge and skills (see section 5.6). Managers can contact public or private sector family planning programmes for initial and refresher training for emergency treatment staff. *Postabortion Care: A Reference Manual for Improving Quality of Care*, published by the Postabortion Care consortium, 1995, provides clinical and managerial guidance on emergency treatment services and their linkages to family planning.

6.7 Monitoring and Evaluation

Existing records such as log books, service statistics, phone records, charts, and routine checklists can be used directly or modified to provide information for monitoring and evaluation (see section 5.7).

One way to monitor the delivery of post-abortion family planning services is to incorporate information about the contraceptive services provided at the time of treatment into procedure logbooks maintained in the treatment area. If a woman selects a method at the time of treatment, the type of method should be noted in the logbook. It may also be helpful to note whether the woman has used a method in the past in order to identify specific problems with contraceptive failure. Whether counselling is offered or not, method delivery should be monitored, regardless of whether the woman accepts a method.

The elements for providing high-quality post-abortion family planning services should serve as a guide for developing the content for evaluating services (see Chapter 2). Whenever possible, existing monitoring or evaluation forms should be adapted to include an assessment of any post-abortion family planning services provided. Patient interviews need to be conducted on a regular basis to evaluate the acceptability of services. Family planning clinic staff can serve as a resource and can periodically be called upon to help evaluate the family planning services provided in the abortion treatment setting.

6.8 Linkage and Referral

If family planning services are not offered in the abortion treatment area, it is the responsibility of the abortion care manager to develop referral protocols and make sure women are referred to a specific place or person within the health facility or in their community where they may obtain these services. Providers should be particularly attentive of the need to inform women about where to obtain follow-up care (including where to go in the event of complications) for long-term methods or re-supply of commodities. The abortion care provider should be careful not to identify the woman as having had an abortion unless this information is essential to the subsequent care she receives. It is especially important that every effort be made to assess the abortion patient's needs for other comprehensive health services, to provide any care available, and to make appropriate referrals.

6.9 Cost

Hospital budgets tend to be divided departmentally, with each department receiving funds to cover services it provides in that area. If family planning counselling and services are provided and budgeted elsewhere in the facility, the emergency treatment area that wants to add post-abortion family planning services may have difficulty obtaining funds to cover the expense of additional staff or contraceptive

supplies. Managers of emergency abortion care settings will need to determine what expenses will not be covered by existing budgets and negotiate these changes with hospital administration and the family planning clinic. However, post-abortion family planning counselling and services do not require costly increases in infrastructure, supplies and staff; even minimal investments can result in marked improvements in the availability of services for patients.

Managers of emergency treatment services should be aware of the cost of contraceptives for the woman, and should try to ensure that each woman is able to obtain the information and services she desires before leaving the hospital. Some ways to reduce the future cost for the woman include: providing the woman treated for abortion complications with a family planning "coupon" that allows her to visit the clinic or obtain a method for free; and providing women who must be referred to another facility for contraceptive services with transportation assistance.

Regardless of whether services are provided in the emergency treatment area or in the family planning clinic of the same hospital, ensuring that women have the opportunity to obtain counselling and methods before they leave the hospital will ultimately prove beneficial to both the woman and the hospital.

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7 FAMILY PLANNING SERVICES

7.1 Types of Family Planning Programmes

The involvement of family planning programmes in serving women who have had an abortion is essential. There are a number of simple, low-cost steps that managers can carry out to reach women who have received abortion care, yet often the linkages between abortion services and family planning services are not developed. Managers who take a leadership role to link these services will find that they are serving an important group of women, and consequently, improving the quality of their programmes.

Table 7 presents characteristics of the major types of family planning programmes, presented in descending order of the strength of linkages, or of potential linkages, with abortion care providers. In other words, hospital-based family planning clinics, primary health care centres, and NGO family planning clinics should have a strong interest in coordinating their services with those of abortion care providers. On the other hand, although community-based services and social marketing programmes are good channels for re-supply of methods, and private providers can offer long-term and permanent methods, these are often more difficult to link directly to abortion services. Therefore, more detailed information will be provided on the first three service delivery channels: hospital-based clinics, primary health care centres, and NGO clinics.

Table 7
Types of Family Planning Programmes

Location and staffing	Services Available	Typical Availability of Contraceptive Methods
Hospital-Based Family Planning Clinics		
Location: In public sector or other types of hospitals. Staffing: May include nurses/nurse-midwives, social workers or counsellors. Physicians may be available on a limited basis.	Usually provide outpatient family planning counselling and services. May provide gynaecological services (eg, cancer testing and screening for STDs). May provide post-partum family planning services (eg, staff may routinely see women on the maternity ward). May receive referrals from primary level facilities.	Temporary methods, such as condoms, oral contraceptives and injectables. Long-term and permanent methods, such as IUDs, Norplant^{R} implants and female sterilization.

