ACOG
The American College of Obstetricians and Gynecologists

ACOG COMMITTEE OPINION

Number 833

Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the Contraceptive Equity Expert Work Group in collaboration with Sarah Horvath, MD, MSHP and committee member Serina Floyd, MD, MSPH.

Access to Postabortion Contraception

ABSTRACT: All contraceptive methods are safe and effective when provided immediately after abortion procedures and when otherwise medically appropriate for a patient. Providing a contraceptive method immediately after an induced or spontaneous abortion can help individuals achieve their desired reproductive outcomes and minimize the burden of multiple appointments. Contraceptive counseling and methods should be made available to all patients who experience induced or spontaneous abortion, and the patient's right to decline or postpone this care should be respected. Recognizing the individual barriers that may exist for each patient is important to providing patient-centered care. It also is important to understand the history of reproductive rights abuses, including contraceptive coercion and forced sterilization, in the United States. Ultimately, clinicians should focus on providing access to counseling and, ideally, providing all methods of contraception, while recognizing that each patient is unique.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions for obstetrician–gynecologists and other clinicians to improve access to postabortion contraception:

- Contraceptive counseling and methods should be made available to all patients who experience induced or spontaneous abortion, and the patient's right to decline or postpone this care should be respected.
- Recognizing the individual barriers that may exist for each patient is important to providing patient-centered care. Patients may have difficulty accessing health care for many reasons, including distance to health care facilities, work constraints, caregiving responsibilities, inadequate or no insurance, unreliable transportation, and language barriers. These challenges can affect access to interval placement or removal of long-acting reversible contraceptives (LARC), repeat visits for depot medroxyprogesterone acetate (DMPA) administration, and pharmacy visits to obtain refills of short-acting methods.
- It is important to understand the history of reproductive rights abuses, including contraceptive coercion and forced sterilization, in the United States. Recognition of one's own biases around induced and spontaneous abortion, pregnancy spacing, and cultural stereotypes is crucial to avoid coercive behaviors, such as clinician pressure for a patient to leave with a contraceptive method that day, pressure to use a specific method such as a LARC, or expression of judgment about the patient's decision to have an abortion.
- Obstetrician–gynecologists and other clinicians should remain current in their knowledge of all methods of contraception.
- Logistical barriers should be minimized to improve patient access to chosen contraceptive methods after induced and spontaneous abortion.
- Continuity of care can be improved by offering management of induced and spontaneous abortion and the full range of contraceptive methods within a practice, or by creating pathways for streamlined referral and follow-up for patients who need such care.
- All contraceptive methods are safe and effective when provided immediately after abortion procedures and when otherwise medically appropriate for a patient.

Background

The postabortion period is a safe and efficient time to initiate contraception for individuals who wish to delay or avoid a subsequent pregnancy. Eighty-three percent of women will ovulate within one month of an induced or spontaneous abortion, and in one study, 51% of participants reported having intercourse within two weeks after an abortion (1–4). Providing a contraceptive method immediately after an induced or spontaneous abortion can help individuals achieve their desired reproductive outcomes and minimize the burden of multiple appointments. Contraceptive counseling should be offered, and immediate provision of all contraceptive methods should be made available, when possible, to any patient interested in contraceptive care in this setting.

Clinicians should recognize that some people do not desire contraceptive counseling, but they may still desire *contraception*. In one study of patients having induced abortions, 70.8% wanted to leave the visit with a contraceptive method in place; however, only 30.8% wanted contraceptive counseling (5). More than half of women who did not want counseling indicated that their reasons included already knowing which method they wished to use (5). A patient may decline the conversation, but still wish to leave the clinical encounter with their preferred contraceptive method. Care may be improved by simply asking the patient beforehand if they have a preferred contraceptive method in mind or if they want to discuss contraception. Questions that allow patient preferences to guide the discussion disrupt the traditional power differential in clinical settings. If patients do have a method in mind, discussion of risks and benefits is appropriate. Alternative models for counseling, such as offering telephone consultation before the day of the abortion appointment, may improve patients' experiences (6, 7).

Identifying the individual reproductive goals of each patient is important. Not all patients who have an induced abortion wish to initiate contraception, and not all patients who experience spontaneous abortion wish to become pregnant again in the near future. Forty-four percent of patients with spontaneous abortion have pregnancies that are unwanted or mistimed, similar to rates in the general population of pregnant individuals (8). This finding, combined with a lack of clarity about optimal pregnancy spacing after pregnancy loss; receipt of care in a variety of settings, including emergency departments; and rapid return to fertility highlight the importance of addressing contraception using a patient-centered approach (8). Contraceptive counseling and methods should be made available to all patients who experience induced or spontaneous abortion, and the patient's right to decline or postpone this care should be respected. For those seeking to delay or avoid pregnancy, obstetrician–gynecologists should provide access to the full spectrum of medically-appropriate contraceptive methods at the abortion care visit, including in the hospital setting.

