 

## *Uterine Evacuation in Crisis Settings Using Manual Vacuum Aspiration*

**Special contraceptive counseling considerations**

**Young women (ages 10-24)**

Young women’s contraceptive needs vary greatly. A young married woman with one child who wants to avoid having a second may have different considerations than a young woman who may be at a higher risk for STIs, including HIV. Some young women may want to become pregnant immediately and do not require contraception. When providing contraceptive counseling and services, it is important to ask what the young woman’s immediate and longer-term reproductive plans are and then provide appropriate counseling.

Contraceptive counseling should also include information on fertility awareness, by asking what the client knows about her menstrual cycle and fertility, and building on that to educate her about the fertile and infertile points in her cycle. Fertility awareness-based methods are not recommended for young women with erratic or irregular menstrual cycles. As with abortion, young women may have concerns about the safety or efficacy of contraceptive methods, which may be based on misinformation. They may not know how pregnancy occurs or is prevented. For example, they may have heard that pregnancy won’t occur if they have intercourse in certain positions, in water, or during menstruation or believe that contraception will cause future permanent infertility. Because of misinformation like this, it is important that providers explain how a contraceptive works, including efficacy, potential side effects such as weight gain or breast tenderness and their incidence, and the long-term clinical implications of any such side effects. Providers can ask indirect questions such as “What are some things your friends say about how you can and can’t get pregnant?” and “What are some things you heard about this method?” to find out whether a young woman is misinformed.

Contraceptive counseling should be reality-based. That is, it should begin by uncovering and addressing what clients believe, whether or not it is accurate, in order to avoid the method’s discontinuation. Providers should also learn from the young woman what barriers she may face in using different contraceptive methods and help the young woman identify the most appropriate option for her. A young woman’s privacy needs can also influence her selection of a contraceptive method; for example, injectables, implants, or an intrauterine device may suit a young woman with high privacy needs, even if her preferred method might otherwise be something else.

Making a larger range of contraceptive methods available is correlated with increased acceptance of a method among young and adult women. In addition to her method of choice, the young woman should be offered to leave the facility with at least one dose of emergency contraceptive pills (ECPs), in case of an accident or contraceptive failure.

The following information should also be presented when discussing contraception with young women:

*Medical eligibility for young women*

Clinical eligibility guidelines for postabortion contraceptives for young women are the same as for adult women. Three methods have implications for young women that bear additional discussion.

*Sterilization*

There is no clinical contraindication for sterilization in young women. However, women under the age of 30 are significantly more likely to experience regret after sterilization. During counseling, providers should emphasize that it is a permanent method, and make it clear that there is no extra benefit to doing the procedure at the time of the abortion versus using a non-permanent method for some time after to be sure it is the method she wants. There may be laws and policies in place that affect a minor’s ability to consent to permanent surgical modification and whether sterilization is an option for minors. Providers should offer information in a factual manner and support the young woman’s informed decision.

*Long-acting contraceptive methods*

Long-acting reversible contraception such as intrauterine devices (IUDs) or implants are safe and effective and benefit young women. For all women, these methods are more effective at preventing pregnancy than other modern methods including pills, injections, and condoms. In addition, because women who use IUDs or implants do not have to remember pills every day, buy more supplies, or get an injection every three months there is no chance of method failure because of problems with use. Young women have more difficulty using short acting methods than older women resulting in pregnancy rates that are double that of older women who use short acting methods. Therefore, the ease of use of IUDs and implants may be particularly beneficial for young women. Finally, women who use IUDs and implants are satisfied with them, leading to longer continuation than pills or injectables. Because unintended pregnancy occurs when women stop or switch methods, satisfaction and continuation are keys to the effectiveness of IUDs and implants.

*Intrauterine devices (IUDs)*

Young women are medically eligible to use IUDs. There are no clinical contraindications based on age alone. IUDs are less likely to be selected by young women than by older women in some countries. It is unclear whether this is in part due to providers’ reluctance to offer IUDs to young women or young women’s reluctance after being given accurate, unbiased information on the method. However, a study in New Zealand found that women who did leave with an IUD in place were 70 percent less likely to return for an abortion in the next three years than those who left with combined oral contraceptive pills (Roberts 2010). Providers should give this information to clients, but not push them to accept an IUD if the young woman is not interested.

*Injectables*

Injectables include progestin-only and estrogen and progestin (“combined”) formulas, including Depo-Provera (DMPA) and Mesigyna and Norigynon (NET-EN). In the same New Zealand study, DMPA was associated with a 40 percent decrease in likelihood of returning for abortion, compared to combined oral contraceptive pills (Roberts 2010).

There has been some concern that DMPA may permanently decrease bone mineral density (BMD) in young women, as it does temporarily decrease BMD and adolescents have not yet attained their peak bone mass. A study specifically on adolescent women found that all of them had complete recovery of BMD within 12 months of discontinuation, and the length of use of DMPA did not affect this recovery. However, the World Health Organization’s latest recommendations on medical eligibility for contraceptives states that most studies have found that women regain BMD after discontinuing DMPA, but it is unclear whether use in young women will affect peak bone mass, and thus lists it as a Category 2 method (“generally use the method” – in comparison, Category 1 means “use method in any circumstances”) for women under 18.

