Information and Training Guide for Medical-Abortion Counseling

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C O N T E N T S

Preface iii

Acknowledgements iv

Section One: Medical-Abortion Counseling and Information 1

Medical Abortion: Overview 2

Principles Of Abortion Counseling 4

Quality-of-Care Framework 5

Communication Skills 6

Rights of the Client 8

Contraceptive Counseling 9

Men as Supportive Partners 11

Providing Counseling And Information 12

Initial Contact 12

First Clinical Visit (Mifepristone) 17

Second Clinical Visit (Misoprostol) 19

Follow-Up Visit 21

Managing Services 23

Service Delivery 23

Monitoring Services 25
Section Two: Training for Medical-Abortion Counseling

- Counseling Training: Overview
  - Designing Training Courses
  - Training Methods
  - Issues to Consider in Arranging a Training Course
- Sample Training Resources
  - Course Objectives and Agendas
  - Role-Plays and Case Studies
  - Behavior/Belief Exercises
  - Attitudes and Values: a Group Exercise
  - Evaluation Form
  - Pre-Tests and Post-Tests
  - Competency-Based Performance Checklist
- Annex: Comparison of Early Abortion Options
- Resources
As first-trimester medical abortion becomes increasingly available in more countries, it is essential to develop or adapt suitable service-delivery and counseling systems. Women must have sufficient information about available abortion options, including medical and early vacuum-aspiration methods, before making a decision. In many settings, women must be prepared for the multi-visit protocols required for medical abortion; in others, where home administration of misoprostol is allowed, they must be prepared to insert or take the misoprostol at home. Women must also be counseled about what they may experience during the process, particularly when the products of conception (POC) are expelled. And, as with any method of abortion, women should be counseled on contraceptive options, including emergency contraception.

As of January 2003, medical abortion is provided routinely in at least 27 countries and as a part of clinical trials in others. However, the availability of guidance on related counseling remains limited, as does the amount of information available to medical-abortion clients. This guide is designed to aid in implementing medical-abortion counseling and information services as a supplement to—rather than a replacement of—existing clinical protocols and service standards.

How to use this guide
This guide is designed for use by anyone involved in providing information and counseling to women considering or undergoing medical abortions. It contains material for counselors, information for clients and suggestions on managing counseling services. Health-care providers, counselors, clinic managers and trainers initiating or improving medical-abortion counseling and information services may also find this guide useful as a training resource. Specific training suggestions and resources are available in Section Two, Training for Medical-Abortion Counseling. Ipas invites comments and suggestions on this guide.

The information in this guide should be used to augment, not replace, medical protocols or procedural guidelines for medical abortion. Ipas also recommends two valuable resources produced by Planned Parenthood of New York City, Inc.: A Physician’s Guide to Patient-Centered Care: Providing Support to Women During First-Trimester Abortion Procedures and Counseling Guide for Clinicians Offering Medical Abortion. They may be ordered from PPNYC’s Clinician Training Initiative, 26 Bleecker Street, Fifth Floor, New York, N.Y., 10012 USA; tel. 212-274-7255; www.ppnyc.org.
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SECTION ONE:

Medical-Abortion Counseling and Information
Each year more than 75 million women worldwide experience an unintended pregnancy, and approximately two-thirds of those pregnancies end in abortion (UNFPA, 1997; WHO, 1998). Clearly, women need access to safe, effective abortion services, and fortunately new techniques are expanding the options available to them.

Because of the more widespread availability of increasingly sensitive pregnancy tests and ultrasound techniques, a woman can identify a pregnancy almost immediately after a missed period and examine her options at a very early stage. Mifepristone, also known as RU486, is a drug developed in France in the early 1980s that has made medical abortion in early pregnancy a reality for many women. As of January 2003, medical abortion with mifepristone is available in at least 27 countries, including: Azerbaijan, the European Union (with the exception of Italy, Ireland and Portugal), Georgia, India, Israel, New Zealand, Norway, Russia, South Africa, Switzerland, Taiwan, Tunisia, Ukraine, the United States and Uzbekistan. Additionally, China manufactures mifepristone (without patent) and makes it available to adjacent Asian countries (Coeytaux, 2003). Early surgical techniques, such as manual vacuum aspiration (MVA), are also expanding options for women seeking early abortions.

Surgical abortion procedures include dilatation and curettage (D&C), dilatation and evacuation (D&E), electric vacuum aspiration (EVA) and manual vacuum aspiration (MVA). Several characteristics of medical abortion make it very different from surgical abortion. Because the procedure is conducted with medications and not surgical instruments, there is no corresponding risk of injury to the cervix or uterus. The process does not involve anesthesia and physiologically resembles a “miscarriage,” which some women feel is more natural than surgical abortion. Medical abortion as described here can only be used in early pregnancies, usually up to 49 or 63 days from the last menstrual period (LMP), depending on the clinical protocol used. In many settings, the process involves a minimum of three visits to the medical provider. Some providers now use protocols requiring fewer visits, which often entail having the client insert or take the misoprostol at home. Compared to an early surgical abortion, post-procedure bleeding may last longer and be heavier; the pain may be more intense; and the woman may see blood clots and/or tissue that she probably would not view during a vacuum-aspiration procedure.

Early pregnancy termination with the two-drug combination of mifepristone and misoprostol is safe and effective. Mifepristone is a synthetic steroid that blocks the action of progesterone, causing the uterine lining to thin and detach the implanted embryo. It also causes the cervix to soften and dilate and increases the production of prostaglandins, which cause uterine contractions. As an antiprogestin, mifepristone is more effective the earlier in pregnancy it is taken when progesterones are present in lower concentrations. Mifepristone is followed by a prostaglandin, often misoprostol, which is administered orally or vaginally. The use of the prostaglandin causes the uterus to contract and speeds the expulsion of the POC. The combination
of mifepristone and misoprostol has an effectiveness rate that exceeds 95% in terminating a pregnancy within the first nine weeks following LMP (Scheepers, 1999).*

Medical abortion can also be provided via a combination of the drugs methotrexate and misoprostol. Methotrexate/misoprostol regimens have been shown to be >90% effective for first-trimester abortions up to 49 days LMP. However, a World Health Organization (WHO) toxicology panel has recommended against the use of methotrexate for medical abortion because of concerns about teratogenicity.

In those countries where medical abortion is available, it is a popular method among women. More than half of abortions within approved gestational limits are performed using mifepristone in Scotland (61%), France (56%) and Sweden (51%) (Jones and Henshaw, 2002). Mifepristone was approved in the United States in 2000, and meaningful information on its rate of use for abortion is not yet available. However, the manufacturer, Danco Laboratories, reported on the two-year anniversary of FDA approval that more than 100,000 American women had used mifepristone and that U.S. sales were 36% higher for the first eight months of 2002 as compared to 2001 (Danco Laboratories, 2002).

* Information in this section is adapted from WHO, 1997; McInerney et al. 2001.
Counseling is a critical component of high-quality abortion care. Fundamental principles of abortion counseling include the effective communication of information and respect for the client’s rights. The process of medical abortion offers an excellent opportunity to provide information and counseling to clients about the abortion itself, as well as about contraceptive methods and services.

What is the purpose of abortion counseling?
Abortion counseling should provide information, address the client’s emotions and support her decisions. In some settings, decision counseling—also called options counseling—is used to help the woman review her options, including termination, continuing the pregnancy and parenting, and continuing the pregnancy and setting up an adoption plan. In most cases, women seeking abortion services have already made unambiguous decisions about the pregnancy. However, all counselors and providers should be prepared and available to talk with a client about her decision to end her pregnancy should she wish to do so. Also, in settings where both medical and surgical abortion are available, counselors should be prepared to explain the woman’s options and to support her in determining her preferred option. Lastly, all counselors should be prepared to provide information to their clients about the procedure, follow-up care, contraception, and referrals to other reproductive-health services.

Who should do counseling?
Some clinics and hospitals have trained, specialized counselors. However, in many facilities, doctors, nurses or midwives who may have little or no counseling training are the designated counselors.

When should counseling be done?
There is no one appropriate time for counseling, which should provide communication and support to the client throughout the process. That said, a specific counseling time prior to the abortion should be designated, ensuring that each woman receives adequate information about her abortion options, expresses any concerns and makes informed decisions about both the abortion and her contraceptive options.

