Options Counseling for Unintended Pregnancy

ROE
Reproductive Options Education Consortium
Overview of presentation

- Background on unintended pregnancy
- Overview of **knowledge, skills and attitudes** needed to provide care to women with unintended pregnancy
- Professional issues

*Attitude* in providing care in a sensitive, respectful manner, acknowledging the need for privacy and confidentiality.

*Skill* in supporting women through their decision-making process with specific counseling techniques

*Knowledge* of the full range of pregnancy options including parenting, adoption, and abortion.
1st point: Every year, more than a million women in the United States have an elective pregnancy termination. Although the abortion rate has been declining, termination of pregnancy is one of the most common gynecologic procedures in the U.S. (Jones, 2008)

2nd point: Though this slide set focuses on the care of women, this does not negate the role of men or the need to involve them in comprehensive reproductive health care.

The United States has a significantly higher rate of unintended pregnancy compared to other industrialized countries. This slide provides interesting comparisons between three European countries and North America regarding adolescent reproductive health. The median age of first intercourse is similar in all five countries. Compared to the U.S., though, young women in other countries are more likely to use contraception and thus have a dramatically lower teen pregnancy rate. The corresponding birth rate and abortion rate is thus much higher in the U.S. than in Canada, Great Britain, France or Sweden. **Before next slide, solicit from class/brainstorm**—So why do U.S. women experience more unplanned pregnancies?

1st point: Contraceptives are unavailable, difficult to obtain or too expensive—E.g., a woman may run out of birth control pills or not be able to get refill promptly; insurance may not cover her birth control or may charge a large deductible. She may be uninsured.

2nd point: Lack of understanding of reproduction/fertility—Many women do not understand when risk of pregnancy is greatest.

3rd point: Sexual assault/abuse/coercion. Women’s use of contraception may be limited due to fears about partner response: women may either use no contraception or rely on methods that can be hidden from their partner. Coercion and lack of negotiating power may contribute to nonuse of contraception along with lack control over the timing of sexual intercourse, which would limit the effectiveness of some methods, such as barrier methods (Heise 1993, 1995). Abusive partners prevent women from using contraception as prescribed or refusing to pay for contraception (Branden, 1998). Victims of sexual assault are often not offered emergency contraception in religious based hospitals and emergency rooms.

4th point: A woman’s religion or her partner may forbid her to use contraception (so even though a woman may not want to have another pregnancy, she may not feel she can use or be able to obtain contraceptives)

5th point: Emotional/psychological reasons: Denial about the possibility of getting pregnant, ambivalence about having a child or the desire to be sure she is fertile sometimes lead women to have unplanned pregnancies.

6th point: Many women still don’t know about the availability of emergency contraception without a prescription. Women under the age of 17 need a prescription (as of 2009).
7th point: Contraceptive failures--No method is perfect. For example, even after surgical sterilization, one woman out of every 200 becomes pregnant. Pregnancies happen when condoms break, or pills stay in their package. Contraceptives are not easy to use exactly right all of the time. A woman has approximately 37 years or 444 months of potential fertility, many cycles in which unplanned pregnancies can occur (Baker & Beresford, 2009).

Reference:
Prevention is important: Applying a Public Health Model

- **Primary Prevention**
  - Preconception care
  - Contraception
  - Emergency contraception

- **Secondary Prevention**
  - Pregnancy diagnostics
  - Early pregnancy loss, ectopic pregnancy screening
  - Pregnancy options counseling
  - Early abortion care, adoption, referral for prenatal care

- **Tertiary Prevention**
  - Late term unintended pregnancy support
  - Pregnancy termination
Primary Prevention

- Preconception care
  - See CDC Reproductive Life Planning
- Contraception
- Emergency contraception
  - OTC and prescription
  - Emerging research suggests overweight & obese women may have decreased efficacy with oral EC.
  - Copper IUDs very effective


When primary prevention is unsuccessful

- **Secondary Prevention**
  - Unintended pregnancy has occurred
  - Pregnancy options counseling
What skills do nurses/APRNs need to provide care to women with unintended pregnancy?

