CONTRACEPTION AND SAFE ABORTION CARE: KEY PRINCIPLES

Dr. Cristina Nebunescu
Dr. Ann Rothman

FMF
Family Medicine Forum
Forum en médecine familiale

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

NOVEMBER 5-8, 2025
RBC CONVENTION CENTRE WINNIPEG, MB

PRESENTER DISCLOSURE

Presenter: Dr. Cristina Nebunescu

Relationships with financial sponsors:

- **Any direct financial relationships, including receipt of honoraria:**

  Not Applicable

- **Membership on advisory boards or speakers' bureaus:**

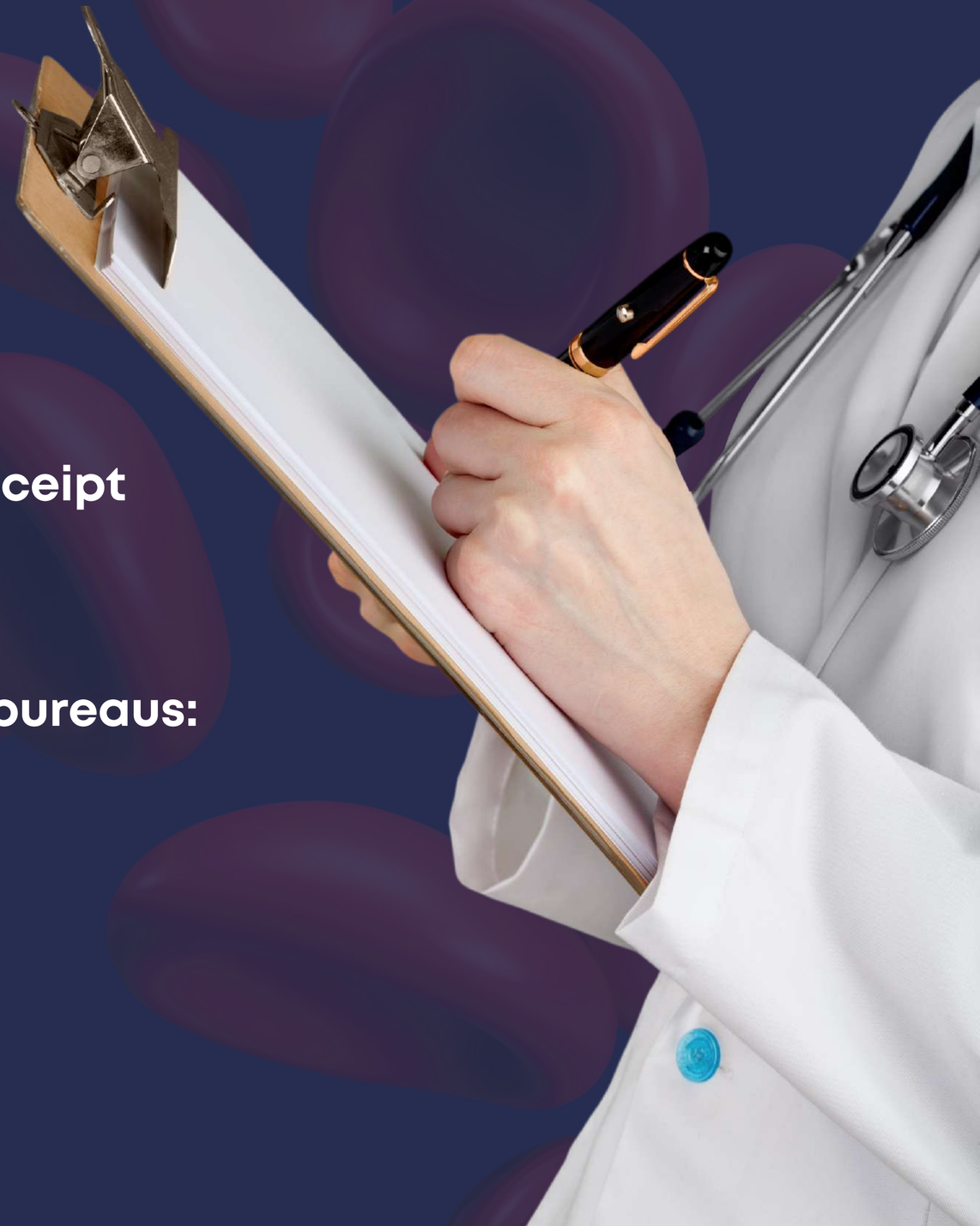
  Not Applicable

- **Patents for drugs or devices:**

  Not Applicable

- **Other:**

  Not Applicable



PRESENTER DISCLOSURE

Presenter: Dr. Ann Rothman

Relationships with financial sponsors:

- **Any direct financial relationships, including receipt of honoraria:**

  Not Applicable

- **Membership on advisory boards or speakers' bureaus:**

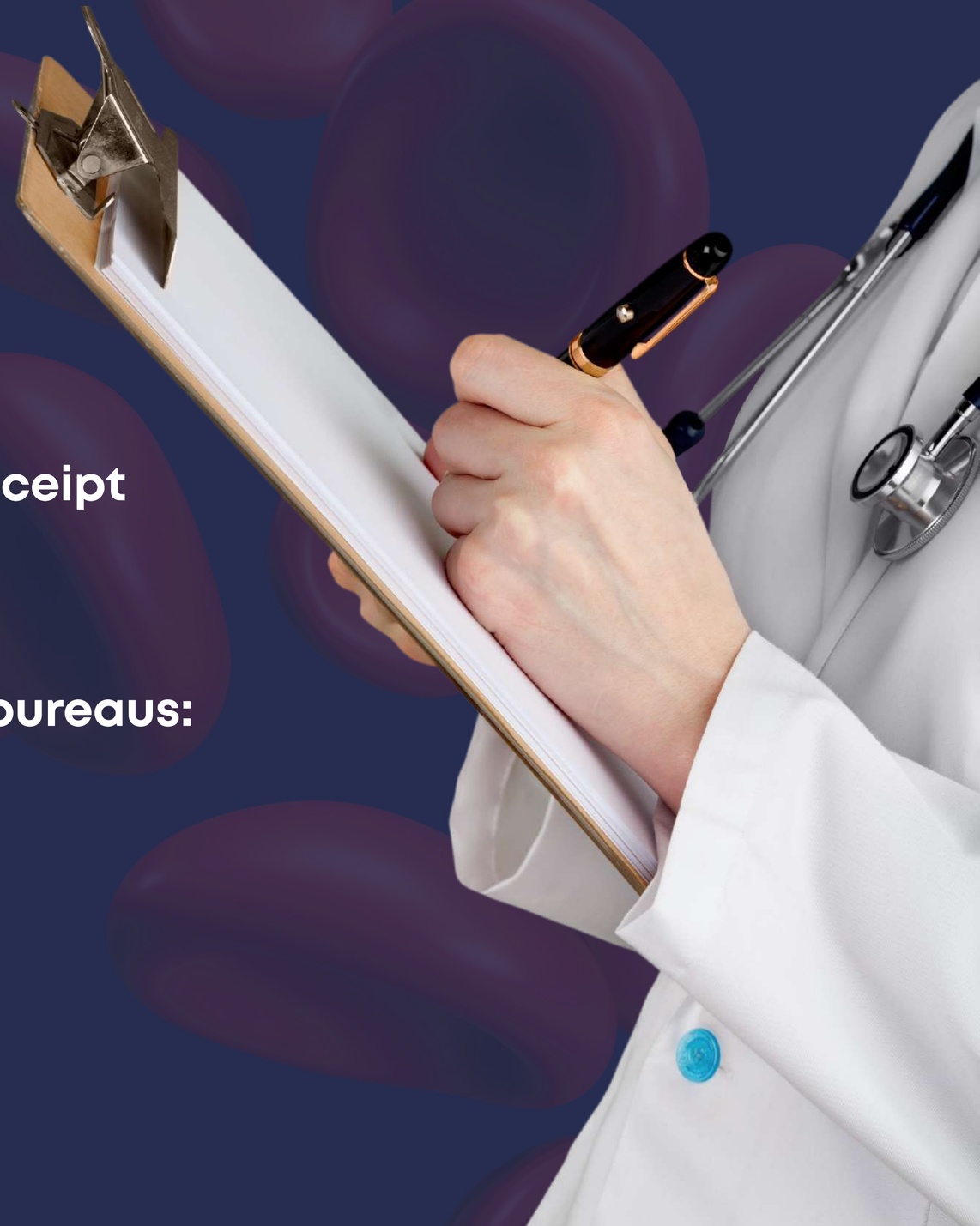
  Not Applicable

- **Patents for drugs or devices:**

  Not Applicable

- **Other:**

  Not Applicable



DISCLOSURE OF FINANCIAL SUPPORT

No external support

Learning Objectives

At the conclusion of this activity, participants will be able to:

	Compare the key characteristics, mechanisms of action, and potential side effects of various contraceptive methods to guide evidence-based decision-making.
	Identify patient-specific factors to select and prescribe the most appropriate contraceptive method.
	Safely prescribe medical abortion, including understanding indications, contraindications, and follow-up protocols.

Outline

Contraception

- Combined Oral Contraceptives (COCs)
- Progestin-Only Pills (POPs)
- Long-Acting Reversible Contraceptives (LARCs)
- Cost per province
- Pain control
- Trauma-informed care

Medical Abortion

- History and current climate
- Review of surgical abortions
- Mifepristone-Misoprostol regimen
- Indications and contra-indications
- Follow-up

