

Client-Provider Communication in Postabortion Care

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Many medical workers who treat women experiencing complications of induced or spontaneous abortion readily acknowledge that such women need “counseling,” but they often view counseling as a nonmedical function requiring specific training, a specially designated time apart from the provision of other postabortion services and a separate, private facility. Thus, providers of postabortion care often believe that counseling is not one of their job responsibilities and that they lack the training and facilities to do it.

However, if counseling is defined as two-way communication conducted to help clients make decisions and to deal with their feelings about their circumstances,¹ providers should routinely integrate counseling into all aspects of postabortion care. Such communication can help providers assess the client’s needs and her feelings about her situation, and can help facilitate the client’s decision-making following the procedure. Postabortion counseling can also provide a client with information and emotional support that can help make the procedure more comfortable for her and easier for the provider.

COUNSELING NEEDS

When a woman seeks medical attention from health care providers for abortion complications, her needs often go beyond immediate treatment. A woman who has had an induced abortion may be concerned about the conditions or circumstances that led to the unwanted pregnancy, and she may fear the legal, physical or social consequences of having ended a pregnancy. Although the client may need a contraceptive method to prevent future unwanted pregnancies, she may place greater importance on other needs—such as tending to her overall health, keeping her situation confidential or protecting herself from a partner, family members or legal authorities.

Women seeking care after a spontaneous abortion may not be interested in preventing future pregnancies, but they may have concerns about the medical treatment that they are about to receive and its potential effects on their health and their ability to carry a future pregnancy to term. Some of these women may feel ashamed that they “lost” the pregnancy. Others may fear that they will be accused of inducing the abortion.

The text box outlines the areas that should be addressed in counseling during postabortion care and provides guidelines on when to discuss these topics (before, during or after the procedure). However, what is said between the provider and the client, and when, can vary according to the client’s circumstances and needs.

KEY COUNSELING TASKS

To meet the needs of postabortion clients, health care providers must perform several basic tasks.

Assessing the Client’s Readiness for Counseling

In working with a client experiencing a complication of abortion, service providers must first assess the severity of her condition and schedule or provide the necessary medical care. After doing so, and before initiating counseling or any in-depth discussions, the provider must assess the client’s readiness to talk. The client’s main concerns at that moment may be pain, confusion or fear, which the provider should address immediately. Until these feelings have been dealt with, the client may be unable to concentrate on other issues. After her needs and concerns have been acknowledged and, if possible, addressed, the client may be ready for counseling.

Dealing with the Client’s Feelings

A woman who seeks care for postabortion complications is likely experiencing numerous, and sometimes conflicting, emotions. After developing an understanding of the

Counseling for clients receiving postabortion care

Before the procedure:

- Assess client’s ability and capacity to give or receive information
- Explore client’s needs and feelings
- Provide information about the following, as appropriate:
 - Treatment procedure and anesthesia
 - Possible side effects, complications and risks
 - Human reproductive processes
 - Available contraceptive methods
 - Examinations, clinical and laboratory findings

During the procedure:

- Maintain emotional support by being
- Positive and empathetic in verbal and nonverbal communication
- Gentle while performing the procedure

After the procedure:

- Explore client’s feelings, questions and concerns—provide support, encouragement
- Remind client of possible side effects, risks and warning signs—client should return if warning signs appear
- Tell client how to take care of herself at home
- Give written postprocedural information (as a reminder of what you are discussing)
- Remind client of importance of follow-up, and schedule an appointment that is convenient for the client
- Discuss chances of becoming pregnant again and available contraceptive methods, as appropriate
- Discuss reproductive tract infections and sexually transmitted infections
- Assess needs for additional counseling or referral for other reproductive health needs or nonmedical issues; schedule next appointment for counseling or make the necessary referrals (and discuss the referral at the client’s follow-up visit)

client's feelings, the provider must consider what kind of response will be most helpful.

Providers cannot be expected to act as therapists or social workers: During the delivery of postabortion care, they can deal effectively with only a limited range of emotional needs. Yet a client may find even such limited support to be of significant help. For example, receiving information about the clinical procedure and what normally happens afterward can relieve the client's fears of such consequences as death, loss of fertility or some kind of legal action or punishment after the procedure (where abortion is illegal). The client may be comforted simply by being assured that her fears and confusion are normal in these circumstances. For a client undergoing a postabortion procedure requiring local anesthesia, having someone talk to her and hold her hand during the procedure may be reassuring. Providers can address such needs by offering basic information and maintaining supportive communication before, during and after the procedure.