Primary Health Care Centres		
Location: In public sector primary health care centres. Staffing: May include nurses or nurse-midwives, technicians. Physicians are not routinely available, but they may visit on a regular basis (eg, weekly or monthly).	Maternal-child health services offered (eg, well-baby care, immunizations). Family planning. May supply methods to CBS workers.	Temporary methods, such as condoms, oral contraceptives, and injectables. Long-term methods (eg, IUDs) may be available during hours when trained staff are available and/or referrals may be made to other facilities.
NGO Planning Clinics (eg, Family Planning Associations, other private organizations).		
Location: Can be anywhere, although more common in urban areas. Staffing: Paramedical personnel, nurses and nurse midwives may provide the majority of care; physicians may be available.	Family planning services. May offer additional reproductive health services (eg, prenatal care and STD screening and treatment). May make or receive referrals.	Temporary methods, such as condoms, oral contraceptives, and injectables. Long-term and permanent methods, such as IUDs, NORPLANT7 implants, and female and male sterilizations. May offer all available methods or may refer clients for methods such as surgical sterilization.
Community-Based Services		
Location: CBS workers function at the community level; often part of a broad public or private sector programme. Staffing: Community members trained to provide some counselling and services.	Family planning information. Sell or give temporary methods. May provide other health services.	Temporary methods such as condoms, oral contraceptives, and injectables. May provide referrals for long-term and permanent methods.
Social Marketing Programmes		
Location: Commercial outlets (eg, pharmacies, markets); programmes often implemented nationally and are based on market research on consumer preferences and ability to pay. Staffing: Pharmacists, trained commercial workers.	Sell methods. Usually provide information via posters, brochures, package inserts etc.	Temporary methods such as condoms, oral contraceptives, and injectables if staff are appropriately trained. May refer customers to local family planning programmes for long-term and permanent methods.
Private Providers		
Location: Usually urban areas. Staffing: Private physicians; to a lesser extent nurse-midwives with their own practices.	Range of services varies with practice.	Doctors may offer a full range of methods or may refer for certain methods. Nurse-midwives, if trained, may offer almost all methods and provide referrals.

7.2 What Family Planning Managers Can Do

There are a number of steps managers of family planning programmes can take to initiate or to improve their post-abortion family planning services. Some family planning managers may need to become familiar with the provision of abortion services, either because they want to integrate these services with their own or because they are asked by an abortion care facility to assist them in setting up post-abortion family planning services. These managers should read Chapter 6 and 8 in addition to reading this chapter.

7.2.1 Hospital-Based Family Planning Clinics

While the family planning and emergency abortion treatment areas are usually physically and administratively separate, the location of the two services within the same hospital presents a good opportunity for linkage. Where staffing patterns permit, offering treatment of abortion complications in the family planning clinic could provide an effective way to ensure that patients leave with the means to prevent a subsequent unwanted pregnancy.

Managers of family planning clinics can do the following:

seek out the emergency abortion treatment staff within their facility;

gather relevant staff from the family planning clinic and the emergency abortion treatment area to discuss how post-abortion family planning services could be implemented most effectively;

develop up-to-date protocols for the family planning clinic and for the emergency abortion treatment area on post-abortion contraceptive methods, counselling, referrals, and management of services;

train staff from both family planning and emergency abortion treatment areas in the use of protocols;

identify obstacles to linkages and discuss how to overcome them;

assign staff to routinely visit the treatment areas and provide counselling services or referral; and

invite women in treatment wards to come to the clinic for services.

Family planning clinic managers may also conduct exit interviews with abortion patients about what needs they have for post-abortion family planning. For example, do women want information on specific methods and/or referral to a source of care in the community? Do women want the opportunity to include their partners in the counselling session? When do patients wish to discuss contraception, before or after treatment? If the patient can read and write, she can fill out a questionnaire or form regarding her abortion experience, and offer suggestions. The results of exit interviews should be shared with staff of family planning clinics and emergency abortion treatment areas and used to decide the most effective way to offer post-abortion services.

Existing family planning materials should be made available for patients, informing them about proper method use, their ability to change methods, and the locations within the community that provide contraceptives.

7.2.2 Primary Health Care Centres

These are often the first and nearest locations that women turn to for family planning services as well as for care for their children. However, treatment of abortion complications is rarely offered at these centres. This means that women seeking abortion care are referred to higher level hospitals or clinics which may or may not offer family planning services. Managers of primary care centres can:

implement training and services, as appropriate, for treatment of incomplete abortion when no other complications are present;

train staff in stabilization and referral of more complicated abortion patients;

develop clinical and managerial post-abortion family planning protocols;

train staff in the use of these protocols;

provide family planning services; and

develop referral mechanisms for methods not provided on site.

Managers may also want to use existing brochures for patients about post-abortion contraceptive methods. Local CBS workers should also receive training about the needs of women for post-abortion contraception, even though women may in general be hesitant to disclose their abortions to these workers; referrals should always maintain women's confidentiality.

Incorporating treatment of abortion complications into the primary care setting is one of the most effective ways to ensure rapid treatment of abortion complications and the subsequent delivery of post-abortion family planning counselling and services.

7.2.3 NGO Planning Clinics

NGO clinics have a unique opportunity to reach women who have undergone abortion. They often have the flexibility to implement new approaches; therefore, they can demonstrate how high-quality post-abortion family planning services can be delivered. The manager can take the following steps to implement a post-abortion family planning programme:

seek out emergency abortion service providers and work jointly to develop a post-abortion family planning programme; and

train clinic staff in the need for post-abortion family planning care, including contraceptive issues specific to abortion patients, counselling needs of women after abortion, referrals, and confidentiality of services.