Counseling plays a critical role in the abortion process, both for the client and the counselor or provider. Women seeking abortion services may experience complex and sometimes conflicting emotions, and counselors need to be keenly aware of their client’s feelings and needs, as well as their own. Empathy is critical to building a strong rapport with the client. The counselor needs to be aware of and acknowledge the woman’s
emotions—including fear, sadness or relief—and address any issues that are important to her. Factors that commonly influence a woman’s emotional state include:

- her feelings about her pregnancy and fertility
- her beliefs about, and experiences with, medical care
- her perception of the quality of abortion services
- her feelings about her partner
- her partner’s beliefs and feelings
- delays in obtaining services
- the attitudes and behaviors of health-care providers
- her level of discomfort

Some providers assume that their own attitudes and beliefs are not reflected in their professional interactions, or that their attitudes and beliefs reflect those of the clinic and its clients. Yet beliefs and attitudes are often deeply ingrained and may be readily apparent to the client. To establish appropriate lines of communication, it is important that providers maintain nonjudgmental attitudes, and respect and support women in their individual situations and decisions. To make the overall experience as positive as possible, the client should receive safe, competent and empathetic care.

QUALITY-OF-CARE FRAMEWORK

Quality of care is a broad term that refers to the overall safety, effectiveness and appropriateness of health-care services (Leonard and Winkler, 1991). A quality-of-care framework—as illustrated below—can be used to design, monitor and evaluate various aspects of abortion-care services, including information and counseling, interactions between women and providers, contraceptive services, and the medical aspects of abortion care. In a recent U.S. study, information and counseling was the single most important factor in clients’ overall ratings of abortion care (Picker Institute, 1999). In that study women also cited the importance of attention to their need for privacy and their overall confidence and trust in staff members. Medical abortion requires a heightened awareness of counseling and information issues specific to the choice of methods available, the process of medical abortion, and the increased autonomy of the woman in that process.
COMMUNICATION SKILLS

Strong communication skills are essential to all high-quality counseling services. Each interaction between the client and health-care staff affects the woman’s ability to communicate her needs and her level of satisfaction with services. Staff members should incorporate the following seven principles of client-centered counseling when training counselors and talking with clients:

- **Listen actively.** Rather than just hearing what a client is saying, listen in a manner that actively communicates interest, understanding and empathy.
- **Use simple language.** Clients need to understand critical information without feeling belittled or confused by medical jargon. Use language that is straightforward and accurate, repeat important points, and speak at an appropriate pace.

- **Ask open-ended questions.** An open-ended question leads to a more informative response than a question that can be answered with “yes” or “no.” For example, compare these two questions: “Do you want a medical abortion?” versus “Can you tell me how you decided to choose medical abortion?” The first question is closed-ended; the second is open-ended.

- **Validate emotions; don’t minimize them.** Acknowledge the stress and emotions a woman may be experiencing without trying to “fix” or minimize them. Communicate with her in a manner that conveys compassion and empathy. For example, if the woman says that she is feeling pain during the abortion process or procedure, respond along the lines of “I understand that you are uncomfortable. You are feeling the uterus contracting, and that is normal.” Merely telling her to “relax” is not helpful.

- **Encourage a client’s questions.** The questions that a client poses may provide insight into her understanding of, and level of comfort with, the process as a whole. It is important to move at the client’s pace and to respect silent moments that give her a chance to communicate without feeling rushed.

- **Watch for nonverbal clues.** Body language often speaks louder than words. Make eye contact with the client and be aware of both her body language and your own. Positive body language, such as sitting facing the client with your body “open” (front of body facing her, hands and arms comfortably in lap or on the table) rather than “closed” (arms crossed in front of you, legs crossed and hips facing away from her) can set a tone for the entire discussion.

- **Use “if/then” statements.** The use of “if/then” statements can allow for a more comprehensive understanding of important information, as well as the rationale behind specific directives. For example: “If you want to use the pill to prevent pregnancy, then you should take one pill every day.”

(Adapted from Planned Parenthood, 1996)
Listed below on the left are sample open-ended questions that represent effective communication techniques. On the right are closed-ended questions that can be answered with a “yes,” “no” or other less-useful response.

<table>
<thead>
<tr>
<th>Open-ended questions:</th>
<th>Closed-ended questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How are you feeling today?</td>
<td>You’re doing fine, aren’t you?</td>
</tr>
<tr>
<td>What questions do you have about the abortion options that we discussed?</td>
<td>Do you have any questions?</td>
</tr>
<tr>
<td>What about medical abortion makes it seem like the right method for you?</td>
<td>Do you want to have a medical abortion?</td>
</tr>
</tbody>
</table>

**RIGHTS OF THE CLIENT**

Respecting the rights of the client is essential to the quality and continuity of care, particularly in abortion and contraceptive services. Every abortion client has the right to:

1. **Information**: To learn about her reproductive-health, contraception and abortion options

2. **Access**: To obtain services regardless of religion, ethnicity, age and marital or economic status

3. **Choice**: To decide freely whether to use contraception and, if so, which method

4. **Safety**: To have a safe abortion and to practice safe, effective contraception

5. **Privacy**: To have a private environment during counseling and services

6. **Confidentiality**: To be assured that any personal information will remain confidential

7. **Dignity**: To be treated with courtesy, consideration and attentiveness
8. **Comfort:** To feel comfortable when receiving services

9. **Continuity:** To receive follow-up care and contraceptive services and supplies for as long as needed

10. **Opinion:** To express views on the services offered

(Adapted from Huezo and Diaz, 1993)

**A note on clinical trials**
When medical abortion is provided as part of a clinical trial, as in any clinical-research protocol, women participating in the study have the same rights and needs as those receiving services outside the study protocol. They also need specific information regarding the trial, including the goal and objectives defined in the clinical-trial protocol. Each client must be assured of the importance given to confidentiality and her right to withdraw from the study without affecting her future medical care. Participants should be asked to sign appropriate consent forms for the study and medical care after having had the opportunity to review the information and ask questions.

**CONTRACEPTIVE COUNSELING**

Worldwide, many unintended pregnancies result from a lack of access to modern contraceptive methods or from a cultural or social preference for traditional, rather than modern, methods. Women are often mired in an unhealthy cycle of unintended pregnancy and abortion—a cycle that could be broken if contraceptive services were available and accessible and if women had adequate information and resources.

According to the WHO, health-care providers and counselors have a responsibility to ensure that contraceptive services are available and offered to women who have abortions (WHO, 1997). Facilities should develop a system for supplying information on various methods of contraception in a supportive, noncoercive environment. Ideally, information should be available on all methods available locally, and various methods should be offered at the site where the woman receives abortion services.

Every woman who has an abortion must leave the clinic or hospital knowing that she can become pregnant within a few days after the abortion and that there are contraceptive methods that can help her prevent a future unwanted pregnancy. She should know that emergency contraceptive pills can be used within 72
hours* after unprotected intercourse, and that IUDs can be inserted within five days of unprotected intercourse to prevent pregnancy (Princeton University et al., 2003). She should know how and where various methods are available and that clinic staff can provide referrals if she has other reproductive-health needs.

Well-informed women will be more satisfied with their choices and more likely to use the contraceptive method regularly and properly. Most methods can be used without risk after a safe abortion, whether medical or surgical. Any method can be started after the abortion is complete—in the case of medical abortion, after confirmation of expulsion of the POC. The one exception is natural family planning, which should not be used until a normal menstrual cycle resumes. When possible, women should be offered contraceptive counseling prior to their abortion so that methods can be provided immediately following the procedure. This should be done in a sensitive manner, recognizing that some women may feel stress regarding the abortion and have problems focusing on information about contraceptive methods.

Because of the multi-visit protocol in use at many sites, medical abortion offers several opportunities to provide contraceptive information and counseling. In general, counseling should be provided as early as possible in the series of visits.

Each woman needs comprehensive information on her chosen contraceptive method, including:

- its effectiveness
- its risks and benefits
- how to use the method
- which side effects are common and how to manage them
- how to acquire additional supplies of the method

Counseling should also include discussion of the woman’s prior experience with contraceptive methods and any problems she has encountered. Questions should include: “What is your experience with contraceptive methods? Have you had any problems with methods you have used? If you were using a method when you became pregnant, how were you using it? Is your partner supportive of your contraceptive use?” Her reproductive intentions should also be ascertained—for example, whether she wants to become pregnant at some point in the future. With this detailed understanding in hand, counselors can provide the woman with more specific, relevant information. However, it must be reiterated that even if the counselor has a suggestion or preference, it must be the client’s informed, autonomous decision to choose a given method.

* Several recent studies have found that the pills are effective when the first dose is started up to five days (120 hours) after unprotected intercourse.
MEN AS SUPPORTIVE PARTNERS

Men can play an important role in the reproductive health of their partners. Clients and health-care providers should be encouraged to include men in contraceptive-counseling discussions, provided it is comfortable for both partners. Some men may be reluctant to use contraceptives due to misconceptions about the safety, side effects or availability of methods, or the belief that family planning leads to infidelity or stifles the “manly” attribute of procreation. In those scenarios, the client should be encouraged to discuss the following points with her partner, either privately or with a counselor:

1. Family planning will enable her partner to take better care of her and their children.
2. Child spacing is healthier for women and their children.
3. Family planning will not encourage a woman to be unfaithful.
4. Family planning can enhance the pleasure of sex by decreasing mutual fears of an unplanned pregnancy.
5. The use of condoms can also prevent transmission of sexually transmitted diseases if the couple is at risk.