Immediate Postabortion Contraception is Safe and Effective

The U.S. Medical Eligibility Criteria (U.S. MEC) for Contraceptive Use lists all methods as Category 1 after first trimester abortion unless the abortion is complicated by sepsis, in which case intrauterine devices (IUDs) become Category 4 (9). Intrauterine devices should not be placed for those with active infections (9,10). Expulsion rates for IUDs placed immediately after second trimester abortion are slightly higher than in the first trimester, but this option remains U.S. MEC Category 2 and thus benefits outweigh risks for this method in this setting (11). Among 575 women undergoing first trimester uterine aspiration for induced or spontaneous abortion who were randomized to immediate IUD insertion versus insertion at a return visit 2 to 6 weeks later, 6-month continuation rates were substantially higher in the immediate insertion group (92.3% v 76.6%) (12). In addition to continuation rates, method satisfaction also is high in women who receive immediate postabortion IUDs (13). Differences in expulsion rates should be a part of informed counseling, because insurance coverage and payment for replacement devices may be complicated in the setting of expulsion. (See the LARC Quick Coding Guide at www.acog.org/education-and-events/publications/larc-quick-coding-guide.) However, a modestly increased expulsion rate should not be a deterrent to offering IUD initiation immediately postabortion.

Patients who choose medical management of induced or spontaneous abortion can be offered most methods at the time of mifepristone administration. "Quick start" initiation of the implant does not interfere with mifepristone's efficacy, which means the implant can be offered at the same visit, as can all short-acting methods including emergency contraception (14). Intrauterine device placement should be deferred until medication abortion completion is confirmed (10). In a large study of patients who initiated DMPA injections at the time of medication abortion, those who received the injection on the day of mifepristone had a slightly increased risk of ongoing pregnancy over those who received the injection at the confirmation visit, but overall ongoing pregnancy rates were very low and there was no increased need for surgical intervention. Rates of repeat pregnancy and contraceptive use at 6 months were no different between the groups, but patients were more satisfied with quick start initiation on the day of mifepristone (15). Shared decision-making should be employed to determine the optimal timing of DMPA administration for each patient.

Immediate Postabortion Contraception as Patient-Centered Care

Recognizing the individual barriers that may exist for each patient is important to providing patient-centered care. Patients may have difficulty accessing health care for many reasons, including distance to health care facilities, work constraints, caregiving responsibilities, inadequate or no

insurance, unreliable transportation, and language barriers (16). These challenges can affect access to interval LARC placement or removal, repeat visits for DMPA administration, and pharmacy visits to obtain refills of short-acting methods. Patients are often satisfied with the convenience of receiving the contraceptive method of their choice immediately after induced or spontaneous abortion. Providing this care together decreases the number of touch points with the health care system, which is advantageous for many reasons, including during a public health crisis. Patients with limited access to care may particularly benefit from efficient provision of contraceptive care. In one study of 1,662 women provided with no-cost contraceptives immediately after abortion, 64.5% chose a LARC method and 35.5% chose short-acting methods (17). The women who chose LARC methods were younger, more likely to live more than 70 miles from the clinic, and more likely to have a nonurban address than those women who chose shorter-acting methods (17). This study also showed that even when cost and accessibility barriers were removed, 18.8% of patients declined any method of contraception (17). Contraceptive care can be improved by providing a full year's prescription for the pill, patch, or ring in advance when these methods are chosen, and by advance provision of emergency contraception. If available, providing free condoms is good practice.