Collaborative activities between abortion care providers and family planning providers include:

training emergency abortion treatment staff in family planning, contraceptive technology, and counselling skills;

ensuring that, at a minimum, a supply of temporary contraceptive methods is available in abortion treatment areas;

assisting in the development of clinical and managerial protocols for post-abortion family planning;

assigning a family planning worker to make regular visits to the emergency abortion treatment area; and

providing referral slips for post-abortion women to receive family planning services.

Although these are the necessary steps that NGO family planning clinic managers must take to strengthen their post-abortion family planning programmes, there are many other actions which can broaden the programme's reach, or make it more effective. For instance, managers can conduct simple surveys of family planning clinic clients to determine the types of abortion and post-abortion family planning services that would be most acceptable to clients. The results should be used to expand or to modify existing services.

Another option is to provide and publicize post-abortion family planning services for groups that are often underserved by traditional family planning programmes, such as adolescents, rural women, and women who have tested positive for HIV. Carrying out focused, community surveys provides ways to learn about an underserved group's particular needs for post-abortion family planning. Effective information, education, and communication (IEC) materials can be prepared based on the results of surveys.

Outreach programmes are another alternative. The manager can arrange for training of private abortion providers in the community on the importance of including contraceptive services. Contraceptive methods should be donated or sold to these providers so that they, in turn, can make them available to their clients.

Finally, disseminating the results of effective models for offering post-abortion family planning services can help other programmes to make the same improvements at their sites. Lessons learned by family planning NGOs can also be particularly useful in prompting improvements in public sector programmes. Where not prohibited by law, family planning NGOs could offer abortion and/or MR services in order to help ensure the provision of safe abortion care. Treatment of abortion complications is also an important alternative, and one that can be offered in all settings (Postabortion Care Consortium, 1995).

7.2.4 Workers in Community Based Services (CBS)

CBS workers are a major source of supplies of temporary methods and referrals. Managers of CBS programmes should guarantee that the following actions occur:

workers receive training in post-abortion family planning methods, counselling, and referral; and

workers know what reproductive health services are available in the surrounding communities, at all levels of the health care system, in order to be able to link women to the services they need.

CBS workers and their supervisors should also set their own quality improvement goals. For instance, a worker might want to emphasize helping women to use methods correctly and to deal with side effects. Managers should focus training and supervision of CBS workers on how to help women and couples successfully use their chosen method, including information on re-supply at the local level.

7.2.5 Social Marketing Programmes

Managers of social marketing activities can expand the broad coverage of these programmes to reach women who have had an abortion. Minimally, managers should include the following in their programmes:

post-abortion family planning information in marketing and promotional materials; and

training of pharmacists, market women, and others on the family planning needs of women who have had an abortion.

An emphasis on the correct use of contraception and on the management of side effects will help women avoid pregnancy while using a method, and will help ensure their continued use of a method. Managers of social marketing programmes may also try to seek out the managers of abortion services. Managers of emergency abortion treatment facilities should be made aware of where methods are available in the community, including through commercial outlets. These sources can be included in information given to clients.

7.2.6 Private Providers

Participating private providers of contraceptives include obstetricians-gynaecologists, general practitioners, nurse midwives, and others. They should seek out training on the clinical, social and other aspects of post-abortion clients. This training could be offered through professional medical or nursing associations. Private providers can also inform personnel in public sector emergency treatment services of their availability to offer post-abortion family planning to referred patients.

7.3 Facilities

In hospital-based family planning clinics, primary health care centres and NGO family planning clinics, space is usually already designated for the provision of methods. This includes storage of contraceptive commodities and health education materials, and an examination room for the insertion of IUDs and/or NORPLANT7 implants. Space may already exist for surgical sterilization services. Many facilities also will have a private area used for counselling.

It is important that contraceptives be stored in a secure place. However, managers should be aware that if only one person has access to a locked area, contraceptive commodities may be unavailable when that individual is not present n for example, on weekends. Managers will have to balance the security of commodities with ensuring their availability at all times.

7.4 Equipment, Supplies, and Commodities

For family planning facilities, few changes in equipment and supplies are needed in order to offer post-abortion family planning services. Adding services for the treatment of incomplete abortion or for legal abortion requires that specific instruments be available. WHO documents and publications listed at the end of this chapter give equipment and instrument lists.

7.5 Client Flow

Family planning clinic staff who currently provide contraceptive methods are likely to already serve post-abortion clients, often without being aware of it. For those family planning managers who wish to expand their services to include treatment of incomplete abortion and/or provision of induced abortion, where not prohibited by law, some modifications will be necessary. Conducting an analysis of current patient flow, as described in Chapter 5, will assist such managers in efficiently adding abortion treatment services to their existing family planning programme.

In some emergency abortion treatment locations with relatively high case loads, abortion patients are "listed"; that is, evacuation procedures are performed one or two times during the day. This is not an optimal arrangement as it can delay care and increase the risk of complications; unfortunately, it is a practice employed in some hospitals. If family planning clinic staff subsequently bring the post-procedure group of women to their clinic for counselling and services, managers should be aware that this may result in an influx of clients at one time. Also, clients may have concerns about being

readily identified as the post-abortion group. In this situation, managers should experiment with ways to efficiently incorporate these women into their clinic schedule while maintaining their confidentiality.