(Adapted from Niemann and Metcalf, 1997)

The ideal scenario is for the male partner to be involved in choosing a contraceptive method. However, men should not make unilateral family-planning decisions; it should be the woman’s choice whether to use any particular female method. Should her partner be opposed to it, even after discussing the benefits, the woman may decide to use a method that can be used without her partner’s knowledge.

Medical abortion may offer a greater opportunity for a woman’s partner to be involved in the overall abortion process. In most surgical-abortion settings, male partners and others are excluded from the procedure room. With medical abortion, a client’s partner or other support person can be with her during her visits to the clinic and during the period after she takes the misoprostol. If the clinic allows the option of home use of misoprostol, it is important that the woman has a companion who can support her while she experiences the resulting bleeding and cramping. In situations where the woman takes the misoprostol at the clinic, there are still ways to involve her partner or support person. At one hospital in Austria, the woman and her partner are encouraged to stay together in the hospital during the post-misoprostol observation period. Providers there have found that this helps the male partner provide significant support for the woman, and better understand the abortion process (Fiala, 1999). Of course, a partner or other support person should only be included in the process to the extent that it is comfortable for the woman.
“Counseling” refers to a session, or particular conversation, during which the client can discuss any concerns she may have about the procedure, abortion in general and her future use of contraception. Ideally, all women should have a private, confidential conversation with a sensitive, informed counselor. However, such counseling is not customary in some settings, and some facility administrators may consider it low priority or unfeasible. It is strongly recommended that administrators review systems to make time and staff members available for counseling. This can often be done without adding significant resources.

Elements of counseling—including active listening, presenting options and information, and clarifying decisions and feelings—can and should happen throughout the medical-abortion process. While not a substitute for a counseling session, this is an important addition. It involves the client more fully in her care, helps establish rapport between the client and staff members, and can usually be accomplished with simple modifications to staff orientation and processes. Clinic staff should place emphasis on continually responding to each woman’s need for counseling and information.

Following are common steps in the medical-abortion process and advice on how the counselor—or anyone providing support and information to the client—can actively meet the woman’s needs.

INITIAL CONTACT

The initial contact may be made either in person or by telephone. Staff members who interact with clients or potential clients should be sensitive, informed about both medical and surgical abortion, and able to provide accurate initial information. Women may not know which methods of abortion are available at the clinic and should receive adequate information so that they can make informed choices.

From the outset, women requesting information about abortion should be treated with respect and be informed of their right to confidentiality. The initial contact or appointment process will give the staff insight into both the woman’s medical situation (for example, the number of weeks since LMP) and her emotional state. If the woman requests a counseling session or expresses ambivalence about having an abortion, she should be invited or referred to speak with a counselor to discuss her options.
Appointment scheduling
When scheduling appointments by phone, in person, or by referral, it is important to allocate enough time for the provider to conduct counseling and medical screening. If a client requests or accepts an offer of a counseling session about her options, she may require additional time to discuss those options comprehensively, especially if she is ambivalent about her decision to have an abortion. Cultural norms can affect a woman's openness in discussing her options, and clinicians should be able to understand and provide services within the context of the cultural frameworks of their clients.

Client information
If a client makes an appointment in person or through a referral source, consider providing her with a reminder notice for her appointment, written information on medical and vacuum-aspiration abortion, and information on what to expect when she first comes to the clinic. If a client makes an appointment on the telephone, ensure that she has a general sense of what to expect on the day of her abortion, including what to bring with her and how long she should expect to be at the clinic.

Initial counseling session
Ideally, there will be an opportunity for a private counseling session. This session should set a tone of comfort and trust for the client. To establish this rapport, the counselor can begin by determining the client’s emotional, physical and psychological state, asking “How are you doing today?” or “How can I help you?”

At this time the counselor should review all options available to the client and the abortion methods available at the clinic. The counselor should assess her state of mind throughout the meeting and solicit her questions and concerns. As discussed earlier, asking open-ended questions and using if/then statements can prove very helpful.

Topics for discussion include her

- existing knowledge and beliefs about abortion options
- knowledge of medical abortion
- previous abortion experience
- thoughts on how a medical abortion would differ from a previous surgical abortion
- contraceptive options
- general reproductive health
Discussion of abortion options (medical or surgical)
This crucial part of the counseling process requires the counselor to be knowledgeable about both surgical- and medical-abortion techniques. Providers should use counseling sessions to discuss abortion options with clients.

An educated counselor should be able to explain:

- the processes in simple terms
- the characteristics of medical and vacuum aspiration abortion, including side effects and duration of each procedure
- the costs associated with either procedure
- the woman’s role in the process
- protocols, if the procedure is part of a clinical trial

Some characteristics of medical and vacuum-aspiration abortion are presented in the “Annex: Comparison of Early Abortion Options,” as well as in the chart below.

<table>
<thead>
<tr>
<th>Medical Abortion</th>
<th>Vacuum Aspiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>High success rate (about 98%)</td>
<td>High success rate (about 99%)</td>
</tr>
<tr>
<td>Usually avoids surgical procedure</td>
<td>Instruments inserted into the uterus</td>
</tr>
<tr>
<td>Requires at least two visits</td>
<td>Can be done in one visit</td>
</tr>
<tr>
<td>Abortion occurs within 24 hours of second medication for most women</td>
<td>Procedure is completed in 5-15 minutes</td>
</tr>
<tr>
<td>May be used early in pregnancy</td>
<td>May be used early in pregnancy</td>
</tr>
<tr>
<td>Oral pain medication can be used</td>
<td>Anesthesia/sedation can be used</td>
</tr>
<tr>
<td>Some of the process may happen at home</td>
<td>Procedure is done in a medical office or clinic</td>
</tr>
<tr>
<td>Medications cause a process similar to a miscarriage</td>
<td>Health care-provider performs the procedure</td>
</tr>
</tbody>
</table>

(Adapted from NAF, 2003)
Counselors should help the client clarify whether medical abortion is an appropriate choice for her. The following broad characteristics of medical abortion should be discussed:

- It can be done early and is simple, safe and effective
- It is noninvasive and does not entail surgery
- It resembles a miscarriage
- It may require multiple visits, per the clinic’s protocol
- Many women will experience cramping, nausea and diarrhea
- There may be a prolonged wait for the passing of POC
- Women may see the POC; however, they should know that the POC will look merely like blood clots or unformed tissue
- Postprocedure bleeding may last longer than with surgical abortion
- If the medical abortion fails, surgical completion is required, as the medications used have a teratogenic effect, which can cause birth defects in the current pregnancy

If the woman will be inserting the misoprostol herself, the counselor should ask about her experience and comfort in inserting tablets vaginally or using diaphragms, cervical caps or tampons without applicators. To ensure that the woman is prepared for the experience, similar questions should be asked to clarify the client’s feelings on viewing the POC and experiencing bleeding, pain or nausea. Some women have reported that seeing the POC is a positive aspect of the medical-abortion process, while others have reported that it is negative (Ellertson et al., 1997). The more realistic a woman’s expectations about symptoms and side effects, the more likely she will be able to manage them and be satisfied with the overall process.

Be straightforward in delivering all information, and explain that a small percentage of women experience a failed medical abortion and require a completion by vacuum aspiration. Counselors need to tell women about the clinic’s protocols in the event of a failed medical abortion; for instance, whether back-up treatment, such as MVA, is available at the clinic. The counselor should also clearly explain whether she would have to be referred elsewhere for treatment, as well as the financial implications of that treatment.

**Eligibility screening**

The clinic should implement an eligibility protocol for screening clients for medical abortion. For example, eligibility depends on the length of the pregnancy and the absence of certain medical conditions. During the medical and physical screening, ensure that the client is aware of what is being done and what to expect. In many settings, the staff person who provides information on the abortion methods also reviews the client’s
health history and discusses additional screening items with her. The provider conducting the pelvic exam should talk the client through the exam, explaining what she will feel.

Psychosocial factors may also influence whether or not medical abortion is appropriate for a given woman. Factors that could affect a client’s eligibility or comfort with medical abortion include:

- indecision about having the abortion
- unwillingness to have a surgical termination
- poor access to telephone, transportation or medical care
- inability to return for the remaining visits
- difficulty in completing all steps of the protocol
- low tolerance for pain or bleeding
- poor support system at home
- inability to give informed consent

(Adapted from Stadalius, 1997)

**Informed consent**

The woman should provide informed consent after she decides to have a medical abortion and the medical and physical screenings are completed. Even if written consent is not customary at the clinic, it is recommended that the woman give clear verbal consent to any abortion procedure after having the opportunity to ask any remaining questions. Optimally, the same person who explained the abortion options and process will be available to answer any questions that arise. If the clinic protocol is to obtain written informed consent, the client should be given as much time as necessary to read and sign the documents. Should the client change her mind, clinic staff members should reiterate that she will receive competent care of her choosing without any repercussions.