Attitude, skills and knowledge

Nurses need specific knowledge, skills and attitudes to provide professional options counseling. An unintended pregnancy is a crisis for most women. Even if a woman eventually decides to continue a pregnancy and is happy about it, if it was not planned, it usually creates a degree of upheaval in her life. Particularly difficult situations include the teenage woman who has become pregnant and doesn’t want her parents to know; the peri-menopausal woman who thought she could no longer become pregnant; or the sexual assault victim who became pregnant as a result of her trauma.
1st point: It is essential that pregnancy options counseling be non-judgmental, sensitive and respectful. Though we may have opinions about what a woman should do when faced with an unintended pregnancy, it is ultimately her decision, and she deserves respect and compassion as she makes that decision and acts upon it. As members of the health care team, it is important to provide sensitive, non-judgmental care. In order to do so, it may be important for students or professional nurses to clarify their beliefs to be certain that their beliefs will not conflict with their ability to provide nonjudgmental care. For individual and group values clarification exercises on providing abortion counseling and care, see The Abortion Option: A Values Clarification Guide for Health Care Professionals. Available at: http://www.prochoice.org/pubs_research/publications/downloads/professional_education/abortion_option.pdf, it contains a variety of exercises designed for individual or classroom use.

2nd point: For a discussion of nurses’ code of ethics in providing care, see ANA Code of Ethics. The statement addresses the need for nurses to examine their conflicts arising from professional and personal values and resolve these in a way that ensures patient safety and preserves the professional integrity of the nurse. Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situation, regardless of the nurses' personal beliefs [...] and to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referral. See The Right to Accept or Reject an Assignment statement for further discussion of potential conflicts due to moral, ethical or religious views (ANA 1989, 1997).
3rd point: Professional nursing organizations, such as the American College of Midwives (ACNM), National Organization of Nurse Practitioner Faculties (NONPF), National Association of Nurse Practitioners in Women’s Health (NPWH), Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN, 1999) have codified the ANA Code of Ethics by providing ethical and legal guidelines for their members.

References:
Skills needed by RN/APRNs to provide options counseling

- Providing non-judgmental, non-directive counseling using specific counseling techniques.
- Addressing issues of ambivalence.
- Supporting the woman in her decision-making.
- Assuring that the informed-consent process includes appropriate, accurate information about the potential benefits and risks of abortion, adoption and continuing the pregnancy.
- Providing resources or referrals to quality providers.

1st point: An unintended pregnancy is a crisis for most women. Even if a woman eventually decides to continue a pregnancy and is happy about it, if it was not planned, it usually creates a degree of upheaval in her life.

2nd point: It is essential to reassure the woman, even if she is a minor, that everything you discuss is confidential. During at least part of the encounter, you should be alone with her as she may not feel comfortable or be able to tell you all of her feelings if a parent, boyfriend, husband or other person is present. It is important to be sure the patient is free from coercion around this important decision.

Some states have parental notification or parental consent requirement for abortion services. Most states with this type of legislation have judicial bypass mechanism for minors who cannot for whatever reason, involve a parent(s) in their decision-making. See the Guttmacher Institute “State Facts about Abortion” which provides current information about parental notification or consent requirements on a state by state basis. http://www.guttmacher.org/statecenter/sfaa.html

3rd point: No matter what her ultimate decision is, every woman deserves good care. If you do not provide the full range of reproductive health services such as prenatal care, abortion services or counseling for adoption at your setting, it is important to refer women to a reputable facility for the care they need. It is essential to know of resources in your community and have brochures and contact information available. For example, in many settings, such as a primary care office, the role of the RN or APRN is to provide options counseling and refer the woman to a facility that provides abortion. The referral agency can then provide specific education about the various abortion options. A few primary care offices do provide abortion services. In this setting, the RN/ APRN needs skill in providing
detailed abortion counseling.