7.6 Staffing

7.6.1 Staffing Patterns

To effectively reach abortion patients through existing services, managers should identify ways of making post-abortion family planning counselling and services available at all times. This means that staff must be equipped to provide such services. Family planning facilities usually offer services for a set number of hours on weekdays; services are usually not offered in the evenings, on weekends, or during holidays. In contrast, emergency abortion treatment occurs on a round-the-clock basis. Managers must ensure that post-abortion family planning counselling, methods and referral are available to all women who seek abortion care, no matter where or when they seek these services. For instance, if a nurse or counsellor from a hospital family planning clinic can visit the emergency abortion treatment area only on weekdays, managers should ensure that evening and weekend emergency abortion treatment staff are trained and assigned to offer post-abortion family planning during those hours. Conversely, if a family planning clinic decides to offer abortion treatment services but is only open during weekdays, managers must arrange for referrals for those women who seek emergency care at other times.

Managers of facilities offering new services will also need to consider staffing patterns as they add post-abortion family planning and/or abortion services. They may want to ensure that specific staff are made responsible for providing counselling and services, including back-up staff to cover vacations and sick leave. For instance, a nurse from a hospital family planning clinic who routinely counsels patients in the emergency abortion treatment area needs to schedule her visits so that she reaches all patients (or the maximum number possible at a time) without leaving a gap in coverage at her clinic.

Managers of both hospital-based family planning clinics services should be aware that the provision of post-abortion family planning will increase the work load of the staff members involved. If a family planning counsellor regularly visits the emergency area to talk with abortion patients, for example, her absence in the clinic may mean increased responsibilities for remaining staff. Strategies for overcoming this difficulty include: 1) shifting other responsibilities among several staff members; 2) requesting additional staff; or 3) looking for the most efficient ways to reach women (e.g., group information sessions).

Abortion caseloads are minimal in many locations, such as district hospitals or rural health centres; many facilities receive only one or two abortion patients per week. No matter what the caseload, however, providing post-abortion family planning should be viewed as a high priority of the family planning staff during abortion care.

7.6.2 Staff Supervision

Frequent supervision of staff is essential, no matter how family planning services are offered. Supervisors who place a high value on post-abortion family planning services and who convey these values to their staff are likely to ensure that high quality services are regularly offered. Further guidance can be found in section 5.5.3.

7.7 Training

Because post-abortion family planning will often be a new component for family planning programmes, managers will likely have to schedule training updates. These sessions can include a re-emphasis of key

points and problem-solving activities specific to all clients. Managers should be sure to provide post-abortion family planning training for new staff members when they first begin work. Staff in those clinics adding new abortion services will require clinical, managerial and counselling training for induced and/or emergency abortion patients. Further training information is found in section 5.6.

7.8 Monitoring and Evaluation

Managers should be aware that a variety of techniques can be used to assess the quality of services. Existing forms and established procedures for routine monitoring can be modified to include post-abortion follow-up. Periodic special evaluations should include an assessment of post-abortion family planning. If new treatment or elective induced abortion services are begun, mechanisms for monitoring and evaluation of the quality of services must be implemented.

7.9 Linkage and Referral

Referrals to other services are important because of the comprehensive nature of women's health. Making effective referrals should be an integral part of post-abortion family planning counselling, but it is an area that is often problematic. Family planning staff should be trained to identify reproductive and other health needs of their clients and be able to make referrals to community services. These referrals can only be effective when providers are knowledgeable about what is available outside their own workplace, and when they take the time to learn what needs or concerns the patient may have.

7.10 Cost

Managers of private facilities, such as NGO clinics, should work to ensure that women are able to obtain abortion and post-abortion family planning services without cost obstacles. In some settings, managers have implemented sliding scales so that clinic fees are based on women's ability to pay. In others, offering comprehensive reproductive health care has helped support family planning services.

Managers of family planning facilities may find that additional financial support to cover new post-abortion family planning services is difficult to obtain. This is particularly true in public sector programmes in which funds are limited.

In any setting, however, expanding ongoing family planning programmes to include abortion patients should not require major new expenditures; in fact, a significant proportion of current family planning clients are likely to have been or will become abortion patients. Improving the availability of post-abortion family planning, in turn, improves the overall quality of family planning programmes. Ultimately, providing contraceptive services is less costly to the health care system and the society-at-large than treating women suffering from abortion complications.

References for Chapter 7

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CHAPTER 8

INDUCED ABORTION AND MENSTRUAL REGULATION SERVICES

8.1 Induced Abortion Services

In almost every country there are legal indications for induced abortion. These indications vary widely, however: some countries restrict legal induced abortion to situations where it is necessary to save the life of the woman; other countries allow induced abortion in pregnancy resulting from rape or incest, and/or the probable presence of fetal abnormalities. Other statutes allow abortion for broad health reasons, contraceptive failure, socioeconomic reasons, and/or by request of the woman. Within the legal constraints in their particular setting, health care providers have an obligation to provide safe abortion services. Managers can consult the technical bulletin, *Earkt Abortion Services: New Choices for Providers and Women*, published by IPAS, for information on technologies for service provision (Winkler et al., 1996)

In some settings, providers of induced abortion services may not be motivated to promote preventive care such as family planning. However, providers and managers have a responsibility to ensure that women who receive pregnancy termination services also are offered family planning. Induced abortion and family planning services must never be coercive, however. Provision of induced abortion services should never be contingent on the woman accepting contraception in general or any particular method.

