

Contraception Following Abortion

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I. INTRODUCTION

Every contraceptive method is efficient and safe when followed by abortion procedures immediately and medically suitable for the patient. Offering a contraceptive option directly following a spontaneous or induced abortion may help patients achieve the desired outcomes for their reproductive health and lessen the stress of numerous appointments. Counseling and methods for contraception should be offered to all patients experiencing an abortion that is spontaneous or induced. The right of the patient to choose to delay or decline the procedure is to be protected. Being aware of the specific limitations that every patient could encounter is essential in providing patient-centered care. We look at the different methods of contraception available following an abortion that is surgical or medical.

The use of effective contraception that is reversible following an abortion is acknowledged as such by the World Health Organization¹ as an essential element of integrated care. Ovulation can happen within eight days after the abortion² three, and over fifty percent of women are reported to return to sexual activity in the two weeks after having an abortion; prompt initiation of a successful contraceptive method is crucial.

II. METHODOLOGY

It is the world health organization's (WHO) medical requirements for the use of contraceptives specify that the use of hormonal methods that are combined (pills patches, vaginal rings, injectable contraceptives) and progestin-only pills could be started immediately following an abortion [55]. The process involved during a surgical or medical first-trimester abortion, which includes bleeding after abortion, is not affected by the prompt initiation of any contraceptive methods. Additionally, using these methods did not result in any more negative or unfavorable vaginal bleeding outcomes, nor in any significant clinical change in the coagulation parameters, compared to women who were using an IUD that was placebo-based, copper-based, which is a non-hormonal contraceptive, or who waited for the initiation the use of contraceptives combined with oral (COCs) [6], [7] [8], [9] [10][11][12], and [13]. So, these techniques can be used and should be initiated on the same day that misoprostol can be used to induce medical abortion, or at the time of surgery in the case of surgical abortion, or on the day of discharge from the hospital following treatment of incomplete abortion or

spontaneous abortion. A possible exception is a vaginal ring. There is limited evidence on initiating the use of the vaginal contraceptive ring immediately following a first-trimester medical or surgical abortion; however, no serious adverse events and no infection related to the use of the ring were found during three follow-up cycles after an abortion [14]. However, if bleeding is heavy, insertion of the ring may be delayed, but for no longer than five days. If the delay exceeds five days, a backup with barrier methods of contraception is recommended.

Implants are typically inserted right following the first-trimester surgical abortion, though most studies of implants focus on the levonorgestrel (LNG)-releasing implants [15][16] and [17].

The WHO's medical eligibility guidelines state that IUDs are inserted after the first trimester, spontaneous abortion, or even induced [55]. It is crucial to remember that all studies of the post-abortion insertions cited by WHO are restricted only to surgery evacuation and surgical abortion without any data regarding medical abortions [18] [19] [20] [21]and [22].

There was no difference in the chance of complications between an immediate and delayed insertion of an IUD following surgery. In addition, no differences were discovered in terms of safety or the rate of expulsion after the post-abortion insertion of the LNG- IUS as compared to IUDs made of copper [23] [24]. If there is abortifacient septicemia, IUDs should not be placed till the patient has had the condition treated successfully. In such cases, alternative methods of contraception should be considered in the interim.

In certain studies, a greater expulsion rate was found when the insertion was immediately following the abortion of an IUD compared to delayed placement [25] and [26] [27]. However, the rapid insertion can increase the percentage of women receiving the IUD.

The possibility of IUD removal when the device is placed after a surgical abortion or uterine expulsion increases by gestational duration and the size of the uterus. The chance of being expelled is higher for women when their IUD is implanted after a second- trimester abortion compared to an abortion that occurred in the first trimester [27] or [28].

It has also been shown that an IUD can be inserted as soon as expulsion has been confirmed in cases of medical abortion [29], [30], [31]. Expulsion rates were no higher if the IUD was inserted one week after medical abortion or during a 3–4-week post-abortion follow-up visit [31]. In addition, no connection was observed between the thickness of the endometrium or ultrasound results and the expulsion [31]. Furthermore, the earlier installation

of the LNG-IUS lowered the duration of bleeding that was heavy following an abortion medically prescribed [31].

Injectable contraceptives with only progestin (DMPA or norethisterone) can be administered immediately after a medical, surgical, and spontaneous abortion [32] [33] [34].

Although DMPA is often used with abortion or post-abortion treatment, no studies have been published regarding the beginning of the contraceptive procedure before the day of misoprostol's administration in the case of medical abortion.

Concerning sterilization, The WHO's medical eligibility requirements stipulate that the procedure can be performed following an uncomplicated abortion. However, it must be avoided in the event of any complications [55]. However, regret following sterilization is more prevalent for younger women and men (less than 30 years old age) [34], [35], (36) and when sterilization is done after delivery in the initial year following the birth [36]. According to these research findings, sterilization should not be routinely done when an abortion is performed among young women. Still, other options for appropriate, safe contraception must be provided, and, in actuality, it is essential to have them available when abortion services are offered.

Barrier methods can be started at any time, but per WHO medical eligibility guidelines, diaphragm, diaphragm, and cap are not suitable for use until six weeks following an abortion in the second trimester [5].

When there is a possibility of transmitting an infection transmitted by sexual contact (STI) as well as HIV, the use of dual protection should be considered, including the use of condoms and a more effective contraception method. The emergency contraceptive pill should be given to women relying on less efficient ways.

Natural family planning methods cannot be used until the menstrual cycle is back.

III. CONCLUSION

The treatment of pregnant women seeking termination of their pregnancy and abortion that is incomplete is not comprehensive or effective if family planning counseling and the supply of a reliable contraceptive method are not integral components of the treatment. We must never forget that most women have decided to have a child shortly. If they conceive again, there is a likely chance that their pregnancy could result in another abortion that is either safe or unsafe, based on their legal rights and available abortion facilities within the country where they reside.

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