# Chapter 1
# Introduction and methodology

## 1.1 The guideline topic

Induced abortion is one of the most commonly performed gynaecological procedures in Great Britain, with around 186 000 terminations performed annually in England and Wales and around 11 500 in Scotland. The Abortion Act does not apply in Northern Ireland and no official abortion statistics are collected.

At least one-third of British women will have had an abortion by the time they reach the age of 45 years. Over 98% of induced abortions in Britain are undertaken because of risk to the mental or physical health of the woman or her children. This guideline has been developed in relation to the care of women seeking abortion on such grounds. Separate RCOG publications address legal, ethical and service issues relating to the minority of abortions undertaken because of fetal abnormality. The recommendations in this guideline do not address the special issues relating to abortion for fetal abnormality.

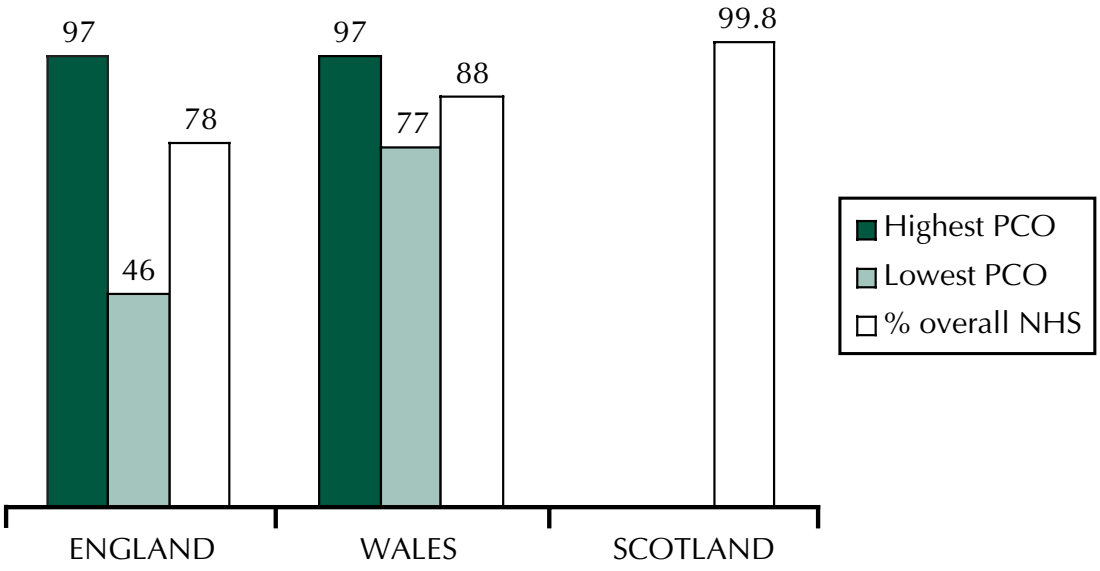



**Figure 1.1 Range of NHS-funded abortion provision among individual PCOs in England and Wales, and in Scotland;** for each country, the bars show the percentage of abortions which are NHS-funded. Primary Care Organisations (PCOs) with the highest, mean and lowest levels of provision are shown (data for England and Wales from Abortion Statistics.[1] Scottish data not routinely published at PCO-equivalent level)[2]

There are large geographical variations in access to NHS-funded abortion. In Scotland in 2002, 99.8% of abortions took place in NHS hospitals. In England and Wales in 2002, of a total of 175 569 abortions for residents of England and Wales, 73 053 (42%) took place in NHS hospitals, 64 045 (36%) were funded by the NHS under agency arrangements with charitable sector providers, and 38 471 (22%) were obtained privately. In England in 2002, women resident in 83 of 304 (27%) primary care organisations (PCO) had less than 75% of their abortions NHS-funded. Figure 1.1 summarises 2002 figures on levels of NHS-funded abortion provision among individual primary care organisations.

Gestation at abortion represents an indicator of accessibility and responsiveness of services. Figure 1.2 summarises the proportions of all abortions performed in different gestation bands for England, Wales and Scotland.

Because of these varying arrangements for provision, the clinical management of women requesting abortion spans a number of care sectors and involves a range of professionals. Abortion care was therefore considered by the RCOG to be a particularly appropriate topic for multidisciplinary guideline development.