8.2 Menstrual Regulation (MR) Services

Although pregnancy may not be confirmed, many women seek menstrual regulation (MR) services because they fear they may be pregnant. Therefore, MR shares some similarities with induced abortion. Providers and managers of MR services need to see that women obtain the means to prevent a subsequent unwanted pregnancy as an integral part of the care they receive.

8.3 Services to Offer

Pre-abortion counselling to give women the opportunity to make a fully-informed choice about the abortion is an integral part of induced abortion/MR services. Managers must ensure that providers understand the necessity of including family planning counselling and service delivery as an essential element of all induced abortion and MR services as well. Since most cases of induced abortion/MR are elective procedures, the opportunities are greater for providing family planning at the time of the induced abortion than during treatment of abortion complications. With induced abortion/MR, the woman is generally neither sick nor heavily sedated; therefore, she is alert and may be receptive to counselling. Frequently the woman will select a contraceptive method prior to the procedure, which can then be provided following the induced abortion or MR.

For those women with unwanted pregnancies, the fact that they are seeking an induced abortion is an indication of a strong motivation to control their own fertility. However, both in cases where the pregnancy was unwanted and in cases where the pregnancy was planned, the woman's emotional state may make it difficult for her to decide at that time which contraceptive method is most appropriate for her, particularly if she is considering a long-term method. Therefore, family planning counsellors should be sensitive to the emotional situation of the patient as well as to the woman's need to make an informed, voluntary method choice.

The particular circumstances that lead a woman to terminate a pregnancy or to seek MR services may also affect her contraceptive choices following the procedure. Therefore, managers must urge counsellors in an induced abortion/MR setting to take into account each woman's particular situation. For example, a woman who has experienced contraceptive failure needs counselling at the time of her

induced abortion to: clarify any misinformation regarding her current method; discuss whether she wants to continue with that method; and help her select a more appropriate family planning method, if necessary. However, the counselling needs for a woman for whom a current or future pregnancy is life-threatening are different; she requires family planning counselling which focuses on highly effective methods of contraception which will protect her from additional health risks. Finally, if induced abortion/MR services are offered in a setting which does not provide routine, ongoing family planning services, patients must be referred to locations where they can obtain re-supply of contraceptive commodities and follow-up care.

8.4 Facilities

Because induced abortion/MR services can be scheduled, there will probably be less overcrowding and better use of space than in those facilities providing emergency treatment for abortion complications. The facilities in which induced abortion services are offered should convey respect for both the patient and the procedure (Hern, 1990). A separate counselling room is not necessary, but a private space, no matter how small, is necessary to make the woman feel relaxed enough to discuss her contraceptive needs openly. The facilities required for providing family planning services in an induced abortion setting are the same as for other settings. Long-term methods, such as IUDs or NORPLANT7 implants, can be inserted in the room where the procedure is performed. For other methods, such as pills and condoms, space is required for storing these contraceptive commodities and accompanying educational materials.

8.5 Equipment, Supplies, and Commodities

The equipment and supplies required for providing family planning services following an induced abortion are no different than those required for providing these services in other settings. Managers must ensure that a range of contraceptive commodities and educational materials are available at the site where induced abortion and MR services are offered.

8.6 Client Flow

Patients generally schedule appointments for induced abortions or MR procedures. With scheduled procedures there is more flexibility regarding when family planning counselling can be provided. Service managers must attend to the following issues:

when patients are scheduled, adequate time must be allowed to counsel them prior to and following the procedure;

family planning counselling must be available any time that induced abortion or MR services are offered;

in a hospital setting, patients may need to be referred to family planning services in another location within the hospital; and

if possible, induced abortion services should be coordinated so family planning services are available on the same day, and in the same place or near by.

Some facilities offer induced abortion/MR services only on specific days of the week. Where this is the case, family planning counsellors may only need to be available at these designated times. As in other settings, small group information sessions, combined with individual counselling, is an efficient approach to reach clients.

For hospitals or settings that provide a broad range of reproductive health services for other patients, induced abortion and MR patients may be incorporated into existing schedules, where not prohibited by law. These schedules may require careful planning in order to identify the most opportune time for offering family planning counselling and services.

8.7 Staffing

8.7.1 Staffing Patterns

To ensure that family planning is adequately addressed at the time of an induced abortion/MR, managers will need to decide whether to:

use existing staff who provide abortion services;

utilize staff who provide services at a family planning clinic; or

hire additional staff who will dedicate their time exclusively to post-abortion family planning.

In clinics that specialize in induced abortion and/or MR services, there are often dedicated staff with family planning expertise who provide post-abortion family planning services. Staff who counsel patients regarding their decision to have an induced abortion may also be responsible for providing the family planning counselling and services. In some cases, staff who actually assist with the procedure also counsel patients in post-abortion family planning. If induced abortion/MR services are offered in a family planning clinic setting, there should be trained knowledgeable counsellors available to provide post-abortion family planning counselling.

