Induced abortion is extremely safe in countries where the procedure is legal and performed by trained professionals under appropriate conditions. However, in countries with restrictive abortion laws, such as the Democratic Republic of the Congo (DRC), women often obtain unsafe abortions that can result in severe complications, including death. In this issue of *International Perspectives on Sexual and Reproductive Health*, Akinrinola Bankole and colleagues follow up on previously published estimates of the annual numbers of induced abortions and related complications in the DRC's capital of Kinshasa with the first comprehensive assessment of the severity and treatment of such complications among women seeking postabortion care at Kinshasa health facilities in 2016. They report that approximately three out of five postabortion care patients had experienced moderate or severe morbidity, such as infection (with or without a fever), organ failure or shock. In addition, women's complications were often treated by midlevel providers using outdated methods, and few women received medication for pain. Together, these findings point to unsafe abortion as being a major problem in Kinshasa—and one that the city's fragile health system is struggling to manage. To address the problem and, in turn, reduce maternal morbidity and mortality, the authors recommend intensifying efforts to promote contraceptive use, improving provision of postabortion care and reviewing the current legal restrictions on safe abortion.

Also in This Issue

- Adolescent childbearing is known to be associated with adverse reproductive health outcomes, and youth who experience multiple pregnancies in the space of only a few years are especially vulnerable to such outcomes. Using 2011 Uganda Demographic and Health Survey data from married and cohabiting women aged 15–22 with at least one previous pregnancy, Holly McClain Burke and colleagues find that nearly three-quarters had experienced a rapid repeat pregnancy—principally defined as a pregnancy occurring within 24 months of a prior pregnancy, abortion or miscarriage. The likelihood of experiencing a rapid repeat pregnancy was greater among rural women, as well as among those who waited longer to get married or to have children after getting married. The authors suggest that interventions to address rapid repeat pregnancy should target women during antenatal care and after their first birth, and women living in rural areas.
- Private health care providers in South West Nigeria often restrict women's contraceptive options, not on the basis of the scientific evidence, but because of personal bias regarding women's marital status. According to a study by Maia Sieverding and colleagues that utilized mystery client visits and in-depth interviews, providers tended to recommend that young unmarried clients use shorter-acting methods, such as condoms and emergency contraception, while recommending that older married clients use longer-acting methods, such as the injectable and IUD. Providers often explained restricting method choice in terms of protecting younger women from damaging their fertility. To address provider bias, the authors suggest that interventions should include "topics such as fears of inadvertently doing clients harm and societal pressures that may make providers reluctant to offer the full array of contraceptives to young women."
- Safer-conception counseling—designed to help people with HIV conceive while minimizing the risk of transmission—is rarely available in low-income countries. To explore the benefits and challenges of delivering such counseling in resource-poor settings, Deborah Mindry and colleagues interviewed HIV-positive clients and uninfected partners who had taken part in a safer-conception intervention at a Ugandan HIV clinic. Participants learned about two methods of safer conception, timed unprotected intercourse and manual self-insemination, and how to use them. Most couples chose timed unprotected intercourse as their method of safer conception; seven had successful pregnancies, and no uninfected partners seroconverted. Nearly two-thirds of participants reported that the counseling was an empowering experience, and that it helped them to make informed choices about childbearing and to understand how to stay healthy while trying to conceive; however, engaging partners in the counseling often proved difficult. The authors recommend that policymakers consider including safer-conception counseling as part of routine HIV care, but caution that clinical trials are needed to determine whether clients use safer-conception methods correctly and to determine rates of pregnancy and transmission.

—*The Editors*