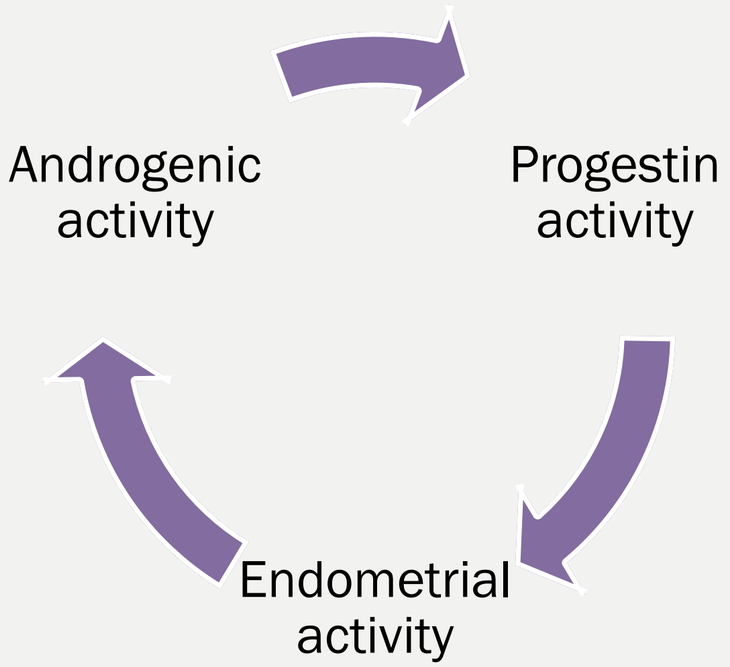
CONTRACEPTION

COC

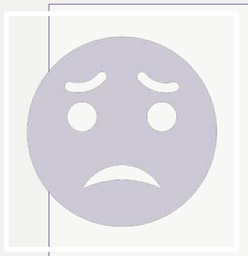
Combined Oral Contraceptives

Products	Ethinylestradiol	Progestin		Progestin activity	Endometrial activity	Androgenic activity
Monophasic						
Alesse	20 mcg	levonorgestrel	0.1 mg	+	+	+
Brevicon 0.5/35	35 mcg	norethindrone	0.5 mg	+	+	+
Brevicon 1/35	35 mcg	norethindrone	1 mg	++	++	++
Marvelon	30 mcg	desogestrel	0.15 mg	+++	++	+
Min-Ovral	30 mcg	levonorgestrel	0.15 mg	++	++	++
Nextstellis	15 mg (estetrol)	drospirenone[1]	3 mg	+++	++	none
Yasmin	30 mcg	drospirenone[1]	3 mg	+++	++	none
Yaz	20 mcg	drospirenone[1]	3 mg	+++	++	none
Biphasic						
Lolo	10 mcg	norethindrone	1-0 mg	++/+++	+	++/+++
Synphasic	35 mcg	norethindrone	0.5-1 mg	++	++	+
Triphasic						
Linessa	25 mcg	desogestrel	100-125-150 mcg	++	++	+
Tri-Cyclen	35 mcg	norgestimate	180-215-250 mcg	+	++	+
Tri-Cyclen Lo	25 mcg	norgestimate	180-215-250 mcg	+	++	+
Triquilar	30-40-30 mcg	levonorgestrel	50-75-125 mcg	+	++	+
Extended-cycle						
Seasonale	30 mcg	levonorgestrel	0.15 mg	++/+++	+	++/+++
Seasonique	30-10 mcg	levonorgestrel	0.15 mg	++/+++	+	++/+++
Intravaginal device						
NuvaRing	releases 15 mcg/day	etonogestrel	releases 120 mcg/day			
Transdermal patch						
Evra	releases 35 mcg/day	norelgestromine	releases 200 mcg/day			

How do I adjust the therapy?

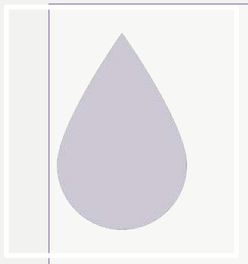


How do I adjust the therapy?

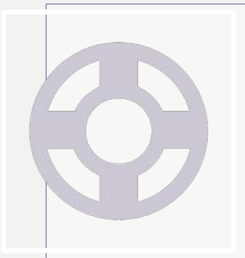


Acne: Switch to low androgenic effects, higher estrogen dose

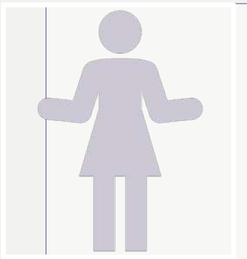
Amenorrhea: r/o pregnancy, higher estrogen dose



Breakthrough bleeding: increase estrogen, switch class of progestin



Vaginal dryness: increase estrogen, consider ring, patch or POP

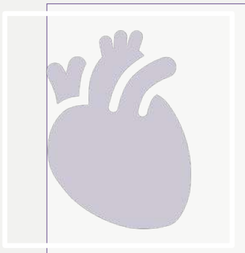


Breast tenderness: decrease estrogen, consider estetrol-DRSP pill, POP

How do I adjust the therapy?

