

# Reproductive Health Issues

## Key Points for Clients and Providers

### *Postabortion Care*

- Fertility returns quickly, as early as 8–10 days and usually within 1 month after spontaneous or induced abortion. Women and couples need to start using a family planning method almost immediately to avoid unplanned pregnancy.
- Information provision and counseling (where desired to support decision-making) regarding the return of ovulation within 2 weeks, contraceptive methods, and self-care at home are essential components of postabortion care.

### *Violence Against Women*

- Violence is not the woman's fault. It is very common. All health care providers can do something to help.

### *Infertility*

- Infertility can often be prevented. Avoiding sexually transmitted infections and receiving prompt treatment for these and other reproductive tract infections can reduce a client's risk of infertility.

## Family Planning in Postabortion Care

Postabortion care includes any or all of the following, as needed or desired: an optional postabortion follow-up visit 7–14 days after the procedure, management of residual side effects or complications, and contraceptive services. Immediately after an abortion, before the client leaves the facility, it is important to provide family planning information and also to offer counseling and methods of contraception. Many different health workers can offer family planning services, including those who provide abortion and postabortion care. When such services are integrated with postabortion care and are offered immediately after an abortion, women are more likely to use contraception to reduce the risk of an unintended pregnancy.

# Help Women Obtain Family Planning

## Provide Important Information

A woman has important choices and opportunities, before, during, and after abortion care. To make decisions about her health and fertility, she needs to know the following.

- Fertility returns quickly. Following an induced or spontaneous abortion, ovulation can return as early as 8–10 days later and usually within 1 month. Hence, initiating a family planning method immediately after abortion if possible, or as soon as possible within the first month, is important for women who desire to delay or prevent a future pregnancy.
- All contraceptive options may be considered after an abortion. The client's wishes and her future plans for childbearing are paramount and the woman should be empowered to make an informed choice. Information provided about the different methods should include failure rates since some women may have sought an abortion due to the failure of the contraceptive method they were using. Ultimately, the choice must be made by the woman but her choice should be an informed one.
- If the woman decides to wait before choosing a contraceptive method for ongoing use, she should consider using a backup method in the meantime if she has sex. Backup methods include abstinence, male or female condoms, spermicides,<sup>1</sup> and withdrawal; the client should be informed that spermicides and withdrawal are the least effective contraceptive methods, and if possible, she should be given condoms and emergency contraceptive pills.
- If the woman decides not to use contraception at this time, providers can offer information on her fertility condition, the most appropriate available methods, and where to obtain them. Providers can also offer condoms, oral contraceptives, and emergency contraceptive pills for women to take home and use later.
- If being treated for infection or vaginal or cervical injury, the woman should wait until she has completed treatment/management of the infection/injury before having sex again.
- If a woman who has suffered a miscarriage wants to become pregnant again soon, the provider should encourage her to wait at least 6 months as this may reduce the risks of low birth weight, premature birth, maternal anemia, and a repeat miscarriage.
- A woman receiving postabortion care may need other reproductive health services. In particular, a provider can help her consider if she

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<sup>1</sup> A client can use spermicides if they have no vaginal or cervical injury.

might have been exposed to sexually transmitted infections, and may need to ask whether she has experienced sexual violence (see section on Violence Against Women, pp. 388–392).

### **Counsel With Compassion**

Counseling is more than information provision. It is a focused, interactive process to provide support, information, and non-directive guidance from a trained and skilled person, in an environment where a person can openly share their thoughts, feelings, perceptions, and personal experiences. The process should support final decision-making by the client about the topic being discussed.

Before or after an abortion, some clients may wish to receive counseling. In particular, a woman who has had postabortion complications may need additional support. A woman who has faced the double risk of unplanned pregnancy and unsafe induced abortion especially needs help and support, including psychological services. The counseling should be client-centered.

When offering and providing counseling, it is essential to apply the following guiding principles.

- Ensure that the person agrees to receive counseling and has had the opportunity to choose not to receive counseling.
- Ask the client to explain what she wants or needs and any concerns she may have, including her wishes regarding pregnancy, and consideration of the pros and cons of different methods such as the likely impact on menstrual bleeding, pain, and acne.
- Give her the time she needs, and actively listen to her expressed values, needs, and preferences (including if she wants someone she trusts to be present during counseling).
- Treat the client with respect and avoid making any judgment or criticism.
- Ensure privacy and confidentiality.
- Communicate information in a manner and language that is understandable to the individual.
- Present all suitable options tailored to the person's medical eligibility, expressed needs and preferences, while avoiding imposing one's personal values and beliefs onto them.
- Make it clear to the client that she will be the one to decide her family planning method.