Counseling for Postabortion Contraception

Obstetrician–gynecologists and other clinicians should understand that the goal of counseling is not to promote uptake of contraception or any particular method, but rather to provide medically appropriate options while respecting patient autonomy, preferences, and the right to decline contraceptive care. Financial factors, preferred clinician, time constraints, and emotional capacity all may affect whether or not a patient opts for contraceptive counseling at the time of abortion care. Clinicians should use shared decision-making to ascertain the patient's reproductive and contraceptive desires. A patient-centered discussion about rapid return to fertility, access to contraception, risks and benefits of quick start methods, and access to services for subsequent removal for implants and IUDs respects patient autonomy. It is important to recognize that a patient's preference to delay conversations about contraception does not mean that contraception is not desired. It also is important to understand the history of reproductive rights abuses, including contraceptive coercion and forced sterilization, in the United States (18). Recognition of one's own biases around induced and spontaneous abortion, pregnancy spacing, and cultural stereotypes is crucial to avoid coercive behaviors, such as clinician pressure for a patient to leave with a contraceptive method that day, pressure to use a specific method such as a LARC, or expression of judgment about the patient's decision to have an abortion (19). Some patients experience repeated attempts at contraceptive counseling as "implicit pressure" to accept a method (20). Rates of discontinuation are higher in patients who feel pressured into accepting a method (21,22). Ultimately, clinicians should focus on providing access to counseling and, ideally, providing all methods of contraception, while recognizing that each patient is unique. Patient preference does not have to align with clinician values. Each conversation and its content should be driven by the patient's individual medical history and contraceptive desires.

Patient and Clinician Challenges to Immediate Postabortion Contraception

Many patients experiencing induced and spontaneous abortion will seek treatment at a location that may not be directly connected to their usual source of care, such as an emergency department, urgent care clinic, or family planning clinic. In the absence of continuity, patients receiving subsequent care for interval contraception in other settings may face obstacles, such as positive pregnancy tests that cause confusion, delays in accessing appointments, or undesired disclosure. Additionally, some patients will not have a usual source of primary, obstetric, or gynecologic care. This highlights the importance of immediate provision of contraceptive methods; referrals for other desired services; and, streamlined pathways to follow-up.

In a survey of abortion care clinics, 98% of clinics offer at least one nonLARC method and 76% offer any LARC method (23). The reasons for not offering all methods are multifactorial and include training gaps, financial burdens, stigma that isolates abortion care, policy restrictions, and restrictions on payment and insurance coverage. State and Federal restrictions on abortion care affect the ability of those who provide abortion care to sustainably offer contraceptive services by denying public funding, disincentivizing insurers to contract with practices that offer abortion, and enacting restrictive policies that force clinic closures (24). The Hyde Amendment, which restricts Federal funding for induced abortion except for reasons of rape, incest, or life-endangerment, creates complicated administrative barriers to providing evidence-based care that disproportionately affect patients with low incomes and lead to inequitable access. Advocacy to remove the Hyde Amendment and other restrictions on public and private insurance coverage for abortion care could increase access and decrease stigma by including abortion care as a covered service.

It can be difficult to navigate the increasing restrictions on both private and public insurance that further complicate the provision of abortion care. Depending on the patient's insurance coverage, payment for procedures and counseling may be lower when multiple services are offered during a single visit. In addition, patient-centered counseling requires time and is often undercompensated —it should be paid at an adequate rate.

Obstetrician–gynecologists and other clinicians should remain current in their knowledge of all methods of contraception. Logistical barriers should be minimized to improve patient access to chosen contraceptive methods after induced and spontaneous abortion.

Continuity of care can be improved by offering management of induced and spontaneous abortion and the full range of contraceptive methods within a practice, or by creating pathways for streamlined referral and follow-up for patients who need such care.

Conclusion

All contraceptive methods are safe and effective when provided immediately after abortion procedures and when otherwise medically appropriate for a patient. There are many barriers to accessing and providing efficient contraceptive care after induced and spontaneous abortion. Resources are available to provide obstetrician–gynecologists and other clinicians with training and capacity support to improve access to the full range of contraceptive methods immediately postabortion (see Postpartum Contraceptive Access Initiative (PCAI) at https://pcainitiative.acog.org/). Further, ACOG encourages obstetrician–gynecologists to advocate for policies that increase insurance coverage, reimbursement, and patient access to the full range of contraceptive methods at the abortion care visit.

