Post-Abortion Contraception, including Long-Acting Reversible Contraceptives

Approximately one in four pregnancies in the world end in an induced abortion each year, which translates to about 55 million abortions.[1] Abortions are needed for a range of reasons, including unintended pregnancy due to lack of access to contraception, failure of contraception, foetal anomaly, or because the pregnancy was a result of sexual assault. Clinical evidence suggests that fertility returns rapidly for women and girls who undergo an abortion. A woman or girl seeking an abortion may be interested in avoiding pregnancy, so provision of an abortion procedure offers an opportunity to discuss and offer contraception.[2,3]

Evidence and best practice consistently show that many women and girls find non-judgemental and sensitive contraceptive counselling appropriate at the time of an abortion.[4,5] Those who are counselled and offered a wide range of options for post-abortion contraception most often choose to initiate an effective method of contraception before leaving the facility.[2] This is especially important for women and girls who would like to start a long-acting reversible contraceptive (LARC) method, as many people who have an abortion and plan to come back for LARC methods tend not to return.[6,7] This remains true even in advanced health care systems and means that in contexts where access to LARC services is restricted, such failures to return could be a common occurrence. Hormonal contraception (implants) can be provided at the same time as mifepristone is taken during a medical abortion, without affecting the effectiveness of the abortion.[8]

FIGO position on the issue

FIGO recognises that post-abortion care is a critical reproductive health service. FIGO also recognises the importance of post-abortion contraception and the importance of offering contraceptive counselling and a wide contraceptive method mix to every woman and girl who desires it when seeking abortion care. Even where abortion is prohibited or restricted by law (leading to variable availability and quality of abortion services), there are no legal or regulatory restrictions on the provision of post-abortion contraception.

Post-abortion counselling and LARC uptake

While LARCs are the most effective and cost-effective reversible contraceptive options, their uptake is often lower than shorter-term contraceptives due to a variety of factors ranging from the availability of LARCS, to training and acceptance of the methods by providers and women and girls. Appropriate post-abortion contraceptive counselling and same-day initiation strategies can result in higher rates of LARC uptake.[9] Such counselling must address common misconceptions regarding the use of LARCs and their immediate initiation, while providing clear information that enables women and girls to understand the safety, convenience and differential failure rate with the typical use of short- and long-acting methods.

LARCs include all types of contraceptive implants, intrauterine devices (IUDs) and hormonal intrauterine systems (IUSs). A large body of evidence shows that they are the most effective methods of reversible contraceptives,[10] as well as the most cost-effective.[11] Furthermore, same-day initiation of a LARC (either on the same day as a surgical abortion or immediately after a medical abortion) has been associated with higher continuation and satisfaction and a lower rate of unwanted pregnancy within the first year of use.[12,13,14]

Importance of contraceptive options

Given that a subsequent pregnancy may not be wanted in the short term, health systems should be sure to offer a wide range of contraceptive options to women and girls on site following an abortion. For women and girls who want to wait more than a year to become pregnant again, LARCs should be offered as part of the method mix, given their safety and long-term effectiveness.

Contraceptive implants, IUDs and/or IUSs must be in the method mix offered to all those who obtain an abortion from a health care provider. In the case of medical abortion, implants must be available as a minimum, and in the case of surgical abortion, both immediate and delayed IUDs and IUS insertion must be made available. Providers should be trained in counselling and insertion of LARCs.

LARCs can be offered as post-abortion contraceptive options irrespective of the gestational age at which the abortion is carried out and should be offered irrespective of the age of the woman or girl. The possibility of getting LARCs removed prior to their full period of efficacy must be explained to each woman and girl, and service availability for LARC removal pointed out.

Consistent with good medical practice, the need for dual protection should be explained to all women and girls who accept a contraceptive method other than condoms. For condom users, the message should focus on correct and consistent use.

Flexibility in provision of services

For women and girls who select a medical abortion at home, arrangements should be made with the provider for post-abortion care, at which a range of appropriate methods should be offered. Similarly, for women and girls who would prefer to wait to begin contraception, arrangements should be made to support their interests and preferences through telemedicine systems, links with pharmacies, referral for outreach and connection with community health workers.

Women and girls must never be pressured, nor the abortion service provision made conditional to the acceptance of contraceptive counselling or adoption of method. Not only does this infringe on their rights, but the practice also gives health services and contraception a poor reputation among communities and may limit care-seeking efforts by others.

FIGO recommendations and commitments

FIGO urges all national member societies to:

- advocate for the availability of the complete range of method mix in their countries and the integration of contraceptive services in settings that provide abortion and post-abortion care
- include the subject of post-abortion contraception in all their future congresses, meeting and courses, with an emphasis on LARCs and appropriate human rights and evidence-based counselling, which must include the right to opt out of counselling.

FIGO commits to:

- work together with the World Health Organization (WHO), UNFPA, International Planned Parenthood Federation and other international organisations to produce a joint recommendation on the need to include post-abortion contraception as an important component of abortion care and heath care professionals' training
- periodically review practice guidelines of national member societies and public health systems to monitor the adoption of appropriate post-abortion care, including LARCs and other effective contraceptive options.

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About FIGO

FIGO is a professional organisation that brings together more than 130 obstetrical and gynaecological associations from all over the world. FIGO's vision is that women of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives. We lead on global programme activities, with a particular focus on sub-Saharan Africa and South East Asia.

FIGO advocates on a global stage, especially in relation to the Sustainable Development Goals (SDGs) pertaining to reproductive, maternal, newborn, child and adolescent health and non-communicable diseases (SDG3). We also work to raise the status of women and enable their active participation to achieve their reproductive and sexual rights, including addressing female-genital mutilation (FGM) and gender-based violence (SDG5).

We also provide education and training for our Member Societies and build capacities of those from low-resource countries through strengthening leadership, good practice and promotion of policy dialogues.

FIGO is in official relations with the World Health Organization and a consultative status with the United Nations.

About the language we use

Within our documents, we often use the terms 'woman', 'girl' and 'women and girls'. We recognise that not all people who require access to gynaecological and obstetric services identify as a woman or girl. All individuals, regardless of gender identity, must be provided with access to appropriate, inclusive and sensitive services and care.

We also use the term 'family'. When we do, we are referring to a recognised group (perhaps joined by blood, marriage, partnership, cohabitation or adoption) that forms an emotional connection and serves as a unit of society.

FIGO acknowledges that some of the language we use is not naturally inclusive. We are undertaking a thorough review of the words and phrases we use to describe people, health, wellbeing and rights, to demonstrate our commitment to developing and delivering inclusive policies, programmes and services.

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