## When to Start Contraceptive Methods

After ruling out the presence of any medical conditions that may affect medical eligibility (see Appendix D – Medical Eligibility Criteria for Contraceptive Use), the following methods may be started immediately.

<b>Contraceptive method</b>	<b>First-trimester medical/surgical abortion</b>	<b>Second-trimester medical/surgical abortion</b>	<b>Special considerations</b>
<i>Reversible methods (in order of effectiveness)</i>			
Intrauterine device (IUD)	Can insert at the time success of abortion is determined	Can insert at the time success of abortion is determined, but insertion must be done by a specially trained person	Avoid after septic abortion
Implant Progestin-only injectables Combined injectable contraceptives (monthly) Combined patch Combined ring Combined oral contraceptives Progestin-only pills	Can start immediately after abortion; in the case of medical abortion, can start immediately after the first pill of the medical abortion regimen		Self-administration of injectable can be considered
Diaphragm and cap	Can start immediately after abortion	Wait for 6 weeks	
Fertility awareness-based methods (FABs)	Can start when regular menstrual cycles return		Special counseling may be needed to ensure correct use of FABs
<i>Irreversible (permanent) methods</i>			
Female sterilization	Can have this surgery immediately after abortion		The decision to have this surgery must be made in advance of the abortion

Additional considerations:

- IUD insertion immediately after a second-trimester abortion is associated with a higher risk for expulsion, which the woman should be informed about, and the insertion requires a specially trained provider.
- The option of self-administration of injectable contraception in the post-abortion period should be offered to women as an alternative to provider-administered injections (see Teaching Clients to Self-inject, in Chapter 4 – Progestin-Only Injectables, p. 83–86).
- If pills are the chosen method, provide up to 1 year’s supply of pills, depending on the woman’s preference and anticipated usage.
- Sterilization is permanent and must be decided upon in advance of the abortion, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure that the client understands they have the option to choose a reversible method (see Because Sterilization Is Permanent, in Chapter 12 – Female Sterilization, p. 230).
- Clients who choose to initiate the contraceptive ring should be instructed to check for expulsion in the event of residual or heavy bleeding during/ after the medical abortion process.
- The diaphragm must be refitted after uncomplicated first-trimester miscarriage or abortion. After uncomplicated second-trimester miscarriage or abortion, refitting of the diaphragm should be delayed 6 weeks to allow the uterus to return to normal size.
- Fertility awareness-based methods (FABs): A woman can start symptoms-based methods once she has no infection-related secretions or bleeding due to injury to the genital tract. She can start calendar-based methods with her next monthly bleeding, if she is not having bleeding due to injury to the genital tract (see Chapter 18 – Fertility Awareness Methods, in particular the sections on Providing Calendar-Based Methods and Providing Symptoms-Based Methods).



# Violence Against Women

Every family planning provider probably sees many women who have experienced violence. Physical violence includes acts such as hitting, slapping, kicking, punching, beating, and using a weapon. Sexual violence includes unwanted sexual contact or attention, coercive sex, and forced sex (rape). Violence against women can be psychological, too, such as insults, intimidation, threats to hurt someone she loves, humiliation, isolating a woman from family and friends, and restricting her access to resources.

Women experiencing violence have special health needs, many of them sexual and reproductive health needs. Providers of reproductive health care are in a good position to identify women who experience violence and to attend to their physical health needs as well as provide psychosocial support and referrals.

Women who experience violence often seek health services, although many will not mention the violence. Violence can lead to a range of health problems, including injuries, unwanted pregnancy, sexually transmitted infections (STIs) including HIV, decreased sexual desire, pain during sex, and chronic pelvic pain. Violence may start or become worse during a pregnancy, placing the fetus at risk as well. A man's violence or the threat of violence can deprive a woman of her right to make her own choice about whether to use family planning or what method to use.

## What Can Family Planning Providers Do?

- 1. Help women feel welcome, safe, and free to talk.** Help women feel comfortable to speak freely about any personal issue, including violence. Assure every woman that what she discloses will be kept confidential.