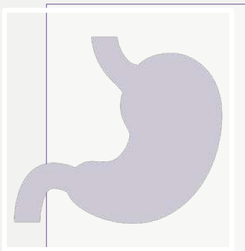
Headache / migraine: switch to contraception without estrogen

Weight gain: correlation not established, but if on implant or DMPA, can switch



Emotional lability: DRSP can reduce symptoms, or vaginal ring

Decreased libido: increase estrogen



N/V: decrease estrogen, avoid patch, could benefit from ring

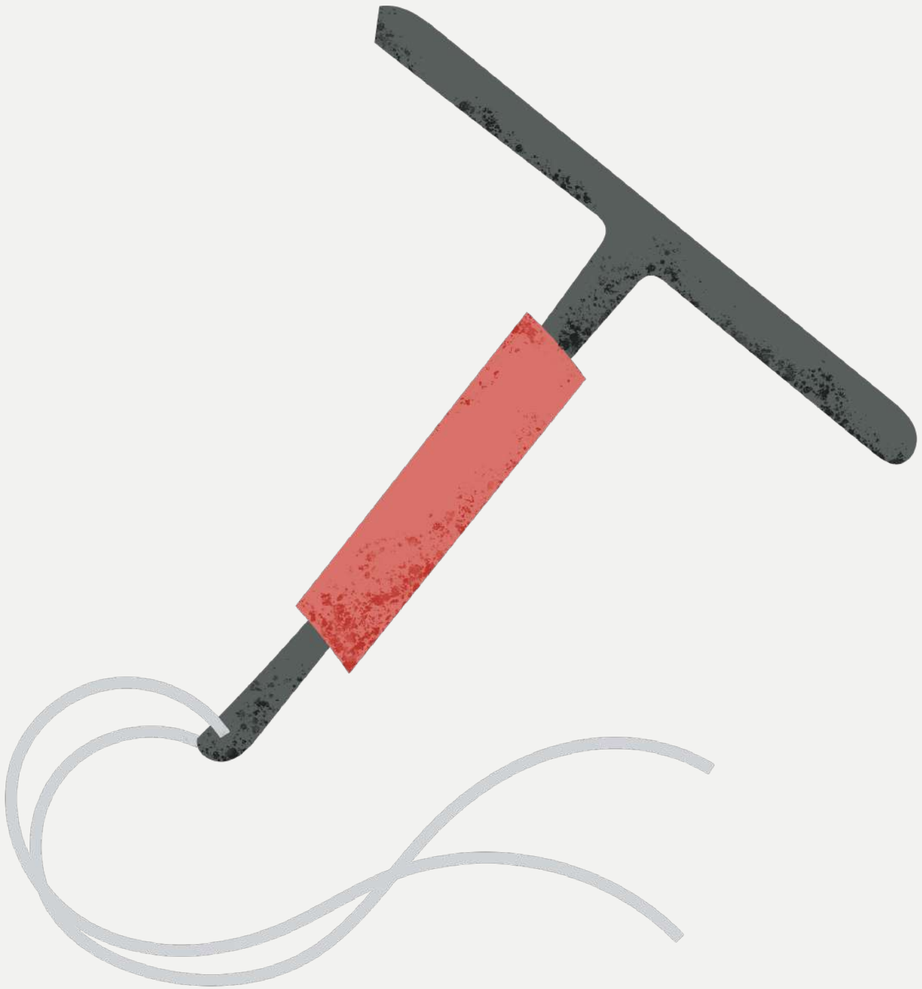
POP

Progestin-only Pills

Products	Progestin		
		Oral	
Micronor	norethindrone	0.35 mg	Must be taken daily
Slynd	drospirenone	4 mg	Take 1 active tablet once a day 24 days per cycle of 28 days
		Injectable	
Depo-Provera	medroxyprogesterone acetate	150 mg IM	Duration of contraceptive effect is 3 months
		Subdermal implant	
Nexplanon	etonogestrel	68 mg (releases 70 mcg/day at maximum)	Duration of contraceptive effect is 3 years
		Intrauterine device¶	
Kyleena	levonorgestrel	releases average of 9 mcg/day	Can be used for up to 5 years
Mirena	levonorgestrel	releases average of 15 mcg/day	Can be used for up to 8 years

LARC

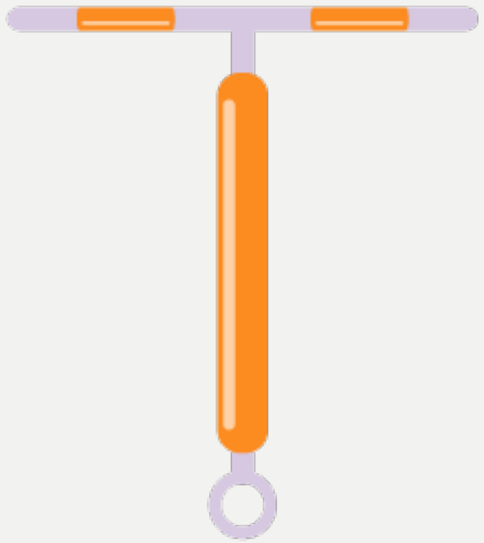
Long-Acting Reversible Contraceptives



Progestin IUDs

- Jaydess (no longer exists) was 3 years only
- Kyleena – 5 years
- Mirena – up to 8 years