4th point: Before undergoing an abortion procedure, all women are counseled by the staff at the facility performing the abortion. Counseling may include options counseling (for those who are not yet decided about their decision), and abortion-specific counseling (for those who are sure they want to terminate the pregnancy, but may not know about the different options for termination). In addition, specific considerations and risks associated with each type of procedure are reviewed. Informed consent is obtained. Any woman who is not able to give full consent (either because of ambivalence, coercion or other limitations, such as age or mental capacity) will not be able to have the procedure until or if alternative mechanisms are in place.
**Skill:** Provide options counseling using non-judgmental, non-directive counseling techniques to promote effective communication:

- Asking questions
- Reflecting
- Normalizing
- Examining consequences
- Reframing

1. **Asking questions** - simple, open-ended questions, such as “How do you feel about being pregnant?” or “What are your thoughts about continuing the pregnancy, having an abortion or considering adoption?” may elicit a response from a client and allow her to begin to process her decision-making with you.

2. **Reflecting** the emotions expressed by the woman is an effective way to show that you are listening and concerned. E.g.- “I’m hearing you say...”

3. **Normalizing**- let women know that their desire to control the size of their family and to control the timing of beginning or completing a family is normal, natural, and appropriate, even though some aspects of society attach stigma to a woman's decisions about her pregnancies.

4. **Examining consequences**. Use “if..then” statements or questions to assist the woman to process and examine the outcomes of her decision. E.g: If you say that you are too young to be a single mother, then you may want to explore the options of adoption and abortion as well as continuing the pregnancy.

5. **Reframing** is a way to look at something from a new perspective. I the woman can shift from looking at the option she has chosen in a negative light to a more positive light, she may begin to cope better with her decision. E.g a woman is overwhelmed with the demands of her current parenting. If she makes the decision to terminate her pregnancy, she can view her decision as providing better parenting for her current children.

**Reference:**
1st point: If the woman appears too overwhelmed with the news of an unintended pregnancy, give her time to absorb the information. Give her permission to take time to respond. If time and space allow, give her a private room to process her thoughts. Did someone accompany her to this visit and if so, does she want the person with her now? Give her the option of a few minutes alone or scheduling a follow-up appointment at another time.

2nd point: Encourage women to think about what it would be like to talk with those who would be supportive of her decision as well as explore what it would be like to tell someone who might not be supportive of her decision. Offer a referral to a professional counselor if she desires.

3rd point: Reassure the woman that it is not necessary to make a decision right away and that she should take the time she needs to process her decision fully. Many women will know what they want to do right away. This does not generally indicate a “snap decision” but rather indicates that they suspected they were pregnancy and have been thinking about their options. Some women will have engaged in theoretical decision-making in that they have thought about what conditions they want in place to be a parent. For e.g., “If I became pregnant before I finished high school, I would terminate the pregnancy”, or “I didn’t have a partner to assist with parenting, I would terminate the pregnancy” or “I would have a child under any circumstances”. A woman may change her viewpoint when faced with the particular circumstances of her life, but she has a basis from which to begin her decision-making.
**Skill: Informed consent**

- **Principles of informed consent:**
  - Client must have appropriate information to make an informed decision
  - Decision-making is not coerced or manipulated
  - Client is capable of understanding information and making a decision

**1st point:** Principles of Informed Consent. The ability to give informed consent depends on: 1) adequate disclosure of information; 2) client freedom of choice; 3) client comprehension of information; and 4) client capacity for decision-making. If these four requirements are met, the necessary conditions of informed consent are satisfied: 1) the client’s decision is voluntary; 2) the decision is made with an appropriate understanding of the circumstances; and 3) the client has carefully considered all of benefits, risks, and reasonable alternatives.

**Reference:**
1st point: As an RN or APRN, even if you are not planning to work in a women’s health setting, if you are caring for women of reproductive age in any setting, it is likely that you will be involved in a discussion about unintended pregnancy at some point. (Remember, almost half of all pregnancies are unintended). In this role you may provide pregnancy testing, options counseling, referrals, contraception, and other prevention services to women.