Give a woman opportunities to discuss issues that concern her—for example, her partner's attitudes toward her use of family planning or any possible problems with using family planning—or you can ask simply if there is anything she would like to discuss. Most women will not bring up that they are being abused, but some may disclose it if asked. Be alert to symptoms, injuries, or signs that suggest violence. Violence at home may lead a woman to refuse family planning or to insist on a specific method, to resist family planning counseling, or to insist on reversal of female sterilization. Many pregnancies close together or requests for pregnancy termination may also be an indication of violence at home. (Of course, there could be many other reasons for these preferences and behaviors.)

## 2. If you suspect violence, ask about it.

Some tips for bringing up the topic of violence:

- To increase trust, explain why you are asking—because you want to help.
- Use language that is comfortable for you and best fits your own style.
- Do not ask such questions when a woman’s partner or anyone else is present or when privacy cannot be ensured.

### “Should I ask all my clients about violence?”

Health care providers should routinely ask all clients about violence only if they are trained in asking about violence and offering first-line support, if privacy and confidentiality can be ensured, and if referral linkages to other support services are in place.

To explore whether a client is experiencing partner violence and to support her disclosure of violence, you can first approach the topic indirectly. You can say, for example:

- “Many women experience problems with their husband or partner or someone else they live with.”
- “I have seen women with problems like yours who have been having trouble at home.”



You can follow it up with more direct questions, such as these:

- “Are you afraid of your husband (or partner)?”
- “Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has this happened?”
- “Does your husband (or partner) or someone at home bully you or insult you or try to control you?”
- “Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?”

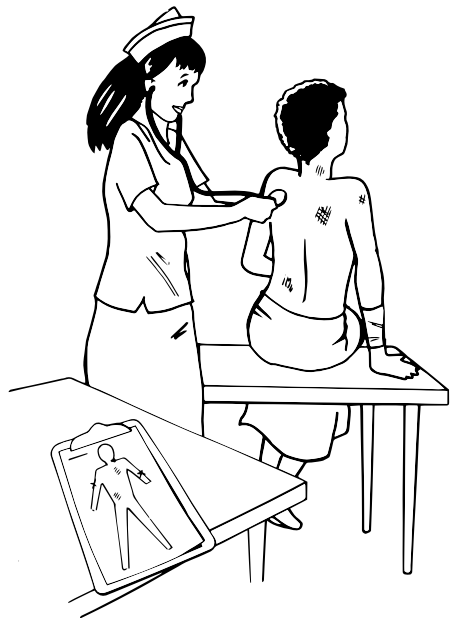
To explore further how violence affects a woman’s reproductive and sexual life, you can ask these 4 questions:

- “Has your partner ever told you not to use contraception, blocked you from getting a method, or hidden or taken away your contraception?”
- “Has your partner ever tried to force you or pressure you to become pregnant?”
- “Has your partner ever refused to use a condom?”
- “Has your partner ever made you have sex without using contraception so that you would become pregnant?”

### 3. Offer first-line support.

In response to a disclosure of violence, you should offer first-line support. First-line support provides practical care and responds to a woman’s emotional, physical, safety, and support needs, without intruding on her privacy.

First-line support is the most important care that you can provide. Even if this is all you can do, you will have greatly helped your client. First-line support involves 5 simple tasks. The letters in the word “LIVES” can remind you of these 5 tasks that protect women’s lives—**L**isten, **I**nquire about needs and concerns, **V**alidate, **E**nhance safety, **S**upport.





## LISTEN

Listen to the woman closely, with empathy, and without judging. Give her a chance to say what she wants to say in a safe and private place to a caring person who wants to help. **Listening is the most important part of good communication and the basis of first-line support.** If she does not want to talk about violence, assure her that you are available whenever she needs you, and that anything she discloses will be kept confidential.

## INQUIRE ABOUT NEEDS AND CONCERNS

Assess and respond to her various needs and concerns. As you listen to the woman's story, pay particular attention to what she says about her needs and concerns—and what she does not say but implies with words or body language. She may let you know about physical needs, emotional needs, or economic needs, her safety concerns, or social support that she needs.

