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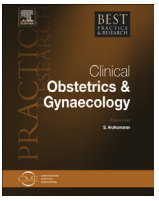

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Postabortal and postpartum contraception

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Healthcare providers often underestimate a woman' need for immediate effective contraception after an abortion or childbirth. Yet, these are times when women may be highly motivated to avoid or delay another pregnancy. In addition, starting the most effective long-acting reversible methods (i.e. the intrauterine device, intrauterine system or implants) at these times, is safe, with low risk of complications. Good evidence shows that women choosing long-acting reversible contraceptives at the time of an abortion are at significantly lower risk of another abortion, compared with counterparts choosing other methods. Uptake of long-acting reversible methods postpartum can also prevent short interpregnancy intervals, which have negative consequences for maternal and child health. It is important, therefore, that providers of abortion and maternity care are trained and funded to be able to provide these methods for women immediately after an abortion or childbirth.

Postabortal contraception

Provision of effective contraception immediately after an abortion is important, as many women are highly motivated to use an effective method and avoid another unintended pregnancy at this time. Women's need for effective contraception immediately after an abortion has been largely underestimated by healthcare professionals. Good evidence shows that more than one-half of women will

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have resumed sex within 2 weeks after an abortion [1]. In one study, as many as 15% of women had resumed sexual intercourse within 1 week of taking mifepristone for early medical abortion; a time when they are still bleeding [1]. Studies have shown that more than 80% of women ovulate in the first cycle after an abortion. Therefore, they are at risk of another pregnancy if they resume unprotected sexual intercourse [2,3].

Access to contraception at the time of an abortion may also be convenient for women, as it avoids another visit to a healthcare provider. Indeed, good evidence shows that up to 50% of women do not attend a scheduled follow-up appointment after an abortion [4]. The need for an extra visit to have an intrauterine device (IUD) or intrauterine system (IUS) fitted has been shown to be a significant barrier to contraceptive uptake after an abortion [5]. The World Health Organization (WHO) has issued recent guidance advising that all methods of contraception can be started immediately at surgical or medical abortion (Table 1) [6].

Healthcare providers should, therefore, discuss future contraception with women before an abortion, so that a plan can be made for starting a suitable contraceptive method after the procedure. The abortion assessment visit, when the woman attends requesting an abortion, is an excellent opportunity to provide accurate information to women about contraceptive methods and dispel any misconceptions that they may have. Contrary to concerns that women may be too distressed or overloaded with information at this time, it has been show that women value the opportunity to discuss future contraception at this visit [7]. In addition, provision of information on post-abortal contraception via an audiovisual DVD can help to educate women about their options and free up time during the consultation to discuss specific contraceptive concerns [7].

Use of long-acting reversible contraceptives after an abortion

It is increasingly being recognised that healthcare professionals should be promoting the most effective long-acting reversible methods of contraception (LARC); namely the IUD, IUS and implant. These methods have been shown to prevent more unintended pregnancies for women and further reduce unintended pregnancies in women who have already had an abortion [8]. Global evidence shows that immediate insertion of an IUD or IUS after an abortion can reduce the risk of a woman having a further abortion [9–14]. Evidence from the UK and USA also shows that immediate uptake of the contraceptive implant at medical or surgical abortion significantly reduces the risk of further abortion [14,15]. The IUD and IUS can safely be inserted intra-operatively at surgical abortion or, for women undergoing a medical method of abortion, it can be inserted when it is reasonably certain that they are no longer pregnant [6]. Healthcare professionals can be reassured that insertion immediately after an abortion is safe and associated with a low risk of complications [16,17].

A randomised-controlled trial (RCT) from the USA of more than 500 women (less than 9 weeks gestation) having either immediate insertion of an IUD or IUS after surgical abortion or delayed insertion (2–6 weeks later), showed that women in both groups had a similar low complication rate [17]. In particular, no perforations occurred, rates of pelvic infection were low (2%), and expulsion rates in both groups were similar (about 5%) at 6 months. The only unintended pregnancies ($n = 5$) that occurred were among women randomised to delayed insertion who failed to attend for this [17].

Table 1
Medical eligibility criteria for contraception after abortion (Adapted from the WHO MEC 2009).

Abortion	Combined hormonal contraception (pill, patch, ring) MEC	Progestogen only (pill, injectable, implant) MEC	Intrauterine system MEC	Intrauterine device MEC	Condom diaphragm MEC
First trimester	1	1	1	1	1
Second trimester	1	1	2	2	1
Septic abortion	1	1	4	4	1

MEC, medical eligibility criteria; MEC 1, condition for which there is no restriction of the contraceptive method; MEC 2, condition where the advantages of using the method generally outweigh the theoretical or proven risks; MEC 3, condition where the theoretical or proven risks generally outweigh the advantages of using the method; MEC 4, condition which represents an unacceptable health risk if the contraceptive method is used.

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