Copper IUDs



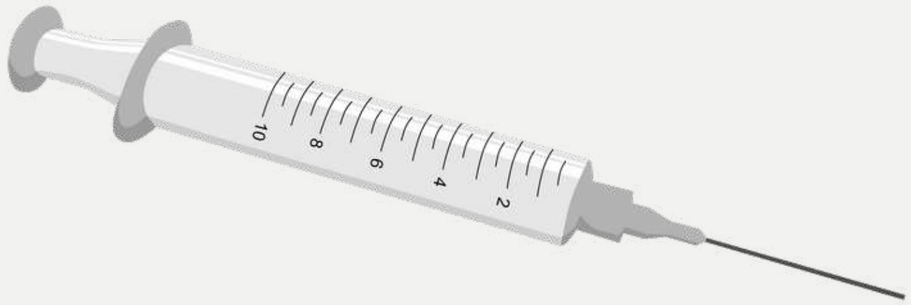
- Mona Lisa (nickel alloy and copper) 5, 5 mini, 10, N
- Liberte (silver and copper) 5, 5 short, 10 — covered for First Nations women
- Mona Lisa 10 insertion is different: https://vimeo.com/42237486

Progestin implant

- Nexplanon – 1 rod, radio-opaque
- Types in other countries: 2 rods, 5 rods, non-radio-opaque

Progestin injection

PROs	No MD needed	Every 12 weeks	Outlying areas	Irregular lifestyle	Not in vagina	Not a pill
CONs	Fertility return	Every 12 weeks	Osteopenia	Weight gain	Acne	Needle



Rule out pregnancy

- Checklist used to assess the possibility of pregnancy
- The provider can be reasonably certain that the patient is not pregnant if the patient has no symptoms or signs of pregnancy and meets ANY of the following criteria:
  - The patient has not had intercourse since last normal menses.
  - The patient has been correctly and consistently using a reliable method of contraception.
  - The patient is within 7 days from the first day of menstrual bleeding.
  - The patient is within 4 weeks postpartum (for nonlactating patients).
  - The patient is within the first 7 days postabortion or miscarriage.
  - The patient is fully or nearly fully breastfeeding, amenorrheic, and less than 6 months postpartum.
- A systematic review of studies evaluating the performance of a pregnancy checklist compared with urine pregnancy test to rule out pregnancy concluded the negative predictive value of a checklist similar to the one above was 99 to 100%.

Data from:
1. Tepper NK, Marchbanks PA, Curtis KM. Use of a checklist to rule out pregnancy: A systematic review. Contraception 2013; 87:661.
2. Curtis KM, Tepper NK, Jatlaoui TC, et al. United States Medical Eligibility Criteria for Contraceptive Use, 2016. MMWR Recomm Rep 2016; 65:1.

Coverage by province/territory

Very variable, but relevant to patient care and will influence decision

Check with your own province and know the differences

Bill C-64 – pending implementation

PAIN CONTROL

Common myths

- The cervix has no nerves
- The pain is very transient and mild
- I’ve been doing IUDs for years using no analgesia and had no bad outcomes
- Syncope is due to stimulation of the vagal nerve of cervix and is normal
- There aren’t enough studies proving it works, so pain control shouldn’t be offered for IUD insertion or endometrial biopsy
- It takes too long to warrant its use, and is an extra expense for my office

Pain control in gynecology

- Patient centered care
- Why don’t we survey patients about procedure pain?
- Oral
- Topical
- Injection
- Inhalation

Analgesia – oral

- Acetaminophen
- NSAIDs
- Lyrica
- Cytotec —- Not for analgesia, but for dilation

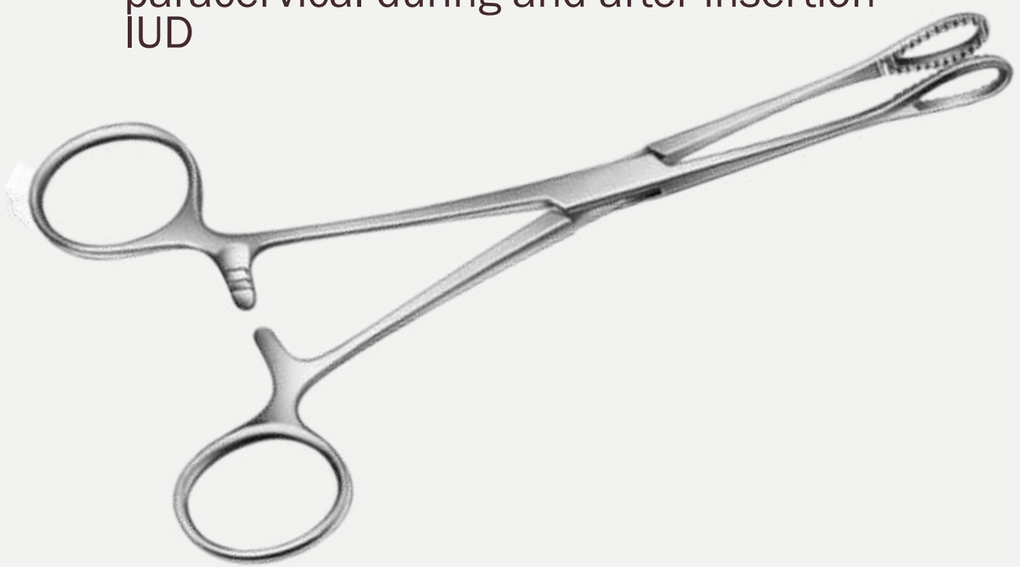
Analgesia – topical

- EMLA creme
- Xylocaine spray
- Xylocaine topical - use 2%, apply with 2x2 gauze held by ring forceps (hold gauze square by all 4 corners, like a little parachute)