The groups which have developed this guideline view induced abortion as a healthcare need and reiterate the recommendation of the RCOG Working Party on Unplanned Pregnancy (1991) that "health authorities should accept responsibility for the abortions needed by women resident in their districts". Although this guideline addresses the discrete topic of abortion care, the guideline developers strongly support the concept that abortion care should be provided as an integral part of broader sexual health services.

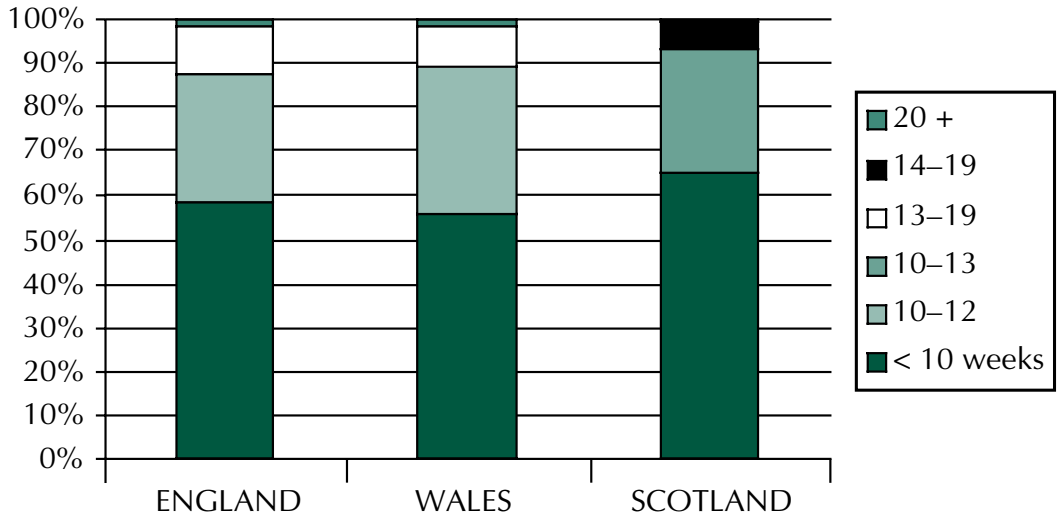



**Figure 1.2** Proportion of legal abortions carried out in different gestation bands, 2002

In 2001, the Department of Health published *The National Strategy for Sexual Health and HIV*. This document highlighted inequalities in access to abortion and reiterated the waiting time targets included within the 2000 edition of this guideline. The RCOG is encouraged by the fact that "addressing the disparities that exist in abortion services" is listed among the targets for the strategy. The provision of abortion as an integral part of broader sexual health services is reflected in the proposal within the strategy to "develop managed networks for sexual health services with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients". Sexual health strategies developed by the National Assembly of Wales and by the Scottish Executive include similar targets for abortion care.

In 1999, the International Federation of Gynecology and Obstetrics (FIGO) published eight recommendations regarding induced abortion for 'non-medical' reasons. The summary recommendation was that "after appropriate counselling, a woman has the right to have access to medical or surgical induced abortion, and that healthcare services have an obligation to provide such services as safely as possible". In 2003, the World Health Organization (WHO) published *Technical and Policy Guidance on Safe Abortion* to assist health systems in making legal abortion safe and accessible. Again, the RCOG is encouraged by the support voiced by FIGO and WHO for the concept of safe abortion care.

Unwanted pregnancies occur because women are unable to regulate their fertility by contraception alone. The complexities of managing sexual behaviour and the fallibility of contraception mean that some unwanted pregnancies are inevitable. The causes of unwanted pregnancies and the reasons why legal abortion remains a healthcare need were clearly summarised by the Birth Control Trust in their document, *Abortion Provision in Britain,* published to mark the 30th anniversary of the 1967 Abortion Act.

## 1.2 Aim of the guideline

Clinical guidelines have been defined as systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions.

The aim of this guideline is to ensure that all women considering induced abortion have access to a service of uniformly high quality. It is hoped that the guideline will be implemented across all relevant healthcare sectors and will promote a consistent standard, regardless of the sectors in which an individual woman is managed.