A client may be struggling with difficult emotional and social issues; for example, she may be trying to hide an induced abortion from her family or may be experiencing the traumatic effects of a rape or sexual assault. In addition, she may have been exposed to HIV or other sexually transmitted infections (STIs). Providers should be aware of these possibilities, ask questions that allow the client to express possible concerns in these areas, listen respectfully to the client's concerns and then refer her to appropriate medical, psychological, financial, legal or social services.

Inviting the Client to Ask Questions

Asking "What questions do you have?" is one of the most fundamental tools of counseling, yet it also is one of the most overlooked. Providers often claim that although they are willing to answer questions, clients rarely ask. Why would this happen? Clients who received postabortion care services in Colombia and Indonesia reported not voicing their questions to providers. According to the clients, their providers seemed too busy, never indicated that it was acceptable to ask questions and provided no good opportunity for asking.² Because clients may be feeling stressed and vulnerable, they may lack the confidence and determination to interrupt a provider to ask a question. Therefore, providers must take the responsibility for asking clients whether they have any questions.

Offering Information

Women seeking postabortion care need information and education: Their health and perhaps even their lives have been endangered, often because of misinformation, inadequate knowledge or misunderstanding of matters of reproduction and contraception, including the availability of contraceptive services. Providers of postabortion care generally appreciate their clients' need for information; however, they may be overwhelmed by the amount of information they think a given client needs and may be skeptical about her ability to understand.

The provider's first step should be to assess what the client already knows about her situation. By asking a woman what she thinks is happening to her body and what she thinks medical staff are going to do to treat her, a provider can quickly determine her perceptions and fears about her condition, as well as her general level of education and any misconceptions or gaps in her knowledge. The provider can then give only the information the client needs and present it in a way that she can comprehend.

Besides assessing what a client may know about her condition and about the medical procedure she may be about to undergo, service providers also should confirm that the client understands that she can get pregnant again before she has her next menstrual period, that she can begin immediately to use certain methods of contraception and that she should have a check-up in case she has contracted an STI.³ Again, asking first what the client knows about these topics is the most effective and efficient approach to providing information.

BARRIERS TO COUNSELING

What prevents health care providers from carrying out these components of counseling?

Lack of Training in Communication

Most medical professionals and ancillary workers are not sufficiently trained in basic communication skills.⁴ One result is that they often give a client only the information they think she needs, rather than asking the client what she already knows and whether she has any questions.

Fear of Dealing with Feelings

Medical staff usually receive little or no training in dealing with clients' feelings, and in some cultures, they may be discouraged from doing so. Many providers are therefore reluctant to ask questions about the emotions a client is experiencing. Also, service providers are typically trained to focus on problem-solving, and they may fear that asking a client how she feels will open up depths of emotion that they are unprepared to deal with.

Time Factor

Medical staff commonly believe that they have too little time to talk with their clients. Although this would be the case in emergency situations, which require immediate treatment, most clients of postabortion care present with non-acute conditions and are scheduled for a procedure at a later time (usually later that day or the next day). In these non-emergency cases, staff have plenty of time to communicate with a client but often are not clear about who should do it and when. For example, staff preparing a client for vacuum aspiration may assume that those performing the procedure will inform or reassure the client, whereas staff in the treatment room may assume that the client has already been adequately counseled in the preparation room. Such issues can be addressed by treatment protocols that clarify the counseling responsibilities of staff members.

Privacy and Confidentiality

A common misconception is that counseling requires a separate room to ensure privacy. Although this may be desirable, it is not always possible. Providers can, instead, take steps such as having curtains hung between beds on the ward and sitting at the client's bedside and speaking softly.

Service providers also need to be trained in the distinction between privacy and confidentiality. Protecting confidentiality means not discussing a woman's personal information (unless she wishes it) with or in the presence of her partner, family members or staff not directly involved in her treatment.

Lack of Integration into Routine Interactions

The perception that counseling should be conducted separately from other services is an important barrier to communication. Providers need to learn how to integrate counseling into all their interactions with clients and how to adjust their communication to each woman's condition and needs. Any task in which a provider has contact with a client—for example, filling out registration papers, taking her temperature, preparing her for surgery, changing bandages or measuring blood pressure—may offer an opportunity to ask the client how she feels emotionally and physically and inquiring whether she has any questions.