**Respect her ability and her right to make her own choices about her life.**

## VALIDATE

**Show her that you understand and believe her.**

Validating another person's experience means letting the person know that you are listening closely, that you understand what she is saying, and that you believe what she says without judgment or conditions. Some important things that you can say:

- “It's not your fault. You are not to blame.”
- “This happens to many women.”
- “You are not alone, and help is available.”

## ENHANCE SAFETY

Discuss a plan to protect herself from further harm if violence occurs again. Explain that partner violence is not likely to stop on its own. It tends to continue and may become worse and happen more often. You can ask:

- “Are you or your children in danger now?”
- “Do you feel safe to go home?”
- “Is there a friend or relative who can help you with the situation at home?”

**If the woman faces immediate danger, help her consider various courses of action. If not in immediate danger, help her make a longer-term plan.**

## SUPPORT

**Support her by helping her connect to information, services, and social support.** Women's needs generally go beyond what you can provide in the clinic. You can help by discussing the woman's needs with her; telling her about other sources of help, such as shelter, social services, child protection, police, legal aid, financial aid, peer support; and assisting her to get help if she wants it.

#### 4. Provide appropriate care. Tailor your care and counseling to a woman's circumstances.

- **Treat any injuries** or see that she gets treatment.
- **Discuss** with her how she can make the best choices for family planning in her circumstances.
  - If your client wants a method that would be hard for her partner to detect or to interfere with, an injectable may be her best choice. You might also discuss IUDs and implants. Be sure to point out that even these methods can sometimes be detected.
  - Make clear that these methods do not protect her against STIs including HIV. Condoms are the only family planning method that protects against STIs as well as pregnancy. Give information and offer referral to support services, if available, for women's empowerment and skills building on condom use negotiation and safer sexual practices.
  - Provide emergency contraceptive pills if appropriate and wanted.

#### 5. Document the abuse experienced by the woman. Carefully and confidentially document the woman's history of abuse along with symptoms or injuries and the cause of the injuries if relevant. Record the relationship of the perpetrator to the woman.

## Infertility

### What Is Infertility?

Involuntary infertility is a disease of the reproductive system: the inability to become pregnant when desired. Involuntary childlessness is the inability to give birth to desired children, whether due to inability to achieve pregnancy or due to stillbirth or miscarriage. These conditions occur in couples who have never had children (primary infertility) and, more often, in couples who have had children previously (secondary infertility). Infertility is defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse. (On average, 85% of women would be pregnant by then.)

Worldwide, infertility affects about 12% of couples who are seeking to have a child—about 2% who have never had children and about 10% who have had children previously. There are differences among regions.

In some countries or communities, infertility or childlessness can have drastic consequences, especially for women but also with significant impact on men. These consequences can include economic deprivation, divorce, stigma and discrimination, isolation, intimate partner violence, murder, mental health disorders, and suicide.

## What Causes Infertility?

Globally, infertility has many causes, which vary depending on the setting. Although often the woman is blamed, the cause of infertility can be in either the man or the woman or in both.

Medically, causes of infertility range from the effects of STIs in one or both partners to hormonal imbalances and defects of the uterus in women and low sperm count, low sperm motility, and malformed sperm in men. Lifestyle factors include smoking, alcohol, and drug abuse as well as obesity and nutritional deficiencies. Exposures to chemicals in the environment that disrupt the endocrine system as well as other environmental and stress-related factors are suspected as well.

A large WHO study in the late 1970s found that STIs were a major cause of infertility in developing countries. It is not known how much STIs contribute to infertility now.

However, the evidence is clear that, if left untreated, gonorrhea and chlamydia can infect the fallopian tubes, the uterus, and the ovaries in women. This is known as pelvic inflammatory disease (PID). Clinical PID is painful, but sometimes PID has no symptoms and goes unnoticed (silent PID). Gonorrhea and chlamydia can scar women's fallopian tubes, blocking eggs from traveling down the tubes to meet sperm. Similarly, untreated gonorrhea and chlamydia in men can cause scarring and blockage in the sperm duct (epididymis) and urethra (see the job aids: Female Anatomy and Male Anatomy).

Other factors or conditions that can reduce fertility or cause infertility include:

- Other reproductive tract infections, including genital tuberculosis (TB) in both men and women
- HIV
- Medical procedures that introduce infection into a woman's upper reproductive tract or uterus, including postpartum and postabortion infections
- Mumps that develop after puberty in men
- Certain disorders of the reproductive tract, such as endometriosis, polycystic ovaries, and fibroids (myomas)
- Anatomical, endocrine, genetic, or immune system problems in both men and women
- Surgical interventions that adversely affect reproductive tissues or organs
- Cancer treatments that affect reproductive health and the capacity to reproduce
- Aging in both women and men.