**Contraceptive counseling**

As mentioned earlier, women should have access to information on contraceptive methods during each contact with the clinic. In many settings, the first visit includes a session that involves contraceptive counseling.
The counselor should talk with the client about her family-planning history and future plans, provide her with information on contraceptive methods and help her choose a method that she thinks is appropriate for her. She should know how to obtain that method, or, if possible and appropriate, she should receive it at the clinic. The counselor should always stress the following points to the woman:

- She can become pregnant again as soon as 10 days after the abortion.
- Contraceptive methods are available that can help her prevent a future unwanted pregnancy.
- Emergency contraceptive pills can be used within 72 hours, and IUDs can be inserted within five days of unprotected intercourse to prevent pregnancy (Princeton University et al., 2003).
- The logistics of how family-planning and emergency contraceptive methods are available at the clinic, hospital or elsewhere in the community.
- Health-care staff can refer her if she has other reproductive-health needs, including the need for sexually transmitted infection (STI) diagnosis and treatment.

**FIRST CLINICAL VISIT (MIFEPRISTONE)**

This section of the guide is organized by the first clinical visit (mifepristone); the second clinical visit (misoprostol); and the follow-up visit. This three-visit protocol is common in many settings; however, the information presented can easily be adapted to a setting with fewer or more visits.

During the first visit clients should have an initial history and screening; tests for pregnancy, hematocrit/hemoglobin, Rh factor (if standard to do so for obstetric patients at the facility), and blood pressure; and an examination to date the pregnancy. The woman should also receive detailed information on the medical and vacuum aspiration abortion options available and, if selecting medical abortion, may take mifepristone to initiate the abortion process. Of course, the specific steps that a client will go through are determined by the clinic’s protocol; in some settings, these steps may occur over two visits. Overall, it is important that the woman know what will happen during the various steps of the visit and have opportunities for any questions and concerns to be addressed. This initial visit is also often an appropriate time to talk with the woman about contraceptive methods.
Administer mifepristone
When administering the mifepristone, the provider should inform the client of the following:

- what she should expect to feel after taking the mifepristone
- when to return or to self-administer the misoprostol, depending on protocol
- what to identify as potential problems
- who to contact in case of questions or emergency
- which pain-management drugs to take and not take
- what not to do: use tampons, douche or have vaginal intercourse
- how to handle the POC (tissue and clots) if expelled away from the clinic
- what range of emotions she may feel

Home use of misoprostol
Research demonstrates that allowing women to take (orally) or insert (vaginally) the misoprostol at home is safe, effective and acceptable to many women. In clinics offering this protocol, clients also have the option of returning to the clinic for the misoprostol. If your clinic offers the option of home administration of misoprostol, ensure that clients have clear instructions about when to take or insert the misoprostol tablets, what to expect upon taking or inserting them, and how to contact the clinic should any questions or concerns arise. (See section on the second clinical visit/misoprostol, below.) Talk with each client about her specific situation, ensure her partner or a support person is present when she takes or inserts the misoprostol, and help her plan for pain management—for example, use of a hot water bottle, ibuprofen or paracetamol.

Client leaves with information
It is highly recommended that each clinic develop tools to assist in its management of counseling and services. One such tool is a form letter from the clinic stating that the client is receiving a medical abortion and outlining the medications received and emergency care available. This letter could be helpful if a client should need medical care and is unable to return to your clinic. It is also helpful for other physicians to note any diagnosis, treatment or prescriptions on the letter for the client to bring on her return visit.

If possible, clinics should provide a small packet to clients when they leave the clinic. This packet may contain the following:

- sanitary pads or cotton wool
• contact information in case of questions or complications
• reminder for the next appointment
• written information on the abortion method and its common side effects and warning signs
• information on the home use of misoprostol, if that option is available to women, including information on what to expect, how to manage pain, and under what circumstances to contact the clinic
• letter from the physician explaining the medications and medical abortion for the rare event that a complication needs to be treated at another health-care facility

SECOND CLINICAL VISIT (MISOPROSTOL)

If protocol calls for the client to return to the clinic for the misoprostol, this visit provides yet another opportunity to answer questions, respond to clients’ concerns and provide information.

Counseling and information
The clinician should begin by answering any questions and assessing how the client has felt since she took the mifepristone. It is important to ask open-ended questions, provide ample time for the woman to express her feelings regarding the procedure so far, and describe the steps that will occur during this visit. It may be easier to establish rapport with the client if the same clinician provides services throughout the visit.

Physical exam
The clinician should explain any physical exam that will take place, including vaginal administration of the misoprostol if that is the clinic’s protocol.

Administer misoprostol
Prior to administering the misoprostol vaginally, review what the client will feel and explain how she should continue vaginal insertions for the designated number of days, if required. If the misoprostol is given orally, explain any additional doses that the client will take at home. (Administration of misoprostol sublingually and bucally is being studied at present. Some clinics may have this route of administration as part of their protocol.)
It is important to help the woman understand what she should expect, including experiencing cramping, bleeding and nausea, and seeing the expelled tissue or clots. Refrain from describing cramping pains that may occur from the medication as similar to labor pains; instead, they can be discussed as similar to heavy or severe menstrual cramps. Providers should encourage women to voice their physical and emotional feelings and attempt to engage clients who are verbally uncommunicative.

**Observe client for a designated period of time**

In many settings, clients are asked to remain at the clinic for approximately three to four hours after the misoprostol is administered, as many women expel the POC during this time. The clinic should prepare appropriate facilities for the waiting time. These may consist of individual rooms with a bed and restroom or, more commonly, a room with several cots and a toilet nearby. Women do not need to be restricted to their bed; they may be more comfortable moving around the room or, as appropriate, the facility. The clinic may provide hot-water bottles to relieve discomfort from cramping and administer pain medications such as ibuprofen or paracetamol before women begin to feel heavy pains.

When several clients are receiving misoprostol on a given day, they may be in the same waiting area. During this time a clinician or counselor should be available to answer questions and address any medical needs, such as nausea, vomiting, diarrhea or cramping. The clinic should also consider allowing the woman to have her partner or support person with her during this time.

This is also an excellent time to talk with women about contraceptive methods, provided they are emotionally and physically able. If the client has already chosen a method, answer any additional questions and talk with her about how and when she will start using the method. If the client has not yet selected a method, this may be a good occasion to review the available options and help her choose one that suits her. The clinician or counselor should also review the key contraception messages presented on Page 17, ensuring that the woman knows she should use contraception as soon as she resumes sexual intercourse if she wants to prevent pregnancy.

**Re-examine the client**

Many women will expel the pregnancy tissue during the first few hours after the misoprostol administration. Prior to leaving the clinic, protocol may require that women have an examination; in some cases the POC are lodged at the cervix and may be removed digitally. As cited earlier, prior to each examination clients should be
informed about what will occur and encouraged to express any questions or discomfort. It is important to inform the woman that she has aborted if the clinician is aware that the POC were clearly identified.

**Client leaves with information and contraceptive method**

As stated previously, clients should clearly understand the following before leaving the clinic:

- what she should expect to feel after taking the misoprostol
- when to return or self-administer any additional misoprostol, depending on protocol
- if she has aborted and, if not, what to expect and notice when she aborts away from the clinic
- what to identify as potential problems
- who to contact in case of questions or emergency
- which pain-management drugs to take and not take
- what not to do: use tampons, douche or have vaginal intercourse
- how to handle the POC (tissue or clots) if expelled away from the clinic
- what range of emotions she may feel

Also, this is a good opportunity to make sure that each client has the following materials from her previous visit, and to provide them again as needed:

- sanitary pads or cotton wool
- contact information in case of questions or complications
- reminder for the next appointment
- written information on the abortion method and its common side effects and warning signs
- letter from the physician explaining the medications and medical abortion for the rare event that a complication needs to be treated at another health-care facility
- condoms and/or other contraceptives for use after the abortion is complete

**FOLLOW-UP VISIT**

When the client returns for her follow-up appointment during the next one to three weeks—depending on protocol—it is important to ensure that the abortion was complete and that the woman has the information she needs and her chosen contraceptive method, if desired.
Counseling information
The clinician should begin the visit by answering any questions and concerns, reviewing any side effects the woman experienced and asking open-ended questions about how she is feeling. Next, describe the steps that will occur at this visit, including any tests and physical or ultrasound examinations.

Physical exam
At the follow-up visit, complete evacuation of the pregnancy must be confirmed. This can be done by physical exam, pregnancy test or ultrasound, depending on the local protocol.