Provider Bias Against Discussing Abortion

Even when all other barriers have been overcome, an individual provider's negative opinions about induced abortion may inhibit communication with a client or make her feel that she has done something wrong. In such cases, a supervisor must address the provider's behavior, because it may prevent a client from getting needed information and services.⁵

TRAINING PROVIDERS

If staff at a health care facility are to recognize and respond to postabortion clients' individual needs for information and support, and to use the treatment period as an opportunity to offer preventive care and guidance, then it is essential for all types of providers to receive training in postabortion counseling. Such training should be based on respect for clients and on recognition of their right to high-quality care, effective verbal and nonverbal communication, and the provision of emotional support and information.

All clients, regardless of their reason for visiting the facility, deserve confidential treatment that shows respect for their dignity and privacy. Simple changes in provider behavior and in service delivery practices—such as turning the foot of the procedure table away from doorways and hallways, and limiting the number of people who pass through the room—can help protect these essential client rights. Moreover, improving providers' communication skills can help make the woman more comfortable during and after the procedure. This can reduce complications during the procedure. In addition, after the procedure it can enhance discussion of what the woman can do to avoid un-

wanted pregnancy in the future (in cases of induced abortion) or to recognize and respond to signs of spontaneous abortion earlier.

Basic training in communication skills can help providers improve the quality of their interactions with clients and achieve better results without increasing the amount of time spent with each client. A key first step is for providers to be aware of the importance of body language and tone of voice. Listening skills are also important. Providers are usually accustomed to giving instructions, but they can benefit from learning to ask questions and to listen when clients speak. The use of uncomplicated language and open-ended questions can improve communication by encouraging clients to participate in discussions.

Clients cannot be expected to absorb important information (about their health status, the procedure or post-procedural care) until they are feeling reasonably calm and comfortable. A key step in preparing providers to deal with clients' emotions is to help them understand what may underlie their feelings. For example, in counseling training, role-playing can help providers "put themselves in the clients' shoes." By acting out the role of a woman who needs postabortion care, a provider can better understand how such a woman may feel.⁶

SUPPORTING EFFECTIVE COUNSELING

Integrating counseling into postabortion care services will require the input and cooperation of policymakers, program planners and supervisors, all of whom have a role to play in restructuring services. Their contributions can be made in four ways. First, policies should be established at the highest levels of the health care system to require the use of counseling in all postabortion care. This recognition, by persons at such a high level of authority, of the essential role of counseling would help providers to accept counseling as part of their jobs. Specifically, such policies should include basic guidelines on how to incorporate counseling into the delivery of postabortion care services. For example, such policies can include requirements for staff training and orientation in comprehensive postabortion care services, including counseling, and for supervision over all postabortion care services. In addition, such policies could specify strategies for overcoming barriers to counseling.

Second, policies should require voluntary and informed choice in family planning counseling, including the right to choose not to use a contraceptive method after receiving postabortion care services. Although the use of contraceptives may be advisable, policies that require clients to leave the service site with a long-term or permanent method violate women's rights and have the potential to deter other women from seeking postabortion care services. Supervisors should routinely monitor the practices of providers to verify that policies on informed choice are being followed.

Third, developers of training programs should ensure that their curricula introduce counseling and clinical training simultaneously. Counseling is frequently overlooked

or underemphasized in training programs, often because the clinical and technical aspects of postabortion care can be covered in more tangible ways in training activities than can counseling. This imbalance can be avoided by instituting training protocols that integrate counseling and clinical care at every step. For example, instruction in how to conduct clinical assessments during postabortion care should emphasize that open-ended questions must be asked (in addition to closed-ended ones) to obtain a thorough overall assessment, and that the client should be encouraged to ask questions.

Finally, supervisory systems must hold providers accountable for conducting high-quality counseling. Supervisors should use routine performance measures, such as monitoring checklists, client satisfaction surveys and other evaluative approaches, to assess providers' counseling skills. The recognition and reward of staff who provide high-quality counseling will motivate providers to use and improve their skills.

CONCLUSION

By incorporating counseling into their delivery of postabortion care services—by using two-way communication, respecting clients' rights, acknowledging clients' difficult situations after an abortion and conveying vital information—providers can play an important role in their clients' reproductive health experiences and decisions. Through

these efforts, the toll that abortion complications take on women's health and lives may be reduced. Policymakers, program planners and supervisors must take the lead in establishing policies and structuring services to support such efforts.

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