For induced abortion services offered in a hospital setting, however, experienced family planning counsellors may not be available. Induced abortion/MR service managers need to make arrangements with the family planning service providers within the hospital to guarantee that women receive post-abortion family planning counselling prior to discharge. For example, an agreement may be reached in which family planning clinic staff come to the location where induced abortion/MR services are offered to provide counselling to patients on certain days of the week or during certain hours of the day when procedures are scheduled.

8.7.2 Staff Supervision

Any service delivery protocols for the provision of post-abortion family planning must include mechanisms to ensure that the provision of induced abortion services is not contingent on a woman's acceptance of a family planning method. Simply having a patient sign a consent form, however, is not adequate to ensure voluntary, informed method choice. This requires that managers supervise their staff to ensure that the woman receives adequate information along with the opportunity to make a voluntary decision.

The often controversial nature of providing induced abortion services may lead to high staff turnover. To address these issues managers can:

organize staff development workshops to help staff members deal with job-related stress;

rotate responsibilities among staff to guarantee that they receive periodic breaks from the stresses of their work; and

implement appropriate security measures to protect staff.

8.8 Training

All staff will require initial and refresher training in basic family planning, post-abortion contraception, counselling techniques and referral. In addition, new staff should receive training in the agency or hospital policies and procedures relating to post-abortion family planning counselling and services (National Abortion Federation, 1988).

Women seeking an induced abortion or MR services may experience a variety of emotions, ranging from distress to relief. It is important that staff be able to respond appropriately; therefore, training in crisis counselling may be helpful (see Chapter 4).

8.9 Monitoring and Evaluation

As with post-abortion family planning offered in any setting, ongoing monitoring of counselling and services within induced abortion or MR services can be used to provide feedback to staff on ways to improve their programme. Ongoing monitoring that includes routine collection of basic data from patient charts or logbooks, observation of counselling, patient interviews and problem-solving discussions among staff are essential.

Managers can also conduct an overall evaluation of the family planning services offered in the induced abortion setting with the assistance of staff from a family planning clinic; existing evaluation strategies of organizations promoting high-quality abortion services can be carried out. Contraceptive acceptance and continuation rates at the time of the follow-up visit can be used as indicators of the effectiveness of counselling. However, these indicators should not be used to establish quotas or to encourage counsellors to use coercive methods to increase contraceptive acceptance. Interviews with patients to determine their perspective on the quality of services is an important element of conducting an overall evaluation.

8.10 Linkage and Referral

In order to ensure that the woman continues, changes, or discontinues method use according to her desires, the manager must make sure that referrals to local family planning resources as well as to other needed reproductive health care are in place.

Counselling at the time of the induced abortion is generally short term in nature. However, the woman may have unresolved issues regarding the abortion, contraceptive use, or her sexuality which require longer term counselling. For example, women who undergo an abortion for indications such as rape or incest may need more intensive psychological follow-up services than other women who have had abortions. Providers should be prepared to offer referral to appropriate services in such cases.

8.11 Cost

The provision of family planning at the time of an induced abortion is a cost-efficient way of delivering services for the patient. For the woman, receipt of a family planning method at the time of the procedure eliminates the need for an additional visit to select a contraceptive. In recognition of the fact that family planning services are a critically important part of induced abortion care, many clinics have a single fee for the abortion procedure which includes contraception (Margolis et al., 1974).

References for Chapter 8

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CHAPTER 9

POLICY AND POST-ABORTION FAMILY PLANNING

9.1 The Role of Policy-makers

Although this book has focused on management practices in the delivery of post-abortion family planning in different health care settings, these practices are far easier for managers and providers to implement and sustain if they are concurrently supported by policies supportive of safe abortion care and post-abortion family planning (IPAS, 1996). Policy-makers have a responsibility to promptly debate and reform those policies which interfere with women's ability to obtain high-quality post-abortion family planning services.

Regardless of the social or legal setting in which this debate occurs, there are reforms in post-abortion family planning that policy-makers can make to promote better overall health care for women. A critical first step is the acknowledgement of the essential nature of the link between women's health and post-abortion care and the realization that abortion care services are incomplete without effective family planning efforts. Many of the changes needed will not require major financial investments. Designating space, creating privacy, and cooperating with existing family planning services can all be achieved at minimal cost. Other changes may require more investment of resources: training staff is of particular importance. It will require coordination of services throughout all levels of the health care system.

Another area for policy support is in authorizing trained lower level providers to offer emergency care in cases of abortion. Countless numbers of women die every year from lack of access to timely, safe treatment for abortion complications. Decentralizing these services to the communities where the women live should greatly reduce abortion-related maternal morbidity and mortality (e.g., by providing less travel time to reach services and better opportunities for follow-up care). This decentralization process should also aid in the linkage of family planning services to emergency abortion care services, since the women usually receive their family planning counselling and commodities within their community, not at a tertiary level hospital miles from their home.

A third area in which policy-makers should work is changing policies that keep women from receiving services that they need n for example, policies that prohibit young people from receiving contraceptives. This policy is particularly onerous to those young women who have demonstrated their need for family planning by risking an unsafe abortion, forcing an outcome in which young women are denied the means to prevent future unwanted pregnancies. Family planning information and services should be available to all women, regardless of age, marital status, or ethnicity, and policies should reflect this. Finally, policy-makers should support the work of abortion care managers and providers.