## 1.3 For whom is the guideline intended?

The guideline has been developed under the auspices of the RCOG for its Fellows and Members practising in the United Kingdom. The guideline may also be of interest to other professional groups who share in caring for women considering abortion: primary care teams, family planning clinic staff, gynaecology nurses, staff participating in non-NHS assessment centres and clinics, and all those professionals providing abortion counselling. Those with responsibilities for planning abortion services, for example directors of public health, NHS trust managers and managers of primary care groups, may also find the guideline helpful.

In this guideline, the term 'clinician' is used to refer to all healthcare professionals who participate in direct clinical patient care. Thus, the term includes doctors, nurses and midwives.

The guideline has been developed in relation to abortion legislation and available resources in England, Wales and Scotland. The different issues surrounding induced abortion in countries with different legislation and with different levels of resources and facilities are not considered.

## 1.4 Local protocol development

It is anticipated that this national guideline will be used as the basis for the development of local protocols or guidelines which will take into account local service provision and the needs and preferences of the local population. Such local adaptation should take place in a similar multidisciplinary group in consultation with all stakeholders affected by the recommendations. It is essential that commissioners of health care, as well as general practitioners, specialists and service users take part in such a process.

## 1.5 Methods used in the development of the guideline

### Literature search strategy

The aim of the literature review was to identify and synthesise relevant evidence within the published literature, thus enabling clinical practice recommendations to be based on evidence wherever possible.

In developing the earlier version of this guideline in 2000, searches were carried out for each topic of interest. The electronic database, MEDLINE (Ovid version), was searched for the period January 1966 to 1999, including foreign language publications. The searches were performed using relevant MeSH (medical subject headings) terms and text words. In addition, the electronic database EMBASE was searched between 1974 to 1999, to identify publications, usually European, not indexed on MEDLINE. The Cochrane Library, up to Issue 2 (1999), was searched to identify systematic reviews, meta-analyses and controlled clinical trials. Reference lists of non-systematic review articles and studies obtained from the initial search were trawled and journals in the RCOG library were hand-searched to identify articles not yet indexed. There was no systematic attempt to search the 'grey literature' (conferences, abstracts, theses and unpublished trials).

In developing this edition, similar literature searches were carried out covering the period 1999 to September 2003. Details of all literature searches are available on application to the FFPRHC Clinical Effectiveness Unit.

The 2000 guideline included a short section on managing the complications of abortion. The Guideline Update Group considered that this topic had been addressed somewhat superficially. It lay outwith the main scope of the guideline and would be better omitted. Recommendations on complications of abortion have therefore been restricted to those included in information for women (Chapter 5).

### Sifting and reviewing the literature

For both the original and updating literature searches, a preliminary scrutiny of titles and abstracts was undertaken and full papers were obtained if they were relevant to the topic. Articles not relevant to the subject in question were rejected, as were articles where relevant outcomes were not reported. For all the subject areas, published systematic reviews or meta-analyses were used, if available. If these did not exist, randomised controlled trials were sought. For subject areas where

a body of systematic review or randomised trial evidence was available, studies of less robust designs were not systematically sought. Where there were no relevant published randomised controlled trials, other appropriate experimental or observational studies were sought.

## Synthesising the evidence

Identified articles were assessed methodologically and the best available evidence was used to form and support the recommendations. If a good systematic review, meta-analysis or randomised controlled trial existed in relation to a topic, studies of a weaker design were ignored. The evidence was synthesised using qualitative methods. These involved summarising the content of identified papers in the form of evidence tables and agreeing brief recommendation statements that accurately reflected the relevant evidence. Quantitative techniques (meta-analysis) were not performed by the guideline development team because of time constraints and the difficulty of combining studies of various designs.

## Forming and grading the recommendations

The definitions of the types of evidence used in this guideline originate from the US Agency for Health Care Policy and Research (Table 1.1). Recommendations were based on, and explicitly linked to, the evidence that supports them. Recommendations were derived from available research evidence using consensus methods. Where there were areas without available research evidence, consensus was again used.

As part of the consensus process, members of the Guideline Development Group were circulated with questionnaires on which draft recommendations were listed. For each recommendation, members were asked to indicate if they thought that the recommendation should be included as it stood, included with modifications or excluded. This questionnaire approach ensured that all group members, not just the more vocal, had an equal opportunity to express their views on recommendations. Examination of the questionnaire responses enabled the more contentious recommendations to be identified for more detailed discussion at subsequent group meetings. The Update Group used an informal consensus process to agree modified recommendations.