In case of a failed medical abortion
If the woman has a continuing pregnancy, she should be counseled and prepared for completion with vacuum aspiration. If the woman has not expelled the POC but the pregnancy is nonviable (that is, no fetal heartbeat exists), fully explain the options available to her, depending on the clinic’s protocols. She may be able to wait to see if the POC are expelled within a determined amount of time, or she may have an aspiration procedure to complete the process. If management of a retained sac and products is prescribed in the clinic’s protocol, this will need to be explained to the woman. The client’s emotional response at this time may vary from sadness to anger, disappointment or confusion. It is important to encourage the woman to articulate her feelings, while helping her understand the next steps in her care.

Discuss contraceptive information
If the client did not select a contraceptive method during a previous visit, this is an important opportunity to provide her with information and help her choose a method. Ensure that she knows how to obtain the method, or, if possible and appropriate, provide it to her.

Ongoing care
Each institution should develop a plan to maintain contact with clients who have faced any side effects that may require additional visits to the clinic or another medical facility. Each client should leave the clinic on her last visit with a clear understanding that her abortion was complete and how to contact the clinic if she has further questions.
The proper management of counseling services is an integral part of abortion care. Review the suggestions listed in this section and tailor them to the needs of your staff, clients and service-delivery setting.* It is also important that the facility has written counseling policies and procedures and that staff members are familiar with those documents.

SERVICE DELIVERY

Client flow
With scheduled or routine procedures, such as medical or surgical abortion, there is some flexibility regarding when counseling and contraceptive services can be provided. To address client flow, service managers should attend to the following:

- When patients are scheduled, allow adequate time to provide information and counseling prior to and following the abortion.
- Contraceptive counseling and services should be available wherever and whenever abortion services are offered.
- In a hospital setting, patients may need to be referred to contraceptive services in another location within the hospital; links with those services must be clearly established.

Ideally, women should have access to information and contraceptive counseling before the abortion procedure is started and access to her chosen method as soon as appropriate. However, caseloads and schedules may require that managers be creative about offering individual discussions to every client. It is therefore important that all staff members be prepared to provide information on both the abortion and contraception at any given time.

Facilities
Ideally, the clinic is not crowded and its space is arranged efficiently. It is important to provide adequate room for privacy during the counseling and treatment sessions. A separate counseling room is not necessary, but a private space, regardless of size, should provide enough privacy for the woman to feel comfortable discussing abortion and contraceptive options.

* Information in this section is adapted from WHO, 1997 and McInerney et al. 2001.
For medical-abortion services, managers should be aware of the need to provide an adequate number of toilets that may be used for longer periods of time by clients. Depending upon individual protocol, clinics may require clients to remain on site for a certain length of time after misoprostol administration, during which time they may experience cramping, bleeding and possible expulsion of the pregnancy tissue. The clinic should provide sanitary napkins or cotton wool to clients as needed.

**Equipment, supplies and commodities**
The standard needs for a medical-abortion service are mifepristone and misoprostol, medications to treat side effects and possible complications, equipment to perform completion by vacuum aspiration as back-up to failed medical abortions, and supplies such as examination gloves, cotton wool and pregnancy tests. It is also important that a range of contraceptive commodities and educational materials be readily available.

**Staffing and training**
Staffing patterns and needs will depend on the type of facility, the range of services provided and the clinic’s caseload. Following are a few suggestions that may help clinic managers:

- Having a limited, but adequate, number of staff involved in each part of the medical-abortion process—for example, making appointments or providing care following misoprostol administration—may increase efficiency and ensure the presence of staff members who are very familiar with the relevant issues.

- Rotating staff members through various positions, when possible, may help prevent work-related burnout and stress.

- Staffing needs may be met by using existing staff in new positions, adding new staff or linking services with staff at a contraceptive-services department.

**Training**
It is highly recommended that all staff members receive initial and refresher training in counseling techniques, specific details of the medical-abortion process, and postabortion contraception. In addition, new employees should receive training and orientation on the facility’s protocol on abortion and counseling services.

Please review Section Two: Training for Medical-Abortion Counseling, for detailed information.
Links and referral
To best meet a client’s reproductive-health needs, managers must provide referrals to local sexual- and reproductive-health centers and other resources as needed. Providers should be prepared to offer clients additional referrals on such issues as domestic or sexual violence and sexually transmitted infections.

MONITORING SERVICES

It is helpful to set up a simple monitoring system when initiating new services or expanding services such as medical abortion counseling. Ideally, monitoring is a continuous process that involves the entire staff and emphasizes ways to improve services. It should be viewed as a supportive, nonthreatening way for staff members to work together to improve the quality of their work. Monitoring may include analysis of how well written policies and procedures are followed by staff. It may include basic data from clinic logbooks, observations of counseling sessions, client interviews, client feedback forms and staff discussions. At a minimum, monitoring efforts should attempt to address these questions:* 

- Are the services effective? Are women getting the information they need on medical abortion and are they receiving contraceptive counseling and services?

- Are the clients’ needs being met? Does client feedback indicate that women are satisfied with the services? In which areas do they suggest the clinic can improve?

- Do services meet service standards and other quality measures? Do they comply with relevant clinical, administrative, and regulatory protocols, policies and procedures?

- Do services meet the facility’s objectives and expected results? Are counselors trained and prepared to provide counseling and information on medical abortion? Are counseling services available to all clients?

- How can staff members improve existing services? Which solutions can the clinic develop to address any identified weaknesses? On which successes can the clinic capitalize the most?

* Information in this section is adapted from WHO, 1997 and McInerney et al. 2001.
SECTION TWO:

Training for Medical-Abortion Counseling
Programs to train staff members to counsel women about medical abortion should be based on 1) the
counselor or provider’s experience in providing abortion care and 2) his or her knowledge and feelings about
medical abortion. Even experienced counselors may need additional training to understand all the differences
between medical and surgical abortion and to help their clients choose between the methods. Providers who
are offering counseling as part of a new or expanded service may need practice in communicating effectively
with women about medical abortion and choosing a family-planning method. In most cases, anyone who will
provide counseling services on medical abortion will benefit from a comprehensive review of information.

Successful international trials on medical abortion have shown the importance of extensive provider educa-
tion in medical abortion, as well as training in dating the pregnancy, diagnosis of ectopic pregnancy and
surgical completion for failed medical abortion. Another notable finding is the “learning curve” that affects
providers. The Population Council has identified that such a learning curve could account for a variance in
success rates among clinical trials of medical-abortion regimens. The council found that providers reported
improved judgment with experience, and that the learning curve was based on these findings (Population
Council, 1997).

- Physicians unfamiliar with providing medical abortion were more likely to intervene surgically with
  regard to bleeding.
- The rate of success of medical abortion increased with heightened experience among the provider or
  clinic staff and with additional confidence in using the method.
- Physicians learned from experience how to better counsel patients about what to expect during the
  medical-abortion process.

To shorten this learning curve, staff members must be prepared to provide accurate information and effective
counseling on medical abortion. It is paramount that counselors have a firm foundation in communication
and counseling skills, the process of medical abortion, and supporting a client throughout the steps involved
in the process.

The training section of this guide is intended as a reference for training people in medical abortion counsel-
ing. Please note that it does not include detailed content information that should be covered in lecture/
discussion format. That information can be found in many of the materials listed in the Additional Resources
section at the end of this document. One highly recommended resource is the Physicians for Reproductive
Choice and Health (PRCH) Medical Abortion Slide and Lecture Presentation, which is available in PowerPoint
’97 for PC-compatible computers and can be adapted for each facility’s use. This presentation can be ordered
from PRCH, 1780 Broadway, 10th Floor, New York, N.Y. 10019 USA. Tel: +1-212-765-2322 ext. 17; Fax: +1-
212-246-5134. E-mail: annieprch@aol.com.
The following three resources are also highly recommended for training and curriculum design:


PRIME. *Reproductive Health Training for Primary Providers: A SourceBook for Curriculum Development*. Chapel Hill, NC: INTRAH, 1997. This resource includes a User’s Guide and a module (Module 1) on counseling clients. This resource is available on line (www.intrah.org) or can be ordered from INTRAH Publications Program, UNC-Chapel Hill School of Medicine, 1700 Airport Road, Suite 300, Chapel Hill, NC 27514 USA. Tel: +1-919-966-5636; Fax: +1-919-966-6816. E-mail: intrah@intrah.org.

DESIGNING TRAINING COURSES

Effective training programs share certain characteristics that help participants learn efficiently and that provide a stimulating, satisfying experience for all involved:

- Training content should be based on the skills and knowledge that the trainees will need to provide counseling to medical-abortion clients. A list of those specific skills can be used as a checklist to evaluate performance.

- The content should be tailored to the existing knowledge and experience of the trainees, which may need to be assessed—for example, through training needs assessments of their performance.

