

Post-abortion contraceptive prevalence rate as a sexual and reproductive health indicator

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Globally, roughly 73 million abortions occur each year and the majority occur in low- and middle-income countries.¹ Post-abortion contraception is part of post-abortion care. It involves contraceptive counseling and provision to increase contraceptive prevalence and reduce unintended pregnancies and unsafe abortion.² Data indicate that women can begin ovulating as soon as 2 weeks post-abortion, with 75% of women restarting ovulation within 6 weeks after an abortion. Rapid return to fertility coupled with high rates of resumption of sex post-abortion indicates the need for early contraceptive counseling and access.²

We propose adoption of an indicator useful for measuring utilization of person-centered post-abortion contraceptive methods to understand gaps in care and inform resource allocation. This indicator would be relevant at all levels of the health system (national and sub-national) to assess the coverage of post-abortion contraceptive services. Preferences for post-abortion contraceptive methods can be tracked and related to continuation and contraceptive failure rates as done with the current World Health Organization (WHO) essential indicator for contraceptive prevalence rate (CPR), which is defined as the percent of women of reproductive age (15–49 years) who are using (or whose partner is using) a contraceptive method at a particular point in time.³

We define post-abortion CPR (modern contraception) as the percent of women of reproductive age (15–49 years) who are using (or whose partner is using) a contraceptive method within 2 weeks after an abortion. The numerator is the number of women of reproductive age at risk of pregnancy who are using (or whose partner is using) a contraceptive method within 2 weeks after an abortion. The denominator is the number of women of reproductive age at risk of pregnancy within 2 weeks after an abortion. Definitions of *contraceptive methods* and *populations at risk of pregnancy* are analogous to the CPR per WHO essential indicators.³

Calculating the denominator (the number of reproductive age at risk of pregnancy within 2 weeks after an abortion) will assume, similar to the assumptions used to calculate the denominator of the CPR, that women with a uterus who are sexually active are at risk of pregnancy. Although a proportion of women may not have regained fertility within this time frame post-abortion, it can be reasonably assumed that women meeting these eligibility criteria will ultimately and very rapidly be at risk of pregnancy and will benefit from contraception during this time frame to prevent unintended pregnancy.

Note that the current convention in the calculation of CPR is to base this calculation on women who are married or in a sexual union. Basing the prevalence estimate for our proposed indicator on women in such relationships would greatly undercount a considerable proportion of women and is *not* suggested for our proposed indicator.

Given what is known about rapid return to fertility and resumption of sexual activity, this indicator is designed to capture method uptake within 2 weeks post-abortion as this is a critical time period in which the need for non-coercive contraceptive counseling and uptake is highest. We recognize that method uptake after this priority time frame, for example, at 4 weeks, may also be of interest.

As with CPR, the Demographic Health Surveys (DHS) or other representative population-based surveys of the intended population can provide data for this proposed indicator that could be supplemented with smaller-scale

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program-level data interrogation. We recommend that data collection methods, periodicity of the data collection methods, data quality, and disaggregation by type of contraceptive method and age be conducted in a manner analogous to the collection of the current WHO essential indicator for CPR.³

Several limitations to existing data sources and methods should be noted. First, estimates of current use of contraceptive methods from population-based surveys depend on respondents correctly reporting the use of different methods, and the most robust current methods of obtaining information on contraceptive use do not allow for tracking the use of more than one method. In addition, given the logistical and financial challenges with collecting national or sub-national indicators for monitoring, the proposed indicator does not capture important considerations such as method interest (e.g. method desired vs actual uptake) or satisfaction after uptake. Finally, though self-reported abortion is currently the main source of nationally representative data on induced abortion, the literature has consistently found that self-reported induced abortion is underreported.^{4,5} A recent study⁶ found evidence that stigma leading to underreporting of abortion in DHS is present regardless of abortion legality. This study suggested that interviewer effects (i.e. the effect of interviewer skills, beliefs, and personal characteristics) may impact reporting accuracy and that increased efforts to recruit interviewers with certain characteristics and enhance the standardization and quality of their training could improve collection of stigmatized sexual and reproductive health data, including abortion, via the DHS.⁶ Self-reported abortion and method uptake post-abortion may also be subject to recall bias.

The adoption of contraceptive methods must be based on contraceptive autonomy and completely voluntary.⁷ Voluntary choice means that decisions to adopt contraception are made freely and not coerced (e.g. by being offered incentives or otherwise pressured to adopt or not adopt a method). Ideally, the adoption of contraceptive methods is also based on informed choice, meaning that users know about the use, benefits, and risks of contraceptive methods. Person-centered approaches such as shared decision-making rely on providers' understanding of client preferences and provision of unbiased information that is respectful of and tailored to those preferences. Sudhinaraset et al have proposed a conceptual model for person-centered reproductive health equity that incorporates societal measures, health-seeking behaviors, and facility quality⁸ while Dehlendorf et al have recently proposed a four-item person-centered contraceptive counseling scale which measures provider respect for patients, provision of information, elicitation of patient preferences for contraception, and fulfillment of patient preferences.⁹

Existing measures that could be used in conjunction with our proposed indicator to evaluate patient centeredness

include two "Women's Empowerment" measures included in current DHS surveys—(1) Women's informed decision-making for reproductive health care and (2) Women's level of informed decision-making for contraceptive use¹⁰—and four "Family Planning: Informed choice" measures included in current DHS surveys—(1) Users informed about side effects, (2) Users informed what to do if experienced side effects, (3) Users informed about other methods, and (4) Users informed that sterilization is permanent. Ideally, our proposed indicator would be viewed as a post-abortion-specific measure of CPR that would be interpreted in the context of such person-centered measures. Additional questions which could provide a more nuanced view of the post-abortion method use indicator include the timing of method uptake by method type, reasons for method use and non-use, and time until resumption of sexual activity post-abortion.

Post-abortion contraception is a critical part of post-abortion care. Measuring and evaluating post-abortion contraception uptake would provide an invaluable indicator of countries' progress in providing quality post-abortion contraception services to increase contraceptive prevalence and reduce unintended pregnancies and unsafe abortion. There are existing measures of voluntary and shared decision-making for family planning that could be used to evaluate our proposed indicator.

Declarations

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Author contribution(s)

Kristin M Wall: Conceptualization; Writing – original draft; Writing – review & editing.

Eva Lathrop: Conceptualization; Writing – review & editing.

Lisa B Haddad: Conceptualization; Writing – review & editing.

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