2nd point: Give pregnancy test results in a confidential and nonjudgmental manner. If a pregnancy test result is negative and the women is disappointed, assess further. If there is a concern of infertility, make appropriate referrals. If the woman is relieved, this is a “teachable moment” for contraceptive counseling and an opportunity for safer sex counseling. For additional information on ordering &/or giving pregnancy tests results, see the ppt. listed in the Resource Slide on Giving Pregnancy Test Results.

3rd point: Many women with unintended pregnancies have questions or are misinformed about their options, therefore it is important for RNs and APRNs to have a working knowledge of each of the options to dispel myths, clarify misinformation and accurately answer questions.
1st point: Women with unintended pregnancies have two primary options—to continue or to end their pregnancies. Within each of these options, there are additional options.

2nd point: Separating parenting from placing a child for adoption or in temporary foster care are important distinctions. Women who are considering adoption should be referred to a professional, such as a social worker, who can offer accurate information and counseling. Adoption is a very complex decision, and anyone considering it needs strong support and accurate information.

3rd point: No matter what her ultimate plan, a woman who chooses to continue her pregnancy should be assisted to begin early prenatal care.

4th point: Abortion is legal in the US, however, restrictions exist that limit a woman’s ability to have one. Restrictions vary from state to state but may include 24 hour waiting periods, prohibitions on Medicaid funding, parental consent laws that require a young woman to get permission from one or both of her parents or a judge or parental notification. It is important to be familiar with the laws that affect abortion in the state where you are practicing.

5th point: Those who choose abortion may have the option of choosing between a medication or an aspiration termination, which we will discuss further later.
1st point: Be sure to ask the woman if she has any concerns.

2nd point: To provide referrals in a seamless manner, the nurse needs to know local referral resources. Have pamphlets and brochures available for:

A. adoption agencies
B. abortion services
C. prenatal care providers
D. counseling services (if not provided in your setting)

3rd point: Resources:


C. Resources and referrals for genetic counselors at March of Dimes: http://www.marchofdimes.com/pnhec/4439_15008.asp

D. A White Paper on Supporting Healthy pregnancies, Parenting, and Young Latinas’ Sexual Health http://www.latinainstitute.org/documents/NLIRH-
E. National Advocates for Pregnant Women
http://www.advocatesforpregnantwomen.org/ works to secure the human and civil rights, health and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable - low income women, women of color, and drug-using women.
Early pregnancy health concerns for any woman with an unintended pregnancy

- Does the woman have any immediate social concerns?
- Does the woman need nursing support or medical management for nausea of pregnancy?
- Screen for domestic violence.
- Screen for abdominal/pelvic pain with vaginal bleeding. If present, refer the woman for an immediate workup for a possible ectopic pregnancy.

1st point: If she complains of abdominal pain, spotting or bleeding along with a positive pregnancy test, she needs a workup for an ectopic pregnancy.

2nd point: Is she at risk for intimate partner violence? It is estimated that one in five women will be abused during pregnancy.) As homicide during pregnancy now surpasses the previous leading causes of death in pregnancy (automobile accidents and falls), (Chang, 2005) it is more important than ever that nurses know the signs and properly screen women for domestic violence.

A. Some 25 to 50 percent of adolescent mothers experience partner violence before, during, or just after their pregnancy (Leiderman & Almo, 2001).

B. Forty percent of pregnant women who have been exposed to abuse report that their pregnancy was unintended, compared to just eight percent of non-abused women (Hathaway et al, 2000).

C. Women experiencing abuse in the year prior to and/or during a recent pregnancy are 40 to 60 percent more likely than non-abused women to report high-blood pressure, vaginal bleeding, severe nausea, kidney or urinary tract infections and hospitalization during pregnancy and are 37 percent more likely to deliver preterm. Children born to abused mothers are 17 percent more likely to be born underweight and more than 30 percent more likely than other children to require intensive care upon birth (Silverman et al, 2006).