9.2 The Role of Managers

Programme managers must consider themselves partners in the movement to effect these reforms. Although policy changes are not needed prior to making the changes in services that are suggested in this book, a supportive policy environment will make the manager's job much easier. In addition, programme managers are specially equipped to provide guidance to policy-makers: they know the problems in delivering services and they know what changes are needed to overcome these obstacles.

References for Chapter 9

IPAS. *Initiatives in Reproductive Health Policy,* 1(2). Carrboro, NC:IPAS, 1996.

Annex 1
Contraceptive Methods Use After Abortion: Presented in Order of Effectiveness

WOMAN'S CLINICAL SITUATION	CONTRACEPTIVE METHOD ISSUES
NO COMPLICATIONS	**Do not delay** starting method use. Most methods can given immediately. Following uncomplicated abortion, there are no medical restrictions for: IUD (copper or levonorgestrel) pills (combined or progestogen-only) injectables (combined or progestogen-only) Norplant implants barrier methods (diaphragm, cervical cap, spermicide, condoms) Female or male sterilization **Wait** until a normal menstrual pattern returns before using natural family planning (rhythm, periodic abstinence).
INFECTION (confirmed or presumptive diagnosis) ▪ signs of unsafe or unclean induced abortion, or ▪ signs or symptoms of sepsis or infection, or ▪ unable to rule out infection	Delay female sterilization or IUD insertion until infection is either ruled out or fully resolved. Provide a short-term method and make a follow-up appointment or referral. Consider any other method.
TRAUMA to genital tract ▪ uterine perforation ▪ serious vaginal or cervical trauma ▪ chemical burns	Delay female sterilization until trauma is healed. If abdominal surgery must be done to repair trauma and if no additional risk is involved, sterilization may be done concurrently. Delay IUD insertion until uterine perforation or other serious trauma has healed. Provide a short-term method and make a follow up appointment or referral. Injuries that affect the vagina or cervix may limit the use of female barriers and spermicides. Consider any other method.
HAEMORRHAGE AND SEVERE ANAEMIA Haemorrhage must be resolved before family planning can be considered.	Delay female sterilization because of the risk of further blood loss. Provide a short term method and make a follow up appointment or referral. The increased blood loss that can occur with use of copper IUDs may be a factor for women who are severely anaemic. Consider any other method.
SECOND-TRIMESTER ABORTION If there is an excessive clotting disorder, as may be seen with missed abortion, special treatment may be needed prior to surgery.	Delay fitting or use of diaphragms or cervical caps for 6 weeks. It may be more difficult to locate the fallopian tubes if female sterilization procedures are done before the uterus returns to pre-pregnancy position. There may be a higher expulsion rate for IUDs inserted immediately after second trimester abortion. Consider any other methods.

From: Leonard and Winkler, Postabortion Family Planning: A Woman's Informed Choice Today Can Prevent an Unwanted Pregnancy. *Advances in Abortion Care* 6(1), IPAS

Annex 2
Factors in Individual Choice of Post-abortion Family Planning[1]

Facility, Provider and Community Capability	Issues to consider	Recommendations
Opportunity, space and private environment for counselling and informed decision-making	Emergency-care settings may be too crowded and hectic to ensure privacy and informed choice. Do not give permanent or long-acting methods without adequate counseling.	Arrange space and time for private counseling. If adequate counselling is impossible: Offer temporary methods (oral contraceptives, condoms, spermicides, female barriers or injectables), AND Provide referrals for further counselling regarding other methods.
Choice of contraceptive methods	Do not limit the range of methods offered. Limiting the availability of methods will deny some women access to the most appropriate methods or to their preferred methods.	Make a range of methods available. Reduce provider bias for or against particular methods by educating providers about appropriate use of all methods.
Links with family planning resources in the community	Consider the woman's access to follow-up care and resupply in recommending methods.	Make sure counsellors and providers know about family planning resources throughout the area served. Establish referral links among family planning resources or between abortion-care and family planning services.

[1] Adapted from: Leonard, A.H. and Ladipo O.A. Post-Abortion Family Planning: Factors in Individual Choice of Contraceptive Methods. *Advances in Abortion Care*, 4(2). Carrboro, North Carolina:IPAS, 1994.

Annex 3
Contraceptive Failure Rates, United States

Method	% of Women Experiencing an Accidental Pregnancy within the First Year of Use		% of Women Continuing use at One Year[3]
	Typical Use[1]	Perfect Use[2]	
Chance	85	85	
Spermicides	21	6	43
Periodic Abstinence	20		67
Calendar		9	
Ovulation Method		3	
Sympto-Thermal		2	
Post-Ovulation		1	
Withdrawal	19	4	
Cervical cap			
Parous Women	36	26	45
Nulliparous Women	18	9	58
Sponge			
Parous Women	36	20	45
Nulliparous Women	18	9	58
Diaphragm	18	6	58
Condom			
Female	21	5	56
Male	12	3	63
Pill	3		72
Progestin Only		0.5	
Combined		0.1	
IUD			
Progesterone T	2.0	1.5	81
Copper T 380A	0.8	0.6	78
LNg 20	0.1	0.1	81
Depo-Provera	0.3	0.3	70
Norplant (6 Capsules)	0.09	0.09	85
Female Sterilization	0.4	0.4	100
Male Sterilization	0.15	0.10	100

[1] Among typical couples who initiate use of a method (not necessarily for the first time), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.
[2] Among couples who initiate use of a method (not necessarily for the first time) and who use it *perfectly* (both consistently and correctly), the percentage who experience an accidental pregnancy during the first year if they do not stop use for any other reason.
[3] Among couples attempting to avoid pregnancy, the percentage who continue to use a method for one year.
Source: Adapted from Hatcher et al. *Contraceptive Technology*, 16th Revised Edition. New York:Irvington Publishers, Inc., 1994 and Trussel et al. Contraceptive Failure in the United States: An update. *Studies in Family Planning*, 21(12):52, 1990.