The recommendations were then graded according to the level of evidence upon which they were based. The grading scheme used was formulated by the Clinical Outcomes Group and recommended by the NHS Executive.

The strength of the evidence on which each recommendation is based is shown in Table 1.2. It is accepted that, in this grading system, the evidence itself is not graded according to quality, although

**Table 1.1 Levels of evidence**

| Level | Evidence |
|---|---|
| Ia | Evidence obtained from meta-analysis of randomised trials |
| Ib | Evidence obtained from at least one randomised controlled trial |
| IIa | Evidence obtained from at least one well-designed controlled study, without randomisation |
| IIb | Evidence obtained from at least one other type of well-designed quasi-experimental study |
| III | Evidence obtained from well designed non-experimental descriptive studies, correlation studies and case studies |
| IV | Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities |

**Table 1.2 Forming recommendations**

| Grade of recommendation | Evidence level |
|---|---|
| A | Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (*evidence levels Ia, Ib)* |
| B | Requires the availability of well-conducted clinical studies, but no randomised clinical trials on the topic of the recommendation (*evidence levels IIa, IIb, III*) |
| C | Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality *(evidence level IV)* |
| Good practice points ✔ | Recommended best practice based on the clinical experience of the Guideline Development Groups |

it is discussed narratively in the text supporting each recommendation. It is also accepted that randomised controlled trials may not always be the most appropriate study design (for example, to investigate diagnostic tests). Similarly, there may be clinical questions that cannot easily be answered by experiment but nevertheless represent good practice. Such recommendations will automatically be graded C or ✔.

The validity of some grade C and ✔ recommendations may be questionable, as they are not based upon incontrovertible evidence. However, the views of the 2000 Guideline and Update Groups combined with comments from extensive peer review, as detailed below, suggest that the recommendations with this grading are acceptable to a wide body of expert opinion.

### Scope and methods of peer review

Successive drafts of the original guideline were written and discussed by the Guideline Development Group. At the fourth draft stage, a formal peer review process was undertaken. Each member of the group suggested names of individuals or organisations from the area of practice that they represented. The draft guideline was submitted to these individuals or organisations with a request for appraisal and comment. The comments made by the peer reviewers were taken into consideration by the Guideline Update Group before the final guideline was generated. Under the independent guideline appraisal system approved by the NHS Executive, the guideline was sent to a further group of reviewers who particularly concentrated on the methodology used in its development.

For this edition, the second draft of the guideline was circulated for peer review to relevant individuals chosen by the Department of Health and the RCOG. The draft was also posted on the RCOG website and comments invited from any Member or Fellow. Comments received were reviewed by the development team and changes were made to the document where necessary. A final draft was then approved by the RCOG Guidelines and Audit Committee.

## 1.6 Implementation and review

This updated guideline was published in 2004. The RCOG will maintain a watching brief on the need to review recommendations in the light of new research evidence.

# Chapter 2
# Summary of recommendations

## 2.1 Organisation of services

✔ 1. Abortion services should have local strategies in place for providing information to both women and healthcare professionals on the choices available within the service and on routes of access to the service.

✔ 2. Access to services should be ensured for women with special needs. For example, as appropriate, special arrangements should be made for non-English-speaking women and a woman doctor should be available.

✔ 3. It is helpful if the referring doctor is able to provide the first signature on Certificate A. If a woman refers herself, or if the referring doctor is not willing to support the abortion, it must be possible for the woman to be assessed by a second doctor within the abortion service.

✔ 4. Any woman considering induced abortion should have access to clinical assessment.

✔ 5. Appropriate information and support should be available for those who consider but do not proceed to abortion.

B 6. The earlier in pregnancy an abortion is performed, the lower the risk of complications. Services should therefore offer arrangements that minimise delay (for example, a telephone referral system and a formal care pathway with arrangements for access from a wide range of referral sources, not just general practitioners).

7. Service arrangements should be such that:
   - ideally, all women requesting abortion are offered an assessment appointment within 5 days of referral.
   - as a minimum standard, all women requesting abortion are offered an assessment appointment within 2 weeks of referral.
   - ideally, all women can undergo the abortion within 7 days of the decision to proceed being agreed.
   - as a minimum standard, all women can undergo the abortion within 2 weeks of the decision to proceed being agreed.