References:


Most adoption professionals today, whether agencies or private attorneys, are moving toward some degree of openness in their practice. It has been widely recognized that the completely closed adoptions that were the norm in years past have not lead to entirely healthy emotional outcomes either for adoptees or birthmothers. Openness in adoption can range from simply sharing information prior to placement between the birthmother and adoptive family, to arrangements in which birthmothers choose the adoptive family and maintain ongoing contact once the child is born. It is important that birthmothers work with agencies that support them in creating adoption plans and agreements that are noncoercive and fully explain her rights and the range of options available to her. Many women who say that they would never consider adoption are more open to the option when they are educated about their role in choosing a family and adoption arrangements in which they would have ongoing contact with the child.

Some women will speak to familial adoptions, in which a member of their family assumes legal rights of the child. While this may seem like an easier solution, referring these women to agencies who can help them navigate the legal and emotional nuances of this process is important.

Finally, many women associate “adoption” with foster care. Educating patients about their active role in choosing a family for their child and empowering them in acknowledging adoption as a responsible and loving parenting choice can help them differentiate adoption
plans from situations in which the state intervenes to terminate their parenting rights. For more information on this, contact Open Adoption & Family Services www.openadopt.org.
Language is powerful, and in our culture we often use negative language to talk about adoption even when we don’t realize it. *(Go through this list - what about each of these phrases sounds positive or negative? Emphasize that parenting should always be talked about as a lifelong decision, as in “parenting the child” rather than “keeping the baby”, just as adoption should always be discussed as a loving choice, as in “making an adoption plan” rather than a casual and detached decision, as in “giving the baby away.” Ask the audience - is there other language they can think of that may influence the dialogue about adoption without realizing it?)*
1st point: In 2001, (the most recent data available) the average charge for a surgical abortion at 10 weeks’ gestation was $468. The average cost for a medication abortion in 2001 in the US was $487.

Second trimester costs may rise to $1,000 or significantly more, depending on the procedure and health concerns. Providing abortions later in pregnancy is somewhat more complicated and thus more expensive. Some 74% of women pay for abortions with their own money; 13% of abortions are covered by Medicaid, and 13% are billed directly to private insurance. Some women who pay for the procedure themselves may receive insurance reimbursement later. (Henshaw et al, 2003).

Additional costs might result if abortion care is not available locally. These might include travel costs, costs for overnight stays, or lost wages in states requiring waiting periods between pre-abortion counseling and the abortion itself.

References:
Method of Abortion: Medication

Advantages:
- May offer more privacy
- Can occur in comfort of home
- Avoids instrumentation procedure

Considerations:
- Two medications: mifepristone administered in the office & misoprostol self administered at home.
- Takes 4-6 hours (on average, maybe longer) to complete abortion at home.
- If unsuccessful, requires f/u aspiration intervention.
- Currently used for abortions up to 9 weeks gestation.

1st point: Mifepristone followed by misoprostol is the most commonly used regimen for medication abortion in the U.S. Efficacy rates are 93-98% effective for this regimen. If the medication regimen is not effective, an aspiration abortion to is used to complete the procedure. Mifepristone is considered teratogenic (Creinin, 2009). Infection is extremely rare, less than 1% (Caitlin, 2004).

2nd point: Misoprostol is a type of synthetic prostaglandin which causes uterine contractions. Bleeding typically begins within one to four hours after administration with a typical time for completion of the abortion 6 to 9 hours. Bleeding will lessen after this time but may persist for 7-10 days. Occasional spotting may persist until the first menstrual period. Cramping may be heavier than a menstrual period and usually can be managed with NSAIDS or other oral analgesia (Moreno-Ruiz et al, 2007). If the woman does not pass the pregnancy tissue within the expected time frame, she may be given a second, or even several additional doses of misoprostol.