**Women with multiple abortions**

If a woman does not want to become pregnant and has experienced multiple unwanted pregnancies and abortions, the provider should help the woman identify any difficulties she may have using or accessing contraception and work with her to resolve those difficulties.

When discussing contraception with a woman who has had multiple abortions:

* Explore with the woman her history of contraceptive use. If she has not been using contraception, ask her about this, using non-judgmental language.
* If she has been using contraception, identify and resolve any difficulties she has experienced with her chosen method or help her select a method that may be more appropriate for her.
* If resupply of her chosen method has been problematic, help her identify a method that she can obtain more consistently.
* Advise the woman about how to access and use emergency contraception (EC) if she has unprotected intercourse or if contraceptive failure occurs. If possible, provide her with a supply of ECPs.

**Women who have experienced violence**

When helping a woman who has experienced violence, select an appropriate contraceptive method and ask her to consider whether there is a connection between the violence and her contraceptive use. If the violence is a result of her contraceptive use, help her consider a method that cannot be detected by others. If the woman cannot control the circumstances of her sexual activity, advise her on using methods that do not require partner participation such as injectables, intrauterine devices, and implants and how to access and use EC. It may be beneficial to provide ECPs in advance.

**Women living with HIV**

The following information should be presented when discussing contraception with an HIV-positive woman:

* Male and female condoms help protect against HIV transmission and need to be used correctly each time intercourse occurs.
* If the woman engages in unprotected sexual intercourse with an infected partner, she may become infected with a different strain of HIV or other sexually transmitted infections (STIs).
* Dual protection is recommended. This practice consists of the simultaneous correct and consistent use of male or female condoms for STI/HIV protection with another, more effective contraceptive method for pregnancy prevention, **or** with ECPs as a back-up method for pregnancy prevention. Women being treated for HIV need information on contraceptive options in relation to their treatment regimens.

**Women who engage in sex work**

The following information should be presented when discussing contraception with women who engage in sex work:

* Providers should recommend the use of dual protection, through the simultaneous use of condoms and another method, for protection against both STIs and unwanted pregnancy. If male condom use is not feasible for the woman, she may want to consider the use of female condoms, if available.
* Providers should advise against using an IUD or IUS, as the woman is at increased risk of having or contracting an STI.
* The woman should be informed on how to access and use ECPs. It may be beneficial to provide the woman with ECPs in advance.

**Women with cognitive and developmental disabilities and/or mental illness**

The provider should begin by assessing what knowledge and experience the woman already has regarding contraception. The provider can then assist her in determining which method is most suitable for her by asking who she has sex with and under what circumstances.

The following information should be considered when discussing contraception with women who have cognitive disabilities and/or mental illness:

* The woman may have difficulty remembering how or when to use certain methods, such as taking a pill every day. However, these methods may still be a good option if instructions are given clearly and the woman has a caregiver who can help to remind her and establish the method as part of her daily or monthly routine.
* Some women with developmental disabilities may have trouble with fine motor skills. In such cases, certain methods–such as diaphragms–may not be advisable.
* Women in this population should be instructed on how to use and negotiate barrier methods, and providers should emphasize that they must be used every time she engages in intercourse if she wants to prevent pregnancy and STIs.
* The provider should demonstrate the method—using actual condoms, diaphragms, or cervical caps—and/or use illustrative instructions.
* Providers should give the woman written and/or illustrative instructions to take home or other helpful tools such as a calendar.
* It is probable that many women in this population do not know in advance when they will engage in sexual intercourse. For this reason, the advance provision of EC pills, with specific instructions, may be advisable.
* Under no circumstances should any method be performed or provided without the woman’s explicit consent. Women with cognitive disabilities and/or mental illness have the same right as other women to make choices regarding childbearing.
* Regarding informed consent, providers should be aware that the woman may or may not be her own guardian. If the woman is able to make decisions about her own care, the provider should make an extra effort to ensure that she clearly understands what she is consenting to and what her choices are.

**Women who have experienced genital cutting**

A woman’s type of genital cutting and her preferences around deinfibulation and reinfibulation need to be considered when supporting her in selecting her preferred contraceptive method. A recent review of the evidence shows no known increased incidence of HIV infection among women who have undergone FGC. As for all women, encourage the use of barrier methods, such as male and female condoms, to decrease the risk of HIV infection.

**Women who partner with women**

Providers should not make contraceptive-related assumptions about women who state that they have female sexual partners. Women who partner with women may also engage in sexual relationships with men, be at risk for STI/HIV and unwanted pregnancy, desire a future pregnancy, and/or need contraceptive information and methods. Providers should engage in an open discussion with the woman to determine her risks and needs.