C
   - as a minimum standard, no woman need wait longer than 3 weeks from her initial referral to the time of her abortion.
   - women should be seen as soon as possible if they require termination for urgent medical reasons.

✔ 8. The assessment appointment should be within clinic time dedicated to women requesting abortion.

✔ 9. In the absence of specific medical, social or geographical contraindications, induced abortion may be managed on a day case basis.

C 10. An adequate number of staffed inpatient beds must be available for those women who are unsuitable for daycase care. In a typical abortion service, up to 5% of women will require inpatient care.

✔ 11. As far as possible, women admitted for abortion should be cared for separately from other gynaecological patients.

✔ 12. Women having second-trimester abortions by medical means must be cared for by an appropriately experienced midwife or nurse. Ideally, they should have the privacy of a single room.

## 2.2 Information for women

B 13. Verbal advice should be supported by accurate, impartial printed information that the woman considering abortion can understand and may take away to consider further before the procedure.

✔ 14. The use of nationally developed patient information (such as that produced by the RCOG or fpa) ensures accuracy and readability. Services are encouraged to adapt national information to reflect local circumstances or to supplement a national leaflet with a sheet summarising local details.

✔ 15. Information for women and professionals should emphasise the duty of confidentiality by which, as for any form of health care, all concerned with the provision of induced abortion are bound.

✔ 16. Clinicians providing abortion services should possess accurate knowledge about possible complications and sequelae of abortion. This will permit them to provide women with the information they need in order to give valid consent.

B 16.1 The risk of haemorrhage at the time of abortion is low. It complicates around 1 in 1000 abortions overall. The risk is lower for early abortions (0.88 in 1000 at less than 13 weeks; 4.0 in 1000 at more than 20 weeks).

B 16.2 The risk of uterine perforation at the time of surgical abortion is moderate. The incidence is of the order of 1–4 in 1000. The risk is lower for abortions performed early in pregnancy and those performed by experienced clinicians.

B 16.3 Uterine rupture has been reported in association with mid-trimester medical abortion. However, the risk is very low, at well under 1 in 1000.

B 16.4 Cervical trauma: the risk of damage to the external cervical os at the time of surgical abortion is moderate (no greater than 1 in 100). The risk is lower when abortion is performed early in pregnancy and when it is performed by an experienced clinician.

B 16.5 Failed abortion and continuing pregnancy: all methods of first-trimester abortion carry a small risk of failure to terminate the pregnancy, thus necessitating a further procedure. The risk for surgical abortion is around 2.3 in 1000 and for medical abortion between 1 and 14 in 1000 (depending on the regimen used and the experience of the centre).

B 16.6 Post-abortion infection: genital tract infection, including pelvic inflammatory disease of varying degrees of severity, occurs in up to 10% of cases. The risk is reduced when prophylactic antibiotics are given or when lower genital tract infection has been excluded by bacteriological screening.

B 16.7 Breast cancer: induced abortion is not associated with an increase in breast cancer risk.

B 16.8 Future reproductive outcome: there are no proven associations between induced abortion and subsequent ectopic pregnancy, placenta praevia or infertility. Abortion may be associated with a small increase in the risk of subsequent miscarriage or preterm delivery.

B 16.9 Psychological sequelae: some studies suggest that rates of psychiatric illness or self-harm are higher among women who have had an abortion compared with women who give birth and to nonpregnant women of similar age. It must be borne in mind that these findings do not imply a causal association and may reflect continuation of pre-existing conditions.

## 2.3 Pre-abortion management

### The abortion decision

C 17. Clinicians caring for women requesting abortion should try to identify those who require more support in decision making than can be provided in the routine clinic setting (such as those with a psychiatric history, poor social support or evidence of coercion). Care pathways for additional support, including access to social services, should be available.

### Blood tests

C 18. Pre-abortion assessment should include:
- measurement of haemoglobin concentration
- determination of ABO and rhesus blood groups with screening for red cell antibodies
- testing for other conditions such as haemoglobinopathies, HIV, and hepatitis B and C if indicated in the light of clinical features, individual risk factors or local prevalence.

B 19. It is not cost effective routinely to crossmatch women undergoing induced abortion.

### Cervical cytology

✔ 20. Assessment prior to induced abortion may be viewed as an opportunity to ascertain each woman's cervical cytology history. Women who have not had a cervical smear within the interval recommended in their local programme may be offered one within the abortion service.