- The training course should be well-organized, include a pre- and post-test, and have a clear agenda, objectives and materials prepared in advance.

TRAINING METHODS

Training programs should be interactive and participation-oriented. Some aspects of the training may best be covered in a lecture/discussion format; other aspects may be better conveyed through video, case studies, role-plays, practice and group exercises. In most cases it is beneficial to use a variety of approaches.

Lecture/discussion

Lecture and discussion are proven methods for providing technical information to a group. For example, the trainer may give a lecture reviewing how medical abortion works and what the clinical protocols are for medical and surgical abortion. The group could then discuss the characteristics of each method and explore how to present the information to clients.

Video

Video can be used to show a taped sample counseling session and to spark discussion. Role-play sessions may also be taped to generate ideas during training.
Case studies

Case studies can be used to introduce participants to various issues they are likely to encounter in providing medical-abortion counseling. Following is a sample methodology for using case studies in training; refer to the training resources at the end of this guide for sample case studies.

- Divide the participants into groups of three and give each group a handout outlining the cases.
- Assign each group specific cases so that all cases will be covered.
- Tell each group to discuss issues that should be addressed in counseling the “clients” in the case studies; they should review what information they would provide to each client and what additional questions they would ask.
- Tell the groups that they may refer to any course materials to check their consensus, but should first try on their own to work through the issues each case raises.
- Each group should appoint a recorder and a reporter who will report back to the full group.
- Allow each group to report on their cases to the full group.
- After each case is presented, allow the full group to add comments.

Role-plays

It is difficult to gain confidence and competence in counseling without actual experience, and role-playing allows such practice in a safe, comfortable environment. The following activity requires close trainer supervision, but is a powerful preparation for real-life scenarios. Refer to the training resources at the end of this guide for sample role-plays.

Develop and adapt role-play scenarios:

- Set the scene: set up chairs and a table in front of the group to create a counseling space.
- For initial role-plays, trainers should demonstrate the technique.
- Following the demonstration, have a course participant volunteer to be the “client” and another to be the “counselor.”
- Give a copy of the role-play scenario to the client, and allow them to review the scenario briefly.
- Have the counselor and client meet—as they will in an actual setting—and begin the counseling session.
- The client may create answers or add information not included in the role-play scenario.
- The trainer should support, clarify and coach as each session progresses.
After the counseling session, the client and counselor should each review the role-play, discussing what they thought went well and what could be improved; the full group should then be invited to add their comments.

Different volunteers should be chosen for each role-playing exercise; if possible, each participant should have at least one opportunity to play the counselor.

Group exercises
Group exercises can help accomplish various objectives. For example, the group could carry out exercises to clarify values or to assess communication styles. Two such exercises are included in the training resources at the end of this guide: a values-clarification exercise and a behavior/belief exercise.

Practice
If possible, counselors should have the opportunity to practice their counseling skills with actual abortion clients during the course of the training. For example, on the second day of the training course, participants could spend the morning counseling clinic clients and the afternoon “debriefing” and discussing their experiences. Exercises could then be tailored to address issues identified during the practice sessions.

ISSUES TO CONSIDER IN ARRANGING A TRAINING COURSE

1. Training design

   - Select staff members for training, but limit the overall group size to allow each attendee to participate in exercises.

   - Assess the background and experience of participants through brief discussions or similar methods.

   - Determine the topics to be covered, as indicated by a training needs assessment or pre-test. Topics typically will include background information on medical and surgical abortion, communication and counseling skills, and counseling-services management.
Set learning objectives for the course based on the roles that participants play and the skills and knowledge they will need to provide counseling services.

Adapt the course outline and activities to meet the training objectives.

Devise an agenda for course participants.

2. Logistics and administrative preparations

Gain any necessary approvals for the training course.

Make any necessary arrangements for the venue, transportation, meals and lodging.

Prepare printed reference materials for participants.

Equip the space to be used, including blackboards or flipcharts and audiovisual or other equipment.

3. Responsibilities of the trainer

Become familiar with the curriculum, trainer’s guide and reference materials to be used.

Define objectives and resources for each area to be covered.

Develop a time-specific agenda for the course.

Prepare any additional handouts or visual materials.

Arrange relevant forms, such as pre-tests, post-tests and course evaluations.

Ensure that, by the course’s end, participants not only demonstrate skills competency, but also express confidence in using their new skills; if this is not the case, arrange for additional training.
4. Training follow-up

☐ Follow up with trainees two to six months after the training course — observe their progress using their new skills and provide any required assistance.

☐ Arrange for additional training if needed.

SAMPLE TRAINING RESOURCES

The following pages include sample course objectives, agendas, pre- and post-tests, case studies, role-play scenarios, group exercises and evaluations. The samples are illustrative, and will not necessarily be appropriate for every setting. Each sample should be adapted based on the needs of the program, participants and trainer.

Course Objectives and Agendas

The following are examples only. To develop effective objectives and an appropriate agenda for a specific course, the planners must set clear and specific training goals and be familiar with the skills and experience of participants.

Sample Workshop No. 1:
For nursing staff who will begin to provide abortion counseling, including counseling on medical abortion.

Objectives: At the end of this three-day workshop participants will be able to:
☐ Describe the principles of effective counseling.
☐ Demonstrate effective “active” listening.
☐ Describe early medical and surgical abortion, including each method’s characteristics, protocols, eligibility criteria, and complications and be able to describe those methods to clients.
☐ Help clients choose an abortion option.
☐ Explain successfully to clients key points that every abortion client should know, including the possibility of becoming pregnant within a few days and available contraceptive options.
☐ Offer support and information to clients throughout the abortion process.
### AGENDA: DAY 1

<table>
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<tr>
<th>Morning</th>
<th>Afternoon</th>
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<tr>
<td>8:30 – 9:30</td>
<td>Pre-test, introduction, discussion of expectations of workshop</td>
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<tr>
<td>9:30 – 9:45</td>
<td>Break</td>
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<tr>
<td>9:45 – 10:45</td>
<td>Overview of abortion counseling and methods</td>
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<tr>
<td>10:45 – 12:00</td>
<td>Video and discussion of counseling skills</td>
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<td>12:00 – 1:00</td>
<td>Lunch break</td>
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### AGENDA: DAY 2

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<th>Morning</th>
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<tr>
<td>8:30 – 9:30</td>
<td>Review characteristics of surgical and medical abortion</td>
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<tr>
<td>9:30 – 9:45</td>
<td>Break</td>
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<tr>
<td>9:45 – 10:15</td>
<td>Discuss clinic's medical abortion protocols; receive written copies of protocols</td>
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<tr>
<td>10:15 – 12:00</td>
<td>Examine case studies</td>
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<tr>
<td>12:00 – 1:00</td>
<td>Lunch break</td>
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### AGENDA: DAY 3

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<th>Morning</th>
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<tr>
<td>8:30 – 12:00</td>
<td>Counsel clients in clinic setting with trainer/supervisor available</td>
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<td>12:00 – 1:00</td>
<td>Lunch break</td>
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Sample Workshop No. 2:
An update on medical abortion for experienced abortion counselors.

Objectives: During this workshop, consisting of two half-days, participants will:
- Improve their ability to understand a client’s specific needs and support her during the abortion process.
- Successfully demonstrate strategies for helping women deal with a failed medical abortion.
- Help develop approaches to monitoring and improving their abortion-counseling services.

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<tr>
<td><strong>Afternoon 1</strong></td>
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Role-Plays and Case Studies

The following four scenarios can guide the “client” during role-plays or be used for discussion as case studies. Trainers may use or adapt these scenarios or create their own. Remember that the client may provide additional information to answer the counselor’s questions or to expand on the counseling session.

■ Client 1: A 20-year-old university student has been dating a classmate for the past eight months. She started having sex with him recently. They were using condoms and one broke. She was worried that she might be pregnant and so came to the clinic for a pregnancy test when her period was only two days late. She wants to have an abortion as soon as possible, as she wants to continue her studies and does not think that the man she is dating will prove to be a long-term partner. She lives in the university’s student housing where she shares a room with one other woman and bathroom facilities with five other women. Her roommate has been very understanding. The roommate came with the client to the clinic and is waiting in the courtyard.

■ Client 2: A 32-year-old married woman has discovered that her period is three weeks late. She has three children under the age of 6 and cannot manage having another child right now. However, she and her husband belong to a church that prohibits abortion, and she is afraid that her husband or other family members will find out about the abortion. She is determined to have an abortion and then to start using a contraceptive method that her husband won’t detect, because she worries that he would disapprove of family planning.

■ Client 3: A 30-year-old woman desperately wanted to be pregnant and was very excited when she missed her period two weeks ago. However, when she went to her doctor for a pregnancy test, she also had an HIV test and learned that she is HIV-positive. She thinks it is unfair to bring a child into the world if she is not going to be able to raise it; however, she is devastated to think about not having the baby she wanted so much.

