CHAPTER 23

Reproductive Health Issues

Key Points for Providers and Clients

Postabortion Care

- **Fertility returns quickly, within a few weeks, after abortion or miscarriage.** Women need to start using a family planning method almost immediately to avoid unwanted pregnancy.

Violence Against Women

- **Violence is not the woman's fault.** It is very common. Local resources may be available to help.

Infertility

- **Infertility often can 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

Women who have just been treated for postabortion complications need easy and immediate access to family planning services. When such services are integrated with postabortion care, are offered immediately postabortion, or are nearby, women are more likely to use contraception when they face the risk of unintended pregnancy.

Help Women Obtain Family Planning

Counsel with Compassion

A woman who has had postabortion complications needs support. A woman who has faced the double risk of pregnancy and unsafe induced abortion especially needs help and support. Good counseling gives support to the woman who has just been treated for postabortion complications. In particular:

- Try to understand what she has been through
- Treat her with respect and avoid judgment and criticism
- Ensure privacy and confidentiality
- Ask if she wants someone she trusts to be present during counseling

Provide Important Information

A woman has important choices to make after receiving postabortion care. To make decisions about her health and fertility, she needs to know:

- Fertility returns quickly—within 2 weeks after a first-trimester abortion or miscarriage and within 4 weeks after a second-trimester abortion or miscarriage. Therefore, she needs protection from pregnancy almost immediately.
- She can choose among many different family planning methods that she can start at once (see next page). Methods that women should not use immediately after giving birth pose no special risks after treatment for abortion complications.
- She can wait before choosing a contraceptive for ongoing use, but she should consider using a backup method* in the meantime if she has sex. If a woman decides not to use contraceptives at this time, providers can offer information on available methods and where to obtain them. Also, providers can offer condoms, oral contraceptives, or emergency contraceptive pills for women to take home and use later.
- To avoid infection, she should not have sex until bleeding stops—about 5 to 7 days. If being treated for infection or vaginal or cervical injury, she should wait to have sex again until she has fully healed.
- If she wants to become pregnant again soon, encourage her to wait. Waiting at least 6 months may reduce the chances of low birthweight, premature birth, and maternal anemia. A woman receiving postabortion care may need other reproductive health services. In particular, a provider can help her consider if she might have been exposed to sexually transmitted infections.

* *Backup methods include abstinence, male or female condoms, spermicides, and withdrawal. She can use spermicides if she has no vaginal or cervical injury. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.*

When to Start Contraceptive Methods

- Combined oral contraceptives, progestin-only pills, progestin-only injectables, monthly injectables, combined patch, implants, male condoms, female condoms, and withdrawal can be started immediately in every case, even if the woman has injury to the genital tract or has a possible or confirmed infection.
- IUDs, female sterilization, and fertility awareness methods can be started once infection is ruled out or resolved.
- IUDs, combined vaginal ring, spermicides, diaphragms, cervical caps, female sterilization, and fertility awareness methods can be started once any injury to the genital tract has healed.

Special considerations:

- *IUD* insertion immediately after a second-trimester abortion requires a specifically trained provider.
- *Female sterilization* must be decided upon in advance, and not while a woman is sedated, under stress, or in pain. Counsel carefully and be sure to mention available reversible methods (see Female Sterilization, Because Sterilization Is Permanent, p. 174).
- The *combined vaginal ring, spermicides, diaphragms,* and *cervical caps* can be used immediately even in cases of uncomplicated uterine perforation.
- The *diaphragm* must be refitted after uncomplicated first-trimester miscarriage or abortion. After uncomplicated second-trimester miscarriage or abortion, use should be delayed 6 weeks for the uterus to return to normal size, and then the diaphragm should be refitted.
- *Fertility awareness methods:* 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.

Violence Against Women

Every family planning provider probably sees many women who have experienced violence. Violence against women is common everywhere, and in some places it is very common. In a recent study of 10 countries more than 1 of every 10 women and up to about 7 of every 10 women reported that they had experienced physical or sexual violence in their lifetimes. Physical violence includes a wide range of behaviors, including hitting, slapping, kicking, and beating. Sexual violence includes unwanted sexual contact or attention, coercive sex, and forced sex (rape). Violence against women can be psychological, too, such as controlling behavior, intimidation, humiliation, isolating a woman from family and friends, and restricting her access to resources.

Women experiencing violence have special health needs, many of them related to sexual and reproductive health. 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. For some women, violence may start or become worse during pregnancy, placing her fetus at risk as well. Furthermore, 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. Therefore, providers of reproductive health care may be more likely than other health care providers to see abused women among their usual clientele.

What Can Providers Do?

1. **Help women feel welcome, safe, and free to talk.** Help women feel comfortable speaking freely about any personal issue, including violence. Ensure every woman that her visit will be confidential.

   Give women opportunities to bring up violence, such as asking a woman about her partner's attitudes toward her using family planning, asking whether she foresees any problems with using family planning, and asking simply if there is anything else she would like to discuss.