Analgesia – injections

Inject on cervix itself

- Apply topical xylocaine 2% first (to not feel the needle)
- Then inject INTO cervix, submucosally 1 mL where you will apply clamp
- PRO: can see injection site better than paracervical block , nowhere near cervical vessels
- CON: not nearly as effective as paracervical during and after insertion IUD



Paracervical block

- Apply topical xylocaine 2% to cervix, and to lateral and posterior fornixes; use 2x2 gauze held with ring forceps — by 4 corners, to make a parachute shape, then wait 1-2 minutes
- Draw up 5 mL of 2% xylocaine in a 5 mL syringe, use a 22/23 g needle, 1 ½ inch length (spinal needle even better)
- Injections will be at 5 and 7 o'clock of the cervix
- Insert just under mucosa (if you feel resistance of needle going into tissue, then stop)
- Draw back to make sure not in blood vessel (vessels are at 3 and 9 o'clock—your needle should be far from this)
- Inject 2.5 mL xylocaine 2% at each of the two sites

Analgesia – inhaled

- Nitrous Oxide
- Penthrox (methoxyflurane gas) - $60 capsule of gas to inhale, somnolence, syncope possible, need someone with patient, can’t drive home

TRAUMA INFORMED CARE

Trauma can look like…

- Difficult patient
- Noncompliant patient, no-show
- Confrontative aggressive patient
- Somatization

Signs and symptoms of trauma

- Psychological
  - *Mood disorder, mood dysregulation, phobias, panic attacks*
  - *Dissociation*
  - *Personality disorder*
  - *Nightmares, flashbacks*
- Physical
  - *Pain: chronic, multiple sites, non-anatomical at times*
  - *Sleep disturbance*
- Behavioral
  - *Aggressivity, addictions, poor attachment, takes risks, poor memory*

Best approach

- Language
  - *Soft voice, calm attitude, take time to listen , explain, ask for feedback, no surprises, patient centered*
- Environment
  - *Comfortable furniture, pleasant lighting, resources, physical comfort (water, a snack, Advil, a cool cloth on forehead, excellent pain control, a blanket, warmed speculums), predictable appointments*
- Team
  - *Multidisciplinary resources*
  - *Communication, confidentiality*
  - *Take good care of your office personnel – team meeting*

Best approach

- Assume any patient could have had past trauma
- Do not try to get the details of past trauma
- Treat the effect of trauma on the patient – make them feel respected, cared for, and safe
- For resources, see annex 1

ABORTION

HISTORY AND CURRENT CLIMATE

Recent history

- Countries who recently legalized abortion - Ireland
- Countries who recently made abortion illegal - some states in USA
- Places where abortion is legal but difficult to obtain - some states in USA
- ***Legal does not mean easily available to all
- See annex 2

Countries where it’s banned

A few countries **completely ban abortion** or make access nearly impossible:

- El Salvador
- Nicaragua
- Honduras *(ban lifted in 2024 but access still pending)*
- Dominican Republic
- Malta *(technically legal for health, but highly restricted)*
- Vatican City

Legal and ethical considerations

- Woman on respirator being kept alive from 9 weeks of gestation until 24 weeks when a c section was performed - Emory Hospital in USA
- In some states, it’s illegal even in cases of pregnancy by rape
- In some states, it is illegal to aid a woman to obtain an abortion (e.g. driving her across a border)
- Higher income and social class — have money and connections to get abortion
- Poor socioeconomic class – less access to medical care, to travel to state or country where abortion is legal
- Since abortion ban, infant mortality increased

Legal and ethical considerations

- If restricted or illegal, abortions will be done anyway :
  - *by unqualified practitioners—lacerations, perforations, hemorrhage*
  - *under unsanitary conditions—infection, sepsis*
  - *women will hide—delay medical care if fever, pain, bleed*
- Long term physical effects—unrepaired physical trauma, scarring, infertility,
- Long term psychological effects—emotional trauma, social ostracization, imprisonment or seeking asylum in safe countries—poverty, removal of kids

SURGICAL ABORTIONS

Manual Vacuum Aspiration (MVA)

Electric Vacuum Aspiration (EVA)

Dilation and Evacuation (D&E)

Dilation and Curettage (D&C) (less common now)

Induction Abortion (combination medical and surgical)

See annex 3 for details

MIFEPRISTONE-MISOPROSTOL REGIMEN

Indications

- Confirmed intrauterine pregnancy ≤ 63 days (9 weeks).
- Patient preference for medical over surgical abortion.
- Ability to understand and consent to the procedure.
- Access to emergency care in case of complications.
- Willingness and ability to return for follow-up.

Contraindications

- Ectopic pregnancy or suspicion.
- Adrenal failure (chronic or acute).
- Chronic corticosteroid therapy (e.g., for autoimmune disease).
- Allergy to mifepristone or misoprostol.
- Porphyria.
- Bleeding disorders or anticoagulant use (relative).
- Inability to access emergency services within 2 hours.
- Hemoglobin <95 g/L (risk of anemia post-abortion).