■ Client 4: A professional woman came to the clinic because she heard that it now provides medical-abortion services. She had a surgical abortion 10 years ago when abortion was illegal in her country, and she vowed that she would never repeat that terrible experience. Her last period was about eight weeks ago, and she is worried that it might be too late for her to have a medical abortion.
Behavior/Belief Exercises

Trainer’s notes
Attitudes and beliefs are communicated to clients both verbally and nonverbally. The following two scenes are intended to initiate discussion of behaviors that express health-care providers’ attitudes toward clients.

1. Select participants to read Scene No. 1. (The trainer may choose to take the role of the counselor if it seems that participants will not be comfortable demonstrating behaviors that may be criticized. The group may want to read through the scene together before presenting it to the full class.)

2. Tell the class to notice what the scene’s characters do and say, which attitudes or ideas they are communicating to the client, and how the client may feel.

3. Make two columns on the blackboard or flipchart: one labeled “Behavior” and the other “Attitude/Belief.”

4. Ask the class to describe the attitudes reflected by the counselor in the scene, and how they exhibited those attitudes. Reiterate that our behavior often reflects our attitudes, even when we think that we are being neutral and positive. The goal is become aware of these attitudes, and to modify our behavior when necessary to maintain a respectful, professional relationship with the client.

5. Give the participants ample time to act out both scenes and to discuss the differences in counselor attitudes and communication styles.

Behavior/belief exercise: Scene 1

Setting: The client has just entered the counseling room, and is about to meet the counselor for the first time. The counselor walks in, leaves the door open, looks at the client, briefly shakes her head and asks for the client’s paperwork.

Counselor: “So, how old are you?”

Client: “23.”

Counselor: “Are you here to terminate your pregnancy?”
Client: “I… think so… I mean yes.”

Counselor: “How many abortions have you had?”

Client: “One and then a miscarriage.”

Counselor: “I see. You got lucky the second time, huh?”

Client: (no response)

Counselor: “The new way of aborting is with medical abortion; it’s simple, easy and should work fine for you, unless you smoke a lot or have any heart problems.”

Client: “OK.”

Counselor: “Wait here while I get some paperwork you need to sign. While I am gone look over this sheet about family-planning contraceptives that you really should have been using all this time and hopefully will use from now on!”

Counselor walks out and leaves the door open.

Some possible responses to Scene 1

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Attitude/Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asks closed-ended questions</td>
<td>Doesn’t want to know the woman’s feelings or thoughts</td>
</tr>
<tr>
<td>Displays impatience</td>
<td>The woman isn’t worth much time</td>
</tr>
<tr>
<td>Says “you got lucky…”</td>
<td>Condescension toward the woman; judgmental</td>
</tr>
<tr>
<td>Assumes the client wants abortion at all, and specifically medical abortion</td>
<td>The woman is incapable of making her own choice</td>
</tr>
<tr>
<td>Says “you really should have been using [family planning] all this time…”</td>
<td>The woman is irresponsible</td>
</tr>
</tbody>
</table>
Behavior/belief exercise: Scene 2

Setting: The counselor goes to the waiting area, calls the client’s name and escorts her to a private counseling room.

Counselor: “My name is _________ and I would like to begin by telling you that whatever we discuss here today or in future meetings will be held in confidence. This falls within your right to confidentiality. Do you have any questions about this?

Client: “No.”

Counselor: “I see, (Insert name of client), that you are here to discuss your options surrounding your pregnancy.”

Client: “That’s right.”

Counselor: “How do you feel about your pregnancy and being here today?”

Client: “I’m sad and angry at myself, but don’t want to have a baby. I’m not ready for this.”

Counselor: “Have you talked with your partner or family about this pregnancy?”

Client: “Yes, my boyfriend and family agree with me about stopping this pregnancy…. We talked about adoption but I can’t do it…. I know abortion is the right thing for me and I just don’t want to wait a long time to have the abortion.”

Counselor: “Well, I need to get some medical history from you first and we can go from there, okay? If you have any questions or don’t understand something I want you to stop me and I will try to explain it another way.”

Client: “Thank you.”

Counseling session continues in the same tone and line of communication.
Some possible responses to Scene 2

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Attitude/Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls the client by her name</td>
<td>The woman is an individual to be respected</td>
</tr>
<tr>
<td>Asks open-ended questions</td>
<td>Wants to know woman’s feelings and thoughts</td>
</tr>
<tr>
<td>Assures client of confidentiality</td>
<td>The woman has rights that should be respected</td>
</tr>
<tr>
<td>Asks about partner/family support</td>
<td>Is interested in the woman’s personal situation</td>
</tr>
<tr>
<td>Says that he/she will explain</td>
<td>The woman has a right to information and is capable of</td>
</tr>
<tr>
<td>things in another way if not understood</td>
<td>understanding it</td>
</tr>
</tbody>
</table>
Attitudes and Values: a Group Exercise

This exercise can be done early in the training course to help participants examine their own attitudes and values and to demonstrate how attitudes and values vary.

Preparation

Review the list of statements included at the end of this exercise and select 8 to 10 to use with the group, or create new ones. Write the categories, below, on a blackboard or flipchart, and post signs with the numbers of the categories throughout the room.

<table>
<thead>
<tr>
<th>Categories of agreement or disagreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>-2</td>
</tr>
<tr>
<td>-1</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
</tbody>
</table>

Instructions for the exercise

1. Lead a brief discussion about the influence that attitudes, feelings, prejudices and beliefs have upon the quality of health-care provision.

2. Review the five categories in the scale. Explain that you will read several statements; following each, participants should go stand under the sign/number that reflects their agreement or disagreement with the statement.

3. Begin to read the selected statements aloud. As you read each one, participants should move to the sign/number that most closely reflects their opinion. There should be no discussion at this time.

4. Note how strongly the group agrees or disagrees with each statement, as well as which statements elicit consensus and which produce divergent responses.
5. After reading all the statements, discuss with the group:

☐ Do the individuals in the full group appear to have the same attitudes or is there a broad range of beliefs?

☐ Which statements caused the widest range of agreement/disagreement? Why might these statements be the most controversial?

☐ Were any of the results surprising? If so, which ones?

☐ How might these attitudes be expressed to clients and how would the clients feel?

☐ How did participants feel when their beliefs were very different from the majority of the group?

☐ Summarize the results of the exercise, and reiterate the importance of being aware of our attitudes and values so that we do not impose them on clients.

Sample belief statements (choose 8 to 10 to use in training)

If a man wants his wife to have an abortion, she should have one, regardless of her opinion.

Abortion should be available to any woman who requests one.

Where there is easy access to abortion, there is more promiscuity.

A woman who is HIV-positive should have access to legal, safe abortion.

Abortion should only be available in cases of rape or contraceptive failure.

An unmarried 14-year-old should be able to have an abortion without her parents’ knowledge.

Medical abortion is always a better option than surgical abortion.

Poor women will be less successful with medical abortion than middle- or upper-class women.
Adolescents should abstain from sexual intercourse.

In a couple, it is the woman who should be responsible for using contraceptives.

Religion is a barrier to family-planning use.

Schools should provide sexuality education.

The less that clients know about the specifics of a medical procedure, the better off they are.

A woman who has several abortions is irresponsible and should be sterilized or use an IUD so that she won’t get pregnant again.

A woman is entitled to a certain number of abortions. After that number, it is to be condemned.

A woman can use emergency contraception as often as she needs it, even if she does not use another method of contraception.

(Adapted from Carolina Population Center, 1982; Yordy et al., 1996)
Evaluation Form

Date:  Day _______________  Month ______________  Year __________

Institution: ____________________________________  Trainer: ________________________________________

To evaluate the success of this training course and to improve future courses, we would appreciate your feedback. Please take a few minutes and use the following key to rate each of the following statements:

5 strongly agree
4 somewhat agree
3 neither agree or disagree
2 somewhat disagree
1 strongly disagree

Counseling Materials
I feel that:

a. The objectives of the training session were clearly defined. 5 4 3 2 1
b. The material was well-organized and presented clearly. 5 4 3 2 1
c. The pre- and post-tests accurately assessed the course’s content. 5 4 3 2 1
d. The competency-based performance checklist was useful. 5 4 3 2 1

Technical Information
a. I learned new information in this training course. 5 4 3 2 1

I now fully understand and can explain:

a. Medical-abortion procedure. 5 4 3 2 1
b. Complications and side effects. 5 4 3 2 1
c. Counseling differences between this abortion process and others. 5 4 3 2 1
d. Follow-up care and contraception. 5 4 3 2 1

Training Methodology
a. The presentation of the course was clear and well-organized. 5 4 3 2 1
b. The lectures were clear and concise. 5 4 3 2 1
c. I found the role-plays effective. 5 4 3 2 1
d. I found the group exercises effective. 5 4 3 2 1

**Trainer’s Performance**
a. The trainer encouraged participation. 5 4 3 2 1
b. The trainer was willing and able to answer all my questions. 5 4 3 2 1
c. The trainer presented information in an organized manner. 5 4 3 2 1
d. The trainer managed the time well. 5 4 3 2 1

**Training Location and Schedule**
The training site was convenient. 5 4 3 2 1
The scheduled course times were convenient. 5 4 3 2 1
The time used for training was appropriate and adequate. 5 4 3 2 1

**Suggestions**
a. What did you feel was the most useful part of this training course?

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

b. What did you feel was the least useful part of this training course?