2. **Ask women about abuse whenever violence is suspected.** While most women will not bring up that they are being abused, many will talk if asked about violence. Asking all clients if they are experiencing violence is recommended only when providers are well-trained in counseling about violence, privacy and confidentiality can be ensured, and there are sufficient resources available to respond adequately to identified cases of violence. Until then, providers can ask whenever abuse is suspected, thereby focusing resources on those who need immediate care.

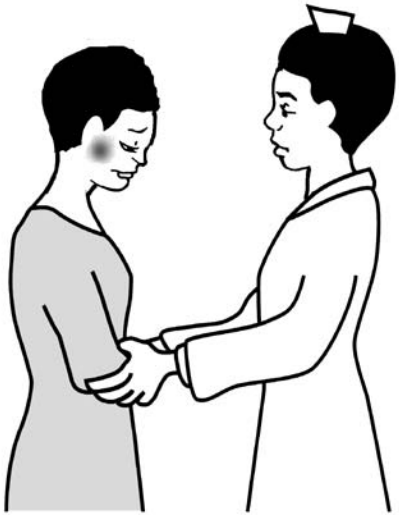
Be alert to symptoms, injuries, or signs that suggest violence. Providers may suspect violence when depression, anxiety, chronic headaches, pelvic pain, or vague stomach pains have not improved over time with treatment. Another sign of violence may be when the client's story about how an injury occurred does not fit the type of injury she has. Suspect violence with any injury during pregnancy, especially to the abdomen or breasts.

Some tips for bringing up the subject 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.
- You can say, "Domestic violence is a common problem in our community so we have been asking our clients about abuse."
- You can ask such questions as:
  - "Your symptoms may be due to stress. Do you and your partner tend to fight a lot? Have you ever gotten hurt?"
  - "Does your partner ever want sex when you do not? What happens in such situations?"
  - "Are you afraid of your partner?"

3. Counsel in a nonjudgmental, sensitive, supportive manner.

An important service for women in violent relationships is counseling. Counseling about violence should be tailored to a woman's particular circumstances. Women may be at different stages of willingness to seek change. This will affect whether and how a woman will accept help. Some women will not be ready to discuss their situation with a health care provider. The point of counseling is not to find out for sure whether the client is experiencing violence, but rather to address the issue with compassion and let her know that you care.



- If she does not want to talk about the violence, assure her that you are available whenever she needs you. Tell her what options and resources are available should she ever want them.

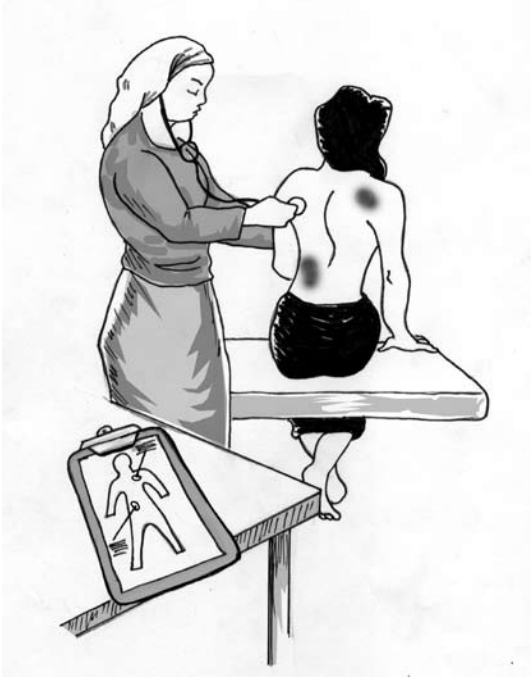
- If she wants to talk about her experience of violence, you can:
  - Ensure confidentiality, and keep the woman's situation confidential. Tell only those who need to know (such as security staff), and do that only with the client's permission.
  - Acknowledge her experience. Listen, offer support, and avoid making judgments. Respect her ability and her right to make her own choices about her life.
  - Try to relieve the woman's possible feelings of shame and self-blame: "No one ever deserves to be hit." "You don't deserve the abuse, and it's not your fault."
  - Explain that violence is a common problem: "This happens to many women." "You are not alone, and help is available."
  - Explain that violence is not likely to stop on its own: "Abuse tends to continue, and often it becomes worse and happens more often."

4. **Assess a woman's immediate danger, help her develop a safety plan, and refer her to community resources.** If the woman faces immediate danger, help her consider various courses of action. If not in immediate danger, help her develop a longer-term plan.
   - Help her assess her present situation:
     - "Is he here at the health facility now?"
     - "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?"
   - Help her protect herself and her children if the violence recurs. Suggest that she keep a bag packed with important documents and a change of clothes so she can leave quickly if need be. Suggest that she have a signal to let children know when to seek help from neighbors.
   - Make and keep up-to-date a list of resources available to help victims of abuse, including police, counseling services, and women's organizations that can provide emotional, legal, and perhaps even financial support. Give a copy of the list to the client.