3rd point: Misoprostol is a safe medication with only a few medical contraindications. Contraindications include long-term corticosteroid use, chronic renal failure, anticoagulant use, inherited prophyria and allergy to the medication. Coagulopathies and severe anemia are contraindications for medication abortion with any regimen (Moreno-Ruiz et al, 2007) It has no known drug interactions. Side effects tend to be most commonly nausea, vomiting, chills, fever and diarrhea, all of which are dose dependent, i.e., more side effects at higher doses. Misoprostol’s side effects are generally self-limiting and do not pose a major threat to a woman’s health. The vaginal or buccal routes of administration are typically used as the efficacy rate of misoprostol is slightly reduced with the oral route.
Sublingual routes usually produce more side-effects than other routes, however a WHO study shows similar efficacy with both sublingual and vaginal routes (Schaff et all 2001, von Hertzen, WHO). Studies are underway both in this country and internationally to research the use of misoprostol alone to induce abortion. Misoprostol is frequently used in other areas of women’s health care. Although misoprostol is not FDA approved for ob/gyn indications, misoprostol is commonly used for labor induction, treatment of postpartum hemorrhage, cervical priming for gyn procedures such as IUD insertions for nulliparous women or hysteroscopy as well as first trimester abortions. It is also used for evacuating the uterus after a failed early pregnancy (miscarriage). The recommended regimen for prevention of postpartum hemorrhage is a single dose of 600 mcg misoprostol orally administered during the third stage of labor.

4th point: Methotrexate/misoprostol regimen: Methotrexate works by inhibiting DNA synthesis, which stops the division of cells that divide rapidly, such as those of a developing pregnancy. Methotrexate has been in use for cancer and arthritis treatment, as well as for the treatment of ectopic pregnancies for a number of years in the US. In recent years it has become more widely used for early pregnancy terminations. Since the FDA approval of mifepristone in 2000, methotrexate has become less common as a method for medication abortion. This is largely due to the fact that it is slightly less effective at 90-95%, and does not offer the same reliability in the timing of passage of pregnancy tissue as it can take longer for bleeding and passage of pregnancy tissue to occur. When it is used to induce an abortion, methotrexate is given as a one-time IM injection with the dose depending on a woman’s bodyweight. Three to 7 days after the methotrexate injection is given, misoprostol (800 micrograms) is administered vaginally, which causes the uterus to expel the POC at some point from hours to weeks later (Moreno-Ruiz, 2007). One benefit of a methotrexate abortion is that it is effective in ending ectopic as well as uterine pregnancies. Thus if a woman has a known or undetected ectopic, a methotrexate abortion can prevent complications that are associated with this condition. In some countries, where mifepristone has not been approved for medication abortion, methotrexate is the medication of choice.

References:


1st point: Vacuum aspiration is the most common type of procedure performed for pregnancy terminations and is the most common procedure performed in the U.S. (Paul et al, 2009). Vacuum aspiration can be performed via electric suction pump or manual vacuum aspiration (MVA). MVA, utilizing a small handheld syringe device, is widely used in resource poor countries. Its use is growing in the US for use with early pregnancy terminations. There is no clear gestational limit in which to use manual vs. electric aspiration. Some providers use to 9 weeks, others to 14 weeks. Current research suggests no differences in efficacy rates or patient satisfaction although some women prefer the “quietness” of the MVA(Paul et al, 2009).

2nd point: A medical and social history are performed to identify patients who are at high risk or ineligible for a procedure. A clinical (pelvic) exam and/or ultrasound is performed to be sure that the EGA correlates to the uterine size. Labs are performed to ensure that the woman is pregnant, that she is not anemic and that there is no infection present that could predispose her to post-abortion endometritis. In addition, women who are Rh negative are identified so that they can be given Rhogam.

3rd point: Pain during the procedure varies from person to person. It is usually compared to strong menstrual cramps. At a minimum, all women receive local anesthesia (usually lidocaine) via a paracervical block. In addition, in many facilities women are offered additional analgesia.
(and/or anti-anxiety) options, including agents that are administered orally or via IV. General anesthesia is offered in some settings, however because it increases the risk and cost of the procedure, it’s use is generally limited to special clinical situations.

References:
**1st point:** First trimester aspiration abortion is extremely safe. Infection rates range from 0.29% - 1.96% for first trimester procedures with ranges of 0.40% - 2.7% for second trimester procedures (Lichtenberg & Grimes, 2009). This makes abortion safer than tonsillectomy, appendectomy or childbearing. The biggest threat to safety is illegality. In places where it is illegal, it remains a leading cause of maternal death.