First visit

Intake

- Empathy, empathy, empathy
- PMH, clear history on LMP, symptoms, allergies
- Prior pregnancies, contraception history
- Confirm pregnancy

Investigations

- bHCG, blood group and Rh
- CBC
- STD if indicated
- Ultrasound if LMP uncertain (role of PoCUS)

Counselling

- Discuss options: continuing pregnancy, adoption, surgical vs medical abortion.
- Explain expected process, side effects, risks, and need for follow-up.

Procedure

Medications

- Mifepristone 200mg
- Misoprostol 4 x 200mcg
- Consider: NSAIDs, anti-emetics

Administration

- Day 1: Mifepristone (blocks progesterone – decidual breakdown)
- Day 2-3 (24-48hrs later): Misoprostol (place 2 tablets in each cheek for 30min then swallow)
- Provide written instructions and 24/7 contact info

Complications and red flags

Symptom	Concern	Action
Fever > 38°C lasting >24 hrs	Infection/sepsis	Immediate ED referral
Soaking >2 pads/hour for 2+ hrs	Hemorrhage	Urgent assessment
Persistent severe pain	Retained POC, infection, ectopic	Assess urgently
Minimal or no bleeding	Failed abortion or ectopic	Follow-up with hCG or U/S
Foul-smelling discharge	Endometritis	Empiric antibiotics

Risks

Incomplete abortion (~2–5%) ⟶ may need misoprostol repeat or surgical evacuation.
Heavy bleeding (<1%).
Infection (~0.1–0.2%).
Ongoing pregnancy (~1%) – offer surgical abortion if continuing.
GI side effects: nausea, vomiting, diarrhea common.

Second visit

- Can be done via telemedicine
- Timing: 7 days after Misoprostol
- Assess bleeding, pain and completion symptoms
- Investigations: bHCG, CBC, ultrasound if uncertainty, symptomatic or inadequate bHCG trend
- Serum bHCG: drop by 80% at 7 days
- Completion symptoms:
  - *Heavy bleeding 1-4 hours post Misoprostol*
  - *Cramping resolves over a few days*
  - *Bleeding tapers over 2-3 weeks*
  - *Negative pregnancy test at 4 weeks (if no access to serum bHCG at 7 days)*

Pearls

Screen carefully for ectopic risk: IUD in place, tubal surgery, previous ectopic, etc.

RhoGAM: 50mcg if <12 weeks, give within 72 hours if Rh-negative.

Empower patients with clear written info and follow-up access.

Respect autonomy and privacy at all stages.

Be ready to escalate for incomplete, ongoing, or complicated cases.

PATIENT INFORMATION: MEDICAL ABORTION WITH MIFEGYMISO

What is a Medical Abortion?

A **medical abortion** uses medications (Mifegymiso) to end a pregnancy up to **9 weeks (63 days)** after the first day of your last period. It is a **safe and effective** option, chosen by many people.

What is in Mifegymiso?

- **Mifepristone (200 mg tablet)** – blocks the hormone **progesterone**, which is needed to continue the pregnancy.
- **Misoprostol (4 tablets, 200 mcg each)** – causes the uterus to **contract and expel** the pregnancy tissue.

How to Take the Medication

STEP 1: Mifepristone – Day 1

- Take **one tablet (200 mg)** by mouth with water.

STEP 2: Misoprostol – 24 to 48 Hours Later

- Place **4 misoprostol tablets** in your **cheek pouches** (2 on each side).
- Let them **dissolve for 30 minutes**, then swallow what's left.

What to Expect

- Bleeding usually starts **within a few hours** after taking misoprostol.
- You may pass **large clots and tissue**.
- Cramping can be **strong**, especially on the first day.
- Bleeding should gradually decrease but may last up to **2–3 weeks**.
- Other symptoms may include **nausea, vomiting, diarrhea, mild fever, or chills**.

When to Get Medical Help

Go to the Emergency Department or call your doctor if:

- You **soak more than 2 pads per hour** for **2 hours in a row**
- You have a **fever higher than 38°C (100.4°F)** for **more than 24 hours**
- You have **severe abdominal pain** that is not improving with pain medication
- You pass **foul-smelling vaginal discharge**
- You have **no bleeding** within 24 hours of taking misoprostol

Follow-Up Care is Important

You will need a follow-up visit or phone call **7 days** after treatment to make sure the abortion is complete.

- Your doctor may check your **blood (hCG)** levels or do a **pregnancy test or ultrasound**.
- A **negative home pregnancy test** 4 weeks after the abortion also confirms success.

Helpful Tips

- Use **ibuprofen (400–600 mg every 6–8 hours)** for cramps.
- Rest, use a **heating pad**, and stay hydrated.
- Avoid tampons, sexual activity, and swimming until the bleeding stops.
- You can start **birth control** as soon as the abortion is complete.

Contact Info

If you have questions or feel unwell:

- 📱 **Clinic/Doctor Name: _____**
- ☎️ **Phone Number (daytime): _____**
- 🌙 **Emergency Number (24/7): _____**
- 📆 **Follow-Up Appointment Date: _____**

You are not alone. If you feel unsure or need support, reach out to your provider or local abortion support services. Your privacy and health matter.