5. **Provide appropriate care.** Tailor your care and counseling to a woman's circumstances.
   - Treat any injuries or see that she gets treatment.
   - Evaluate risk of pregnancy and provide emergency contraception if appropriate and wanted.
   - Offer emergency contraceptive pills for future use (see Emergency Contraceptive Pills, p. 45).

- If she wants, give her a contraceptive method that can be used without a partner's knowledge, such as an injectable.
- Help women think about whether they could safely propose condom use, without risking further violence.
- In cases of rape:
  - First collect any samples that could be used as evidence (such as torn or stained clothing, hair, and blood or semen stains).
  - Provide or refer for HIV and STI testing and treatment. Some women may need such services repeatedly.
  - Consider post-exposure prophylaxis for HIV, if available, and presumptive treatment for gonorrhea, chlamydia, syphilis, and other, locally common STIs.

6. Document the woman's condition. Carefully document the woman's symptoms or injuries, the cause of the injuries, and her history of abuse. Clearly record the identity of the abuser, his relationship to the victim, and any other details about him. These notes could be helpful for future medical follow-up and legal action, if taken.



Infertility

What Is Infertility?

Infertility is the inability to produce children. Although often the woman is blamed, infertility occurs in both men and women. On average, infertility affects 1 of every 10 couples. A couple is considered infertile after having 12 months of unprotected sex without pregnancy. A couple can be infertile whether or not the woman has been pregnant in the past.

Among couples with no fertility problems, 85% of women will become pregnant over one year. On average, pregnancy occurs after 3 to 6 months of unprotected sex. There is great variation around this average, however.

Pregnancy wastage is another form of infertility: A woman can become pregnant, but miscarriage or stillbirth prevents a live birth.

What Causes Infertility?

Different factors or conditions can reduce fertility, such as:

- Infectious diseases (sexually transmitted infections [STIs], including HIV, other reproductive tract infections; mumps that develop after puberty in men)
- Anatomical, endocrine, genetic, or immune system problems
- Aging
- Medical procedures that bring infection into a woman's upper reproductive tract

STIs are a major cause of infertility. Left untreated, gonorrhea and chlamydia can infect fallopian tubes, the uterus, and ovaries. 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. Men can have scarring and blockage in the sperm duct (epididymis) and urethra from untreated gonorrhea and chlamydia (see Female Anatomy, p. 364, and Male Anatomy, p. 367).

Other reasons for male infertility include a natural inability either to produce any sperm at all or enough sperm to cause pregnancy. Less commonly, sperm are malformed and die before reaching an egg. Among women, natural inability to become pregnant often is due to blocked fallopian tubes or inability to ovulate.

Fertility is also related to age. As a woman gets older, her ability to become pregnant naturally deceases over time. Emerging evidence suggests that, similarly, men, as they age, produce sperm that is less able to fertilize an egg.

Postpartum and postabortion infections also can cause PID, which may lead to infertility. This happens when the surgical instruments used for medical procedures are not properly disinfected or sterilized. A woman can also develop PID if an infection present in the lower reproductive tract is carried into the upper reproductive tract during a medical procedure.

Preventing Infertility

Infertility is often preventable. Providers can:

- Counsel clients about STI prevention (see Sexually Transmitted Infections, Including HIV, Preventing Sexually Transmitted Infections, p. 280). 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 Sexually Transmitted Infections, Including HIV, Symptoms of Sexually Transmitted Infections, p. 278). Treating these infections helps preserve fertility.
- Avoid 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 Infection Prevention in the Clinic, p. 312).

Contraceptives Do Not Cause Infertility

- With most contraceptive methods, there is no delay in the return of fertility after use is stopped. The return of fertility after injectable contraceptives are stopped usually takes longer than with most other methods (see Progestin-Only Injectables, Questions 6 and 7, p. 79, and Monthly Injectables, Questions 10 and 11, p. 100). In time, however, women who have used injectables are as fertile as they were 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. Still, research has not found that former IUD users are more likely to be infertile than other women (see Copper-Bearing IUD, Question 4, p. 155).

Counseling Clients With Fertility Problems

Counsel both partners together, if possible. Men often blame women for infertility when they themselves might be responsible. Tell couples:

- A man is just as likely to have fertility problems as a woman. It may not be possible to find who is infertile and what caused the infertility.
- Try for pregnancy for at least 12 months before worrying about infertility.
- The most fertile time of a woman's cycle is several days before and at the time an egg is released from the ovary (see The Menstrual Cycle, p. 366). Suggest they have sex often during this time. Fertility awareness methods can help couples identify the most fertile time of each cycle (see Fertility Awareness Methods, p. 239). Teach or refer if the couple wants to try this.
- If after one year the suggestions above have not helped, refer both partners for evaluation, if available. The couple also may want to consider adoption.