✔ 21. If a cervical smear is taken within the abortion service, then mechanisms are essential to ensure that the smear result is communicated to the woman, acted on appropriately and recorded within the local cervical cytology programme.

### Ultrasound scanning

B 22. All services must have access to scanning, as it can be a necessary part of pre-abortion assessment, particularly where gestation is in doubt or where extrauterine pregnancy is suspected. However, ultrasound scanning is not considered to be an essential prerequisite of abortion in all cases.

C 23. When ultrasound scanning is undertaken, it should be in a setting and manner sensitive to the woman's situation. It is inappropriate for pre-abortion scanning to be undertaken in an antenatal department alongside women with wanted pregnancies.

### Prevention of infective complications

A 24. Abortion care should encompass a strategy for minimising the risk of post-abortion infective morbidity. As a minimum, services should offer antibiotic prophylaxis.

B Ideally, services should offer testing for lower genital tract organisms with treatment of positive cases.

C 25. The following regimens are suitable for periabortion prophylaxis:
- metronidazole 1 g rectally at the time of abortion
  plus
- doxycycline 100 mg orally twice daily for 7 days, commencing on the day of abortion

OR
- metronidazole 1 g rectally at the time of abortion
  plus
- azithromycin 1 g orally on the day of abortion.

## 2.4 Abortion procedures

✔ 26. As a minimum, all services should be able to offer abortion by one of the recommended methods for each gestation band.

B 27. Ideally, abortion services should be able to offer a choice of recommended methods for each gestation band.

### Surgical methods

B 28. Conventional suction termination should be avoided at gestations below 7 weeks.

B 29. Early surgical abortion using a rigorous protocol (which includes magnification of aspirated material and indications for serum βhCG follow-up) may be used at gestations below 7 weeks, although data suggest that the failure rate is higher than for medical abortion.

B 30. Conventional suction termination is an appropriate method at gestations of 7–15 weeks, although, in some settings, the skills and experience of practitioners may make medical abortion more appropriate at gestations above 12 weeks.

✔ 31. During suction termination, the uterus should be emptied using the suction curette and blunt forceps (if required) only. The procedure should not be completed by sharp curettage.

B 32. Suction termination is safer under local anaesthesia than under general anaesthesia. Consideration should be given to making this option available, particularly for low-gestation procedures.

C 33. If conscious sedation is used in place of general anaesthesia to reduce the pain and anxiety associated with surgical abortion, it should be undertaken only by trained practitioners and in line with Department of Health guidance.

A 34. For first-trimester suction termination, either electric or manual aspiration devices may be used, as both are effective and acceptable to women and clinicians. Operating times are shorter with electric aspiration.

A 35. For gestations above 15 weeks, surgical abortion by dilatation and evacuation (D&E), preceded by cervical preparation, is safe and effective when undertaken by specialist practitioners with access to the necessary instruments and who have a sufficiently large caseload to maintain their skills.

B 36. Cervical preparation is beneficial prior to surgical abortion and should be routine if the woman is aged under 18 years of age or at a gestation of more than 10 weeks.

C 37. Abortion regimens containing misoprostol are not licensed within manufacturers' summaries of product characteristics. European Community regulations permit doctors to prescribe unlicensed regimens and permit pharmacists to dispense and nurses to administer medicines prescribed outside of a product licence. Women should be informed if a prescribed treatment is unlicensed.

B 38. Based on available evidence, the following regimen appears to be optimal for cervical preparation prior to first- or second-trimester surgical abortion. This advice is based on considerations of efficacy, adverse-effect profile and cost:

* misoprostol 400 micrograms (2 x 200-microgram tablets) administered vaginally, either by the woman or a clinician, 3 hours prior to surgery.

The following regimens are licensed within manufacturers' summaries of product characteristics and are also appropriate for cervical preparation prior to first- or second-trimester surgical abortion:

- gemeprost 1 mg vaginally, 3 hours prior to surgery
- mifepristone 600 mg orally 36–48 hours prior to surgery.

## Medical methods

B 39. Medical abortion using mifepristone plus prostaglandin is the most effective method of abortion at gestations of less than 7 weeks.

A 40. Medical abortion using mifepristone plus prostaglandin continues to be an appropriate method for women in the 7–9 week gestation band.