**2nd point:** Dilation and evacuation (or D&E) involves the additional use of forceps to remove the pregnancy. Advanced procedures involve one or more methods of dilating the cervix: 1) the use of medication, such as misoprostol to soften the cervix a few hours prior to the procedure, 2) the use of an absorbent material which is placed in the cervix (laminaria), where it swells as it draws moisture from the surrounding cervical tissue, causing the cervix to dilate. Laminaria is inserted a few hours or day(s) prior to the procedure, 3) with dilators that are tapered rods of increasing size. D & E (occasionally referred to as D&X) has been erroneously called “partial birth abortion” by groups opposed to abortion. This term partial birth abortion is a political term only and is not correct or customary medical terminology.

**3rd point:** Induction/instillation involves inducing labor through administration of medications. This procedure accounts for 0.4% of abortion procedures; most commonly used for late terminations for women with fetal anomalies.

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**Aspiration abortion procedures**

**Methods and timing:**

1. **Vacuum aspiration**  
   Up to 14-15 weeks

2. **Dilation and evacuation**  
   15-23 weeks

3. **Induction or instillation**  
   Used <1% of procedures, usually between 20-23 weeks

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U.S. (Jones, 2008). Some of the main reasons for later abortions include:
• Fetal anomalies discovered by genetic testing or ultrasound that are performed after 15 weeks gestation;
• Maternal medical problems that would worsen with full term pregnancy, such as heart disease.
• Late detection of pregnancy
• Delays in access caused by restrictive laws, including parental consent laws
• Difficulty getting money to pay for service

5th point: The cost of the procedure increases with gestational age.

References:
1st point: When a woman presents with a positive pregnancy test, some possible opening questions to ask are: How are you feeling about being pregnant? Did you expect this result, or are you surprised?

2nd point: In helping a woman consider her alternatives, you might ask her: Do you know what your choices are? Or What are your thoughts about adoption/becoming a parent/abortion?

3rd point: Encourage her to talk with her friends, family, or partner. It can be a red-flag if a patient tells you she has no one she can tell/talk to, as it may indicate a lack of social support/isolation. These clients may need more intensive follow-up.

4th point: The decision to have an abortion is time-sensitive. Abortion is possible until ~24 weeks, but it is safest if done by 12 weeks. Also, cost increases with gestational age, and many settings that provide abortions are not able to perform procedures after the first trimester. Follow-up may include scheduling additional visits for continued support with decision-making. If you do not realistically have time to do counseling, refer her to someone else for options counseling.
1st point: ANA Code of Ethics provides an ethical framework for nursing care and directs the nurse “to practice with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems”.


A. American College of Nurse Midwives (ACNM), 2005

“Code of Ethics” emphasizes conflict resolution, respect for human and reproductive rights, and midwives’ respect for their own dignity. Sharing of relevant information and seamless continuity of care are addressed.

B. American Nurses Association (ANA), 1989

Addresses the need for nurses to examine their conflicts arising from professional and personal values and resolve these in a way that ensures patient safety and preserves the professional integrity of the nurse (see “The Right to Accept or Reject an Assignment” statement for a discussion of potential conflicts related to moral, ethical, or religious views).

C. Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN), revised 1999

Nurses have the right, under responsible procedures, to refuse to assist in [. . .] abortion or sterilization procedures, in keeping with their personal moral, ethical, or religious beliefs.
Nurses have the professional responsibility to provide high quality, impartial nursing care to all patients in emergency situation, regardless of the nurses’ personal beliefs [. . .] and to provide nonjudgmental nursing care to all patients, either directly or through appropriate and timely referrals.

D. National Organization of Nurse Practitioner Faculties (NONPF), 2006
Acknowledges the need to prevent personal biases from interfering with the delivery of quality care to persons of differing beliefs and lifestyles.

References:
Additional resources

- www.roeresources.org
- Thank you to Grayson Dempsey of Backline for the ppt. slides on adoption.
- PPT updated Feb. 2014

Please contact us if you have any questions or feedback about the slide show at info@provideaccess.org