THANK YOU!

PLEASE FILL OUT YOUR SESSION EVALUATION NOW!

FMF
Family Medicine Forum
Forum en médecine familiale

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

FOLLOW US

FamilyMedicineForum

FamilyMedForum

ANNEX 1

We’ve come a long way

- No one talked about Trauma (PTSD, CPTSD) until 1960’s (war vets, abuse victims)
- No one tried to treat in a big way until 1978 — after Vietnam
- Approaches by psychologists, psychiatrists and neuropsychologists:
  - *Before 1990s made the suffering worse*
  - *Since the 1990s – they treat the effect*
- Some useful resources:
  - *Bessel Van der Kolk – The Body Keeps the Score*
  - *David Servan-Schreiber — EMDR*
  - *Gabor Maté*
  - *Janina Fischer, Peter Levine, Nadine Burke, Richard Schwartz*

ANNEX 2

Countries where it’s legal

These countries allow abortion **on request**, typically with gestational limits (often 12–24 weeks), though some allow beyond that for medical reasons.

Americas:

- *Canada (no legal restrictions)*
- *United States (legal in many states, though others restrict or ban it)*
- Argentina
- Colombia
- *Mexico (legal nationally since 2023, though implementation varies by state)*
- Uruguay
- Cuba

Europe:

- France
- Germany
- Italy
- Spain
- *United Kingdom (up to 24 weeks in most cases)*
- Sweden
- Norway
- Denmark
- Netherlands
- Portugal
- Romania

Africa:

- South Africa
- Tunisia
- Mozambique
- Cape Verde

Asia-Pacific:

- Australia
- New Zealand
- India *(up to 24 weeks with conditions; broader access than before)*
- Nepal
- Vietnam
- Cambodia
- China
- Japan *(requires spousal consent in some cases)*
- South Korea *(decriminalized in 2021)*

Middle East:

- Israel *(legal under certain conditions)*
- Turkey *(on request up to 10 weeks)*

*Non exhaustive list

Countries with restrictions

- **Legal with Restrictions (Therapeutic or Socioeconomic Grounds)**
- Abortion is legal **only under certain circumstances** such as:
  - *risk to the woman's life or health*
  - *rape or incest*
  - *Fetal anomalies*
  - *Socioeconomic reasons (less common)*

Examples:

- Poland *(only for rape, incest, or danger to life)*
- Brazil *(only in cases of rape, risk to life, or anencephaly)*
- Indonesia *(limited exceptions)*
- Nigeria *(only if the woman’s life is at risk)*
- Philippines *(generally banned, with limited exceptions)*
- Iran *(fetal abnormalities or danger to mother's life)*

ANNEX 3

Manual Vacuum Aspiration (MVA)

- Used: Up to ~12 weeks of pregnancy
- **How it works:**
  - **A thin plastic tube (cannula) is inserted into the uterus through the cervix.**
  - **A handheld syringe creates suction to remove the pregnancy tissue.**
- Setting: Can often be done in clinics without general anesthesia.
- Anesthesia: Local anesthesia or sedation
- Duration: ~10–15 minutes

Advantages:

- Quick recovery
- No electricity needed (used in low-resource settings)

Electric Vacuum Aspiration (EVA)

- Used: Up to ~14–16 weeks
- **How it works:**
  - *Similar to MVA but uses electric suction instead of manual.*
  - *The cervix may be dilated in advance.*
- Setting: Outpatient clinic or hospital
- Anesthesia: Local, sedation, or general anesthesia
- Duration: ~10–20 minutes

Advantages:

- Effective and fast
- Often preferred in high-volume clinics

Dilation and Evacuation (D&E)

- **Used:** Between ~13–24 weeks (second trimester)
- **How it works:**
  - ***The cervix is dilated gradually (often the day before).***
  - *A combination of* ***suction and surgical instruments (forceps)*** *is used to remove the pregnancy.*
- **Setting:** Hospital or surgical center
- **Anesthesia:** Often sedation or general anesthesia
- **Duration:** ~20–30 minutes

Advantages:

- Safest and most common second-trimester method
- Can be life-saving in cases of fetal anomalies or maternal risk

Dilation and Curettage (D&C)

- **Used:** Occasionally for early abortions or incomplete miscarriages
- **How it works:**
  - *The cervix is dilated.*
  - *A curette (sharp instrument or suction) is used to scrape the uterine lining.*
- **Setting:** Clinic or hospital
- **Anesthesia:** Local or general
- **Duration:** ~15–20 minutes

Note: D&C is now **less commonly used for elective abortion** due to higher risk of complications (e.g., uterine scarring).

Induction Abortion

- **Used:** After ~20–24 weeks (third trimester in some jurisdictions)
- **How it works:**
  - *A combination of* ***medications (misoprostol, mifepristone)*** *induces labor.*
  - ***Sometimes followed by D&E or fetal demise prior to removal (if legally required).***
- **Setting:** Hospital
- **Anesthesia:** Depends on stage and method

Less Common— used only in complex medical or legal cases (e.g., severe fetal anomalies).