* This regimen is unlicensed.

A 41.* For early medical abortion a dose of 200 mg of mifepristone in combination with a prostaglandin is appropriate.

A 42.* Misoprostol (a prostaglandin $E_1$ analogue) is a cost-effective alternative for all abortion procedures for which the $E_1$ analogue gemeprost is conventionally used (that is, early medical abortion, cervical priming, mid-trimester medical abortion).

B 43. Based on available evidence, the following regimen appears to be optimal for early medical abortion up to 9 weeks (63 days) of gestation. This advice is based on considerations of efficacy, adverse-effect profile and cost:

* mifepristone 200 mg orally followed 1–3 days later by misoprostol 800 micrograms vaginally. The misoprostol may be administered by a clinician or self-administered by the woman. For women at 49–63 days of gestation, if abortion has not occurred 4 hours after administration of misoprostol, a second dose of misoprostol 400 micrograms may be administered vaginally or orally (depending upon preference and amount of bleeding).

The following regimen is licensed within manufacturer's summary of product characteristics and is also appropriate for early medical abortion up to 9 weeks (63 days) of gestation:

* mifepristone 600 mg orally followed 36–48 hours later by gemeprost 1 mg vaginally.

A 44. Medical abortion using the following regimen is a safe, effective and acceptable alternative to surgical abortion for women between 9 and 13 weeks of gestation:

* mifepristone 200 mg orally followed 36–48 hours later by misoprostol 800 micrograms vaginally. A maximum of four further doses of misoprostol 400 micrograms may be administered at 3-hourly intervals, vaginally or orally (depending on the amount of bleeding).

B 45. For mid-trimester abortion (13–24 weeks of gestation) medical abortion with mifepristone followed by prostaglandin is an appropriate method and has been shown to be safe and effective.

A 46. For mid-trimester medical abortion, a dose of *200 mg of mifepristone is adequate.

B 47. Surgical evacuation of the uterus is not required routinely following mid-trimester medical abortion. It should only be undertaken if there is clinical evidence that the abortion is incomplete.

A 48. Based on available evidence, the following regimen appears to be optimal for mid-trimester medical abortion. This advice is based on considerations of efficacy, adverse-effect profile and cost:

* mifepristone 200 mg orally, followed 36–48 hours later by misoprostol 800 micrograms vaginally, then misoprostol 400 micrograms orally, 3-hourly, to a maximum of four oral doses.

The following regimen is licensed within manufacturer's summary of product characteristics and is also appropriate for mid-trimester medical abortion:

* mifepristone 600 mg orally, followed 36–48 hours later by gemeprost 1 mg vaginally every 3 hours, to a maximum of five pessaries.

* This regimen is unlicensed.

### General

B 49. Some women will require analgesia after surgical abortion or during and after medical abortion. Requirements for analgesia vary and there is no benefit in routine administration of prophylactic analgesics. Services should make available a range of oral and parenteral analgesics in order to meet women's needs.

B 50. Routine histopathological examination of tissue obtained at abortion procedures is unnecessary.

## 2.5 Aftercare

### Rhesus prophylaxis

B 51. Anti-D immunoglobulin G (250 iu before 20 weeks of gestation and 500 iu thereafter) should be given, by injection into the deltoid muscle, to all nonsensitised RhD negative women within 72 hours following abortion, whether by surgical or medical methods.

### Post-abortion information and followup

✔ 52. Following abortion, women must be given a written account of the symptoms they may experience and a list of those that would make an urgent medical consultation necessary. They should be given a 24-hour telephone helpline number to use if they feel worried about pain, bleeding or high temperature. Urgent clinical assessment and emergency gynaecology admission must be available when necessary.

C 53. Each woman should be offered, or advised to obtain, a follow-up appointment (either within the abortion service or with the referring clinician) within 2 weeks of the abortion.

✔ 54. On discharge, each woman should be given a letter that includes sufficient information about the procedure to allow another practitioner elsewhere to deal with any complications.

C 55. Referral for further counselling should be available for the small minority of women who experience long-term post-abortion distress. Risk factors are ambivalence before the abortion, lack of a supportive partner, a psychiatric history or membership of a cultural group that considers abortion to be wrong.