Annex 4
Checklist for Evaluation and Supervision of Counselling Skills

The following checklist is designed to be used for self-evaluation by the counsellor or in conjunction with observational evaluation of counselling skills by an external evaluator. The external evaluator should be someone experienced in counselling techniques. The checklist may be modified and adapted to conform with the counselling training curriculum used in the original training.

To Assess Listening Skills the Evaluator Should Observe Whether the Counsellor:

___ Meets with clients in a private, comfortable place.

___ Accepts clients as they are; treats each one as an individual.

___ Listens to what clients say and how they say it; observes tone of voice, choice of words, facial expressions and gestures.

___ Puts him/herself in the client's place as she talks.

___ Keeps silent sometimes, giving the client time to think, ask questions, and talk.

___ Listens carefully to the client instead of thinking of what to say next.

___ Repeats occasionally what has been heard to ensure understanding by both parties.

___ Sits comfortably, avoids distracting movements and looks directly at client.

To Assess Questioning Skills the Evaluator Should Observe Whether the Counsellor:

___ Uses a tone of voice that shows interest, concern and friendliness.

___ Asks only one question at a time and waits for an answer.

___ Asks questions that let the client express her needs.

___ Asks open-ended questions that cannot be answered with a simple "yes" or "no" answer to encourage communication.

___ Uses words such as "then", "and", "oh" to encourage the client to keep talking.

___ Avoids beginning questions with "why" since this word can connote judgement of the client.

___ Asks the same question in different ways to ensure the client has understood a point.

Source: Adapted from Lettenmaier, C. and Gallen, M. Why Counselling Counts. *Population Reports*, Series J, No. 36, 1987.

Annex 5
Suggestions for Observing Counselling Sessions

Before Counselling Begins

1. Limit the number of observers to one or, at most, two, in any counselling session. It is often useful to sit in on several counselling sessions to observe interactions with different clients.

2. The manager or supervisor should inform the counsellor in advance that he/she will be observing the counselling session and give the reason for the observation (e.g., to provide support and technical assistance; to identify needs for additional training or assistance; to learn how counselling can be better integrated or replicated in other programs, etc.). It is preferable to present the observation not as a test of the counsellor's abilities or work, but as an opportunity to understand strengths and areas needing improvement, to provide support and assistance, and/or to respond to questions.

3. The observer should explain that the counsellor should conduct the counselling session as if the observer were not there, and that there will be an opportunity after the client leaves to talk.

During Counselling

1. The observer (or the counsellor) should ask the client's permission to observe the session, and explain the reasons for the observation (e.g., to learn how to improve services or counselling at the clinic), and ensure her of the confidentiality of whatever occurs during the session.

2. The observer should try to be as unobtrusive as possible during the counselling session (e.g., sitting away from the counsellor-client). The observer should not interrupt the session unless vital information is presented incorrectly or a difficult situation emerges. Under almost all circumstances, it is better for the observer not to intervene, since this is likely to undermine the counsellor's confidence and credibility with the client.

3. Although a checklist can be used as a visual guide to identify counselling skills or knowledge to be assessed, observers should avoid writing during the observation. Taking notes during a counselling session can be unnerving to both the client and to the counsellor, and can distract the observer from gaining an overall perspective on what is happening. Observers can record their impressions after the session ends.

Afterwards

1. The observer should begin by asking the counsellor his or her opinions about the session. The observer can then supplement these remarks by offering positive comments about the counsellor's demonstration of skills or knowledge, as well as suggestions for improvement. If counsellors need technical updates regarding the information they present, it is useful to give them (or refer them to) appropriate resource materials.

2. The observation also provides an opportunity to talk with counsellors about other elements which affect their work. Is counselling understood by and supported by other staff? Do they have suggestions for how counselling could be improved, extended, or integrated? Do they identify needs for additional support, such as training or supplies of informational materials? What barriers do they face and what suggestions do they have for overcoming them?

Remember

Having an observer present during counselling can be unsettling both for the counsellor and the client. The client may feel more reluctant to discuss what is already highly personal information. The counsellor may be nervous about being watched, and may wonder how the results will be used. Observers can put both clients and counsellors at ease by explaining their role, being respectful and sensitive, and viewing this is an opportunity to learn from the counsellor and clients rather than to judge or teach them.

Source: Verme, C.S. "Observation as an Approach to Evaluating Counselling (adapted)." A Workshop to Build Better Counselling Evaluation for Family Planning Providers. Baltimore, Maryland: March 31, - April 1, 1992.