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Guideline

Society of Family Planning clinical recommendations: contraception after surgical abortion

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ABSTRACT

These recommendations present an evidence-based assessment of provision of contraceptives at the time of surgical abortion. Most methods of contraception, including the intrauterine devices (IUD), implant, depot medroxyprogesterone injection, oral contraceptive pill, contraceptive patch, monthly vaginal ring, barrier methods and some permanent methods, can be safely initiated immediately after first- or second-trimester surgical abortion. Provision of postabortion contraceptives, particularly IUDs and implants, substantially reduces subsequent unintended pregnancy. IUD insertion immediately following uterine aspiration is safe. While this may be associated with a higher risk of device expulsion than with interval placement, expulsion rates remain low, and this risk must be weighed against the fact that patients often do not receive their desired IUD at an interval insertion and therefore experience higher rates of subsequent unintended pregnancy. Many patients experience barriers that prevent access to the full spectrum of postabortion contraceptive options, particularly IUDs and implants. Advancements in health-systems-based point-of-care provision and policies are needed to improve comprehensive contraceptive availability following surgical abortion. These recommendations will address clinical considerations for postabortion contraceptive provision and recommend interventions to improve contraceptive access following uterine evacuation.

Background

Ovulation can occur as early as 10 days after surgical abortion [1], and more than 80% of women ovulate within 1 month of a first-trimester surgical abortion [2]. Fifty-one percent of women report having intercourse within 2 weeks after an abortion [3]. Since both ovulation and sexual activity resume quickly, women should be offered the opportunity to discuss contraception if they wish to avoid future pregnancy [4–6]. Women with one unintended pregnancy are at risk for a subsequent unintended pregnancy; subsequent abortion accounts for 45% of all abortions in the United States [7], between 20% and 60% of abortions in the European Union [8,9] and 50% in parts of Asia [10]. Women seeking a subsequent abortion are as likely as [11] or more likely than [12,13] women seeking a first abortion to have been using a contraceptive method at the time of conception but are more likely to have used less-effective methods or to have used their method inconsistently [14,15].

The abortion visit is an optimal time to initiate use of effective contraceptives. The provider can be sure that a woman who has had a surgical abortion is no longer pregnant once uterine evacuation is complete and products of conception are confirmed in the evacuated tissue. The woman, after experiencing an unintended pregnancy resulting in abortion, may feel an urgent need to avoid a subsequent pregnancy and to leave her abortion appointment with a contraceptive method [16,17]. Many women prefer to receive contraceptive services in the reproductive care setting of abortion clinics rather than at other health care facilities [16]. For women who do not regularly seek or have access to gynecologic or preventive health services, the abortion visit may be one of their only interactions with the health care system and an important opportunity to discuss contraception. Thus, abortion care providers are uniquely positioned to offer counseling on and provision of contraceptives, and these services should be integrated into the surgical abortion counseling and visit. These recommendations provide the evidence for incorporation of contraceptive counseling and provision into the context of first- and second-trimester surgically induced abortion.

Clinical questions

1. How should contraceptive counseling be performed at the time of abortion?

Contraceptive education and counseling should be integrated into the abortion care of women who would like to prevent pregnancy

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