### Contraception following abortion

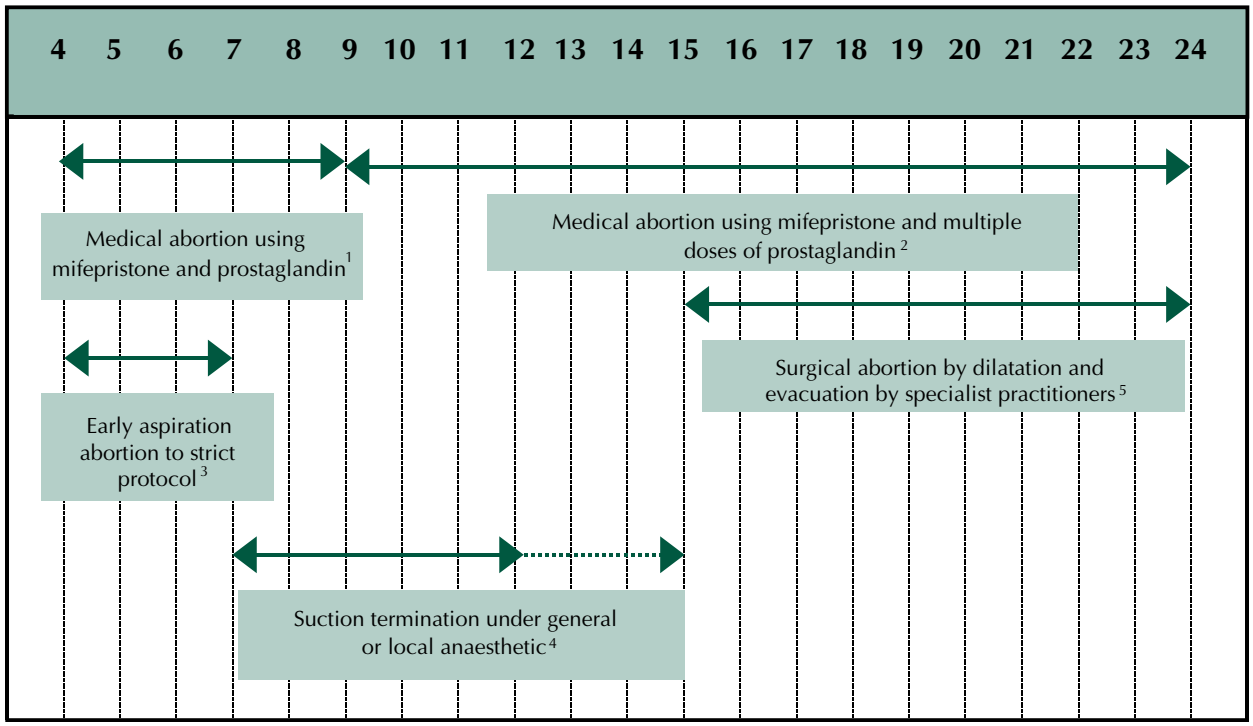
B 56. Before she is discharged following abortion, future contraception should have been discussed with each woman and contraceptive supplies should have been offered if required. The chosen method of contraception should be initiated immediately following abortion.

B 57. Intrauterine contraception can be inserted immediately following a first- or second-trimester termination of pregnancy.

B 58. Sterilisation can be safely performed at the time of induced abortion. However, combined procedures are associated with higher rates of failure and of regret on the part of the woman.

# Appendix:
# Recommended methods of abortion for different gestatations

**Gestation (weeks from date of last menstrual period)**




1 Medical abortion using a single oral dose of the anti-progesterone, mifepristone, followed by a single dose (vaginal or oral) of prostaglandin (also known as pharmacological or non-surgical abortion).
2 Medical abortion using a single oral dose of the anti-progesterone, mifepristone, followed by multiple doses (vaginal or oral) of prostaglandin (also known as pharmacological or non-surgical abortion).
3 Surgical abortion by means of suction aspiration (using electric or manual suction) at gestations below 7 weeks. To increase confidence that the gestation sac has been removed, protocols include safeguards such as magnification of aspirate and follow-up serum βhCG estimation.
4 Conventional suction termination using electric or manual suction, under general or local anaesthetic. The uterus is emptied using a suction curette. Sharp curettage with metal instruments is not employed.
5 Surgical abortion at later gestations using a combination of suction (usually electric) curettage and specialised forceps.