## Preventing Involuntary Infertility

Involuntary infertility often can be prevented. Providers can:

- Counsel clients about STI prevention (see the section on Avoiding STIs, in Chapter 22 – Sexually Transmitted Infections, Including HIV, p. 345). Encourage clients to seek treatment as soon as they think they might have an STI or might have been exposed.
- Treat or refer clients with signs and symptoms of STIs and clinical PID (see the section on Signs and Symptoms of STIs, in Chapter 22 – Sexually Transmitted Infections, Including HIV, p. 343). Treating these infections can help to prevent infertility.
- Avoid causing infection by following proper infection-prevention practices when performing medical procedures that pass instruments from the vagina into the uterus, such as IUD insertion (see the section on Infection Prevention in the Clinic, in Chapter 26 – Family Planning Provision, p. 404).
- Treat or refer clients with signs or symptoms of infection postpartum or postabortion.
- Help clients with fertility problems become aware of risks to fertility—not only infections but also lifestyle and environmental factors.
- Counsel clients about available options for their future childbearing—that is, fertility preservation techniques such as sperm freezing for men and in vitro fertilization or freezing eggs—if they are being treated or are having surgery for cancer or other diseases that may affect reproductive tissues or organs.

## Counseling Clients With Fertility Problems

- Counsel both partners together, if possible. A man may blame his partner for infertility if he doesn't understand that the problem could be on his side or may lie with both partners.
- Explain that a man is just as likely to have fertility problems as a woman. In more than 40% of couples with fertility problems, it is because of semen or sperm abnormalities, or other health problems of the male partner. In 20% of couples with fertility problems, both male and female factors reduce fertility. Sometimes it is not possible to find the cause of the problem.
- Recommend that the couple attempt pregnancy with unprotected sex for at least 12 months before they suspect infertility. Provide educational materials and guidance on risks to fertility. (See the section on Safer Conception for HIV Serodiscordant Couples, in Chapter 22 – Sexually Transmitted Infections, Including HIV, p. 347.)

- The most fertile time of a woman's cycle is several days before and at the time of ovulation (when an ovary releases an egg) (see the job aid in this Handbook, The Menstrual Cycle). Fertility awareness methods can help couples identify the most fertile time of each cycle (see Chapter 18 – Fertility Awareness Methods). Provide educational material about these methods and/or refer the couple to a fertility care provider or specialist.
- If, after 1 year, following the suggestions above has not resulted in a pregnancy or live birth, refer both partners to a qualified fertility care provider for evaluation and assessment, if available. Referral to a fertility care provider or specialist may be particularly helpful in the following situations: the couple is affected by HIV or suspected genital TB; the woman is age 35 or older; she has polycystic ovary syndrome or has been diagnosed with endometriosis; the woman or the man suspects they had an STI and it was not treated; either had been treated for a cancer or had surgery that may have affected the reproductive tissues or organs.
- The couple also may want to consider adoption or other alternatives to having children or more children of their own, such as taking in nieces and nephews.

## Contraceptives Do Not Cause Infertility

- With most modern contraceptive methods, there is no significant delay in the time to desired pregnancy after contraception is stopped. On average, pregnancy occurs after 3 to 6 months of unprotected sex. There is great variation around this average, however, related to the age and the health status of the individuals in the couple. When counseling couples who stop contraception and want to have a child, aging and other factors affecting the fertility of the woman and the man need to be considered.
- The return of fertility after injectable contraceptives are stopped usually takes longer than with most other methods (see Chapter 4 – Progestin-Only Injectables, Questions 7 and 8, pp. 93–94, and Chapter 5 – Monthly Injectables, Questions 10 and 11, p. 118). In time, however, a woman will be as fertile as before using the method, taking aging into account.
- Among women with current gonorrhea or chlamydia, IUD insertion slightly increases the risk of pelvic inflammatory disease in the first 20 days after insertion. However, research has not found that former IUD users are more likely to be infertile than other women (see Chapter 10 – Copper-Bearing Intrauterine Device, Question 4, p. 189).