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

c. Would you recommend this training course to a colleague? Please explain your reasons.

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

d. What suggestions would you make to improve the training course?

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

(Adapted from Farrell and Huber, 1998)
Pre-Tests and Post-Tests

Pre-tests and post-tests are useful tools for determining the baseline knowledge of participants in a training course, and for evaluating change in knowledge at the course’s end. The tests can be designed in different ways; for example, it is common to have multiple-choice questions in a pre-test and open-ended questions in a post-test. The examples below show open-ended questions. For a pre-test, the designer can list some correct and some incorrect choices to each question and make them multiple choice if the participants are very new to the information. If the participants have some background with the information, the open-ended format may be more appropriate. Pre- and post-evaluations are not intended to be threatening. They are intended to help the trainers select appropriate content for the training course and ensure that participants understand the material.

List three characteristics of medical abortion:

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

List three characteristics of surgical abortion:

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

List three exclusion criteria for medical abortion:

1. ______________________________________________________
List three times at which to provide counseling and offer contraceptive information to women having medical abortion:

1. ____________________________
2. ____________________________
3. ____________________________

List four effective communication principles (for example, asking open-ended questions):

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________

Give an example of an open-ended question you would use in talking with a medical-abortion client:

________________________________________________________

List 5 of the 10 rights of the client:

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________
4. ______________________________________________________
5. ______________________________________________________

Which contraceptive methods can be provided to women immediately following medical abortion (after expulsion of the POC)?

________________________________________________________

List three things a client should know about her medical abortion:

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

List three things a client should know about postabortion contraceptive use:

1. ______________________________________________________
2. ______________________________________________________
3. ______________________________________________________

Describe your clinic’s protocol for failed medical abortion:

________________________________________________________
Competency-Based Performance Checklist

A competency-based performance checklist can help evaluate counseling skills during role-plays and supervised counseling practice, and can be used for continuing supervision and evaluation. For each step in the counseling process, indicate whether the skill is performed competently (C), adequately (A), or not well (N). *Please note that this is an abbreviated checklist.* Facilities should adapt it based on their evaluation needs and counseling processes.

Checklist for counseling session during first clinical visit (mifepristone)

<table>
<thead>
<tr>
<th>CLIENT CASES</th>
<th>Client 1</th>
<th>Client 2</th>
<th>Client 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INITIAL COUNSELING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Greets client in a friendly, respectful manner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ensures appropriate privacy.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Sits with open body language, smiles and makes eye contact as appropriate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Asks client how she is feeling.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Explains what to expect during the visit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Asks appropriate questions about reproductive-health history.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Confirms with client in a sensitive manner that she wants to terminate her pregnancy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Solicits woman’s feelings regarding the abortion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Explains which abortion methods are available, including characteristics, effectiveness and the timing/visits required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Finds out what client knows about each method and clarifies information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Explores client’s views on the options and what abortion method is best for her, asking open-ended questions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. If client chooses medical abortion, counselor provides more information on the method in simple terms.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Clarifies the client’s feelings on:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ Possibility of viewing blood clots or tissue (products of conception)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ Possibility of having the abortion at home</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. Ensures that client understands:
   - Common side effects and symptoms of medical abortion.
   - Importance of attending all required clinic visits.

15. Explains clinic protocol for failed medical abortion.

16. Asks client whether she has additional questions.

17. Obtains informed consent for medical abortion (verbal or written, per protocol).

### CONTRACEPTIVE COUNSELING

18. Asks client if she would like her partner to join a discussion on contraceptive methods, as appropriate.

19. Asks client about her contraceptive plans and reproductive-health goals (to delay, space or limit births).

20. Explains the rapid return to fertility after abortion.

21. Offers client information on contraceptive methods, and provides information on methods, including:
   - Effectiveness
   - Side effects
   - Benefits
   - Local availability and cost

22. Asks client whether she has additional questions.

23. Finds out which method she prefers (if any).

24. Helps client decide which method suits her personal needs.

### MIFEPRISTONE/MISOPROSTOL

25. Explains what to expect after taking the mifepristone.

26. Explains protocols for the misoprostol visit or home administration of misoprostol.

27. Explains which pain-management drugs to take and not take.

28. Explains what to do in case of questions or problems.

29. Asks client whether she has additional questions.
## ANNEX: COMPARISON OF EARLY ABORTION OPTIONS

<table>
<thead>
<tr>
<th></th>
<th>Vacuum Aspiration (VA)</th>
<th>Mifepristone / Misoprostol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>VA is a uterine-evacuation procedure that uses electric or manual suction instruments.</td>
<td>Mifepristone is an antiprogesterin. Misoprostol is a prostaglandin.</td>
</tr>
<tr>
<td><strong>How does it work?</strong></td>
<td>Uterine contents are evacuated from the uterus through a cannula into a handheld manual vacuum syringe or electric pump.</td>
<td>Mifepristone prevents progesterone from supporting the pregnancy. Misoprostol causes uterine contractions that expel the pregnancy.</td>
</tr>
<tr>
<td><strong>When can it be used?</strong></td>
<td>From detection of pregnancy up through 12 weeks LMP.</td>
<td>Depends on protocol; often from detection of pregnancy up to 9 weeks (63 days) LMP (Scheepers, 1999).</td>
</tr>
<tr>
<td><strong>How effective is it?</strong></td>
<td>More than 98% effective</td>
<td>96-98% effective</td>
</tr>
<tr>
<td><strong>How is it typically used?</strong></td>
<td>VA procedure time is 5-15 minutes. The woman is usually able to leave within an hour. Local cervical anesthesia and cervical dilatation are commonly used. Products of conception are examined and confirmed immediately.</td>
<td>Mifepristone is given orally at a clinic visit. About two days later, the woman takes misoprostol, either vaginally or orally. A follow-up visit is scheduled and further visits may be needed depending on clinic protocol.</td>
</tr>
<tr>
<td><strong>What happens if the regimen fails?</strong></td>
<td>VA is repeated if there are signs of incomplete abortion.</td>
<td>Vacuum aspiration (for example, MVA) is standard for failed procedures.</td>
</tr>
</tbody>
</table>
Organizational resources

The following organizations have extensive experience with medical abortion or abortion in general, and can provide materials and additional information.

**Ipas**
300 Market Street, Suite 200
Chapel Hill, NC 27516  USA
Tel: +1-919-967-7052
Fax: +1-919-929-0258
E-mail: ipas@ipas.org
Website: <http://www.ipas.org>

**Planned Parenthood of New York City**
Clinician Training Initiative
26 Bleecker Street, Fifth Floor
New York, NY 10012  USA
Tel: +1-212-274-7200
Fax: +1-212-274-7218
Website: <http://www.pppnyc.org>

**Planned Parenthood Federation of America**
Medical Division
810 Seventh Avenue
New York, NY 10019  USA
Tel: +1-212-261-4632
Fax: +1-212-261-4314
Website: <http://www.plannedparenthood.org>

**Physicians for Reproductive Choice and Health**
55 West 39th Street 10th Floor
New York, NY 10018
Tel: 646-366-1890
Fax: 646-366-1897
Email: info@prch.org
Web: www.prch.org

**National Abortion Federation**
1755 Massachusetts Avenue NW,
Suite 600
Washington, DC 20036  USA
Tel: +1-202-667-5881
Fax: +1-202-667-5890
E-mail: naf@prochoice.org
Website: <http://www.prochoice.org>

**The Population Council**
1 Dag Hammarskjold Plaza
New York, NY 10017  USA
Tel: +1-212-339-0500
Fax: +1-212-755-6052
E-mail: pubinfo@popcouncil.org
Website: <http://www.popcouncil.org>

**University of Rochester**
Family Medicine Center
1000 South Avenue, Box 101
Rochester, NY 14620  USA
Tel: +1-716-341-6292
Fax: +1-716-341-6293
E-mail: eschaff@aol.com
General Resources

The following articles and documents were used as background resources for this guide and may be useful to those providing medical-abortion services. This is not intended to be an exhaustive list of articles on medical abortion, as documents are published on an ongoing basis.


References