References

1. Lähteenmäki P, Luukkainen T. Return of ovarian function after abortion. Clin Endocrinol (Oxf) 1978;8:123–32.
2. Schreiber CA, Sober S, Ratcliffe S, Creinin MD. Ovulation resumption after medical abortion with mifepristone and misoprostol. Contraception 2011;84:230–3.
3. Donnet ML, Howie PW, Marnie M, Cooper W, Lewis M. Return of ovarian function following spontaneous abortion. Clin Endocrinol (Oxf) 1990;33:13–20.
4. Boesen HC, Rorbye C, Norgaard M, Nilas L. Sexual behavior during the first eight weeks after legal termination of pregnancy. Acta Obstet Gynecol Scand 2004;83:1189–92.
5. Cansino C, Lichtenberg ES, Perriera LK, Hou MY, Melo J, Creinin MD. Do women want to talk about birth control at the time of a first-trimester abortion? Contraception 2018; 98:535–40.
6. Lohr PA, Aiken AR, Forsyth T, Trussell J. Telephone or integrated contraception counselling before abortion: impact on method choice and receipt. BMJ Sex Reprod Health 2018;44:114–21.
7. Roe AH, Fortin J, Gelfand D, Janiak E, Maurer R, Goldberg A. Advance notice of contraceptive availability at surgical abortion: a pilot randomised controlled trial. BMJ Sex Reprod Health 2018;44:187–92.
8. Flink-Bochacki R, Meyn LA, Chen BA, Achilles SL, Chang JC, Borrero S. Examining intendedness among pregnancies ending in spontaneous abortion. Contraception 2017;96:111–7.
9. Curtis KM, Tepper NK, Jatlaoui TC, Berry-Bibee E, Horton LG, Zapata LB, et al. U.S. medical eligibility criteria for contraceptive use. MMWR Recomm Rep 2016;65(RR-3): 1–103.
10. Long-acting reversible contraception: implants and intrauterine devices. Practice Bulletin No. 186. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e251–69.
11. Fox MC, Oat-Judge J, Severson K, Jamshidi RM, Singh RH, McDonald-Mosley R, et al. Immediate placement of intrauterine devices after first and second trimester pregnancy termination. Contraception 2011;83:34–40.
12. Bednarek PH, Creinin MD, Reeves MF, Cwiak C, Espey E, Jensen JT. Immediate versus delayed IUD insertion after uterine aspiration. Post-Aspiration IUD Randomization (PAIR) Study Trial Group. N Engl J Med 2011;364:2208–17.
13. Flamant A, Ouldamer L, Body G, Trignol-Viguier N. Rates of continuation and satisfaction of immediate intrauterine device insertion following first- or second-trimester surgical abortion: a French prospective cohort study. Eur J Obstet Gynecol Reprod Biol 2013;169:268–74.
14. Raymond EG, Weaver MA, Tan YL, Louie KS, Bousieguez M, Lugo-Hernandez EM, et al. Effect of immediate compared with delayed insertion of etonogestrel implants on medical abortion efficacy and repeat pregnancy: a randomized controlled trial. Obstet Gynecol 2016;127:306–12.
15. Raymond EG, Weaver MA, Louie KS, Tan YL, Bousieguez M, Arangure-Peraza AG, et al. Effects of depot medroxyprogesterone acetate injection timing on medical abortion efficacy and repeat pregnancy: a randomized controlled trial. Obstet Gynecol 2016;128:739–45.
16. White K, Portz KJ, Whitfield S, Nathan S. Women's postabortion contraceptive preferences and access to family planning services in Mississippi. Womens Health Issues 2020;30:176–83.
17. Fang NZ, Sheeder J, Teal SB. Factors associated with initiating long-acting reversible contraception immediately after first-trimester abortion. Contraception 2018;98:292–5.
18. Harris LH, Wolfe T. Stratified reproduction, family planning care and the double edge of history. Curr Opin Obstet Gynecol 2014;26:539–44.
19. Brandi K, Woodhams E, White KO, Mehta PK. An exploration of perceived contraceptive coercion at the time of abortion. Contraception 2018;97:329–34.
20. Gomez AM, Wapman M. Under (implicit) pressure: young Black and Latina women's perceptions of contraceptive care. Contraception 2017;96:221–6.
21. Kalmuss D, Davidson AR, Cushman LF, Heartwell S, Rulin M. Determinants of early implant discontinuation among low-income women [published erratum appears in Fam Plann Perspect 1997;29:60. Fam Plann Perspect 1996;28: 256–60.
22. Chang T, Moniz MH, Plegue MA, Shaffer KS, Vance HB, Gold KJ. Patient or clinician: duration of use of intrauterine devices based on who initiated discussion of placement. J Am Board Fam Med 2016;29:24–8.
23. White KO, Jones HE, Lavelanet A, Norman WV, Guilbert E, Lichtenberg ES, et al. First-trimester aspiration abortion practices: a survey of United States abortion providers. Contraception 2019;99:10–5.
24. Donovan MK. Postabortion contraception: emerging opportunities and barriers. Guttmacher Policy Rev 2017; 20:92–6.

Published online on July 22, 2021.

American College of Obstetricians and Gynecologists
409 12th Street SW, Washington, DC 20024-2188

Access to postabortion contraception. ACOG Committee Opinion No. 833. American College of Obstetricians and Gynecologists. Obstet Gynecol 2021;138:e91–95.