NICE National Institute for Health and Care Excellence

Royal College of Obstetricians & Gynaecologists

NICE guideline

Abortion care

NICE guideline
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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline is the basis of QS129 and QS199.

Overview

This guideline covers care for women of any age (including girls and young women under 18) who request an abortion. It aims to improve the organisation of services and make them easier for women to access. Detailed recommendations on conducting abortions at different gestational stages are also included, to ensure that women get the safest and most effective care possible.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Those responsible for training curriculums
- Women requesting an induced abortion

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding. Note that mifepristone and misoprostol do not have UK marketing authorisations for most of the uses recommended in this guideline. When an unlicensed use is recommended, this is highlighted with a footnote in the recommendation.

Abortion Act 1967

Abortion in England, Scotland and Wales is primarily regulated by the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990) and regulations made under that Act – currently the Abortion Regulations 1991 (SI 1991/499). The Abortion Act regulates when and where abortions can take place lawfully.

In May 2014, the Department of Health and Social Care issued guidance in relation to requirements of the Abortion Act 1967. This guidance is intended for those responsible for commissioning, providing and managing the provision of abortion services to help them comply with the Abortion Act. Also in May 2014, the Department of Health and Social Care published procedures for the approval of independent sector places for the termination of pregnancy. Further government guidance has recently been issued in the form of letters from the Chief Medical Officer.

Providers of abortion services must comply with the Health and Social Care Act 2008 and regulations made under that Act. In particular, providers must register with the Care Quality Commission (CQC). This is because under section 10 of the Health and Social Care Act 2008, it is an offence to carry out a regulated activity without being registered with the CQC, and abortion is a 'regulated activity' under Regulation 3 and Schedule 1 (paragraph 11) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014/2936). The CQC imposes specific requirements on providers that are not English NHS bodies (see regulation 20 of the Care Quality

Commission (Registration) Regulations 2009).

Additional relevant guidance:

- the views of the British Medical Association on the laws and ethics of abortion
- the termination of pregnancy nursing framework from the Royal College of Nursing
- guidance from the Royal College of Obstetricians and Gynaecologists on the care of women requesting induced abortion.

This NICE guideline makes evidence-based recommendations on how to organise services and on how to conduct abortions within the legal framework set out by the Abortion Act 1967. It does not repeat things already covered by the legislation, Department of Health and Social Care guidance or other statutory regulations, and practitioners should therefore ensure they are adhering to all other applicable requirements when using this guideline.

Consent and Montgomery

Healthcare professionals should ensure that women have the information they need to make decisions and to give consent in line with General Medical Council guidance and the 2015 Montgomery ruling.

Gender

This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant.

1.1 Service organisation

Making it easier to access services

1.1.1 Commissioners and providers should work together to:

- make information about abortion services (including how to access them) widely available
- ensure that women are promptly referred onwards if a service cannot provide an abortion after a specific gestational age or by the woman's preferred method
- avoid the need for women to repeat key steps (such as returning to their GP for referral, or repeated assessments or investigations).

1.1.2 Commissioners and providers should allow women to self-refer to abortion services.

1.1.3 Healthcare professionals should not allow their personal beliefs to delay access to abortion services.

1.1.4 Commissioners should consider upfront funding for travel and accommodation for women who:

- are eligible for the NHS Healthcare Travel Costs Scheme **and/or**
- need to travel to a service that is not available locally.

  Commissioners should make information available about any upfront funding to access services.

Waiting times

1.1.5 Commissioners should work with providers to ensure abortion services have the capacity and resources to deliver the range of services needed with minimal delay.

1.1.6 Ensure minimal delay in the abortion process, and ideally:

- provide the assessment within 1 week of the request
- provide the abortion within 1 week of the assessment.

1.1.7 For women who would prefer to wait longer for an abortion, help them to make an informed decision by explaining the implications, including:

- the legal limit for abortions, as stated in the Abortion Act
- that delaying the abortion will increase the risk of complications, although the overall risk is low.

1.1.8 Do not require women to have compulsory counselling or compulsory time for reflection before the abortion. Provide or refer women for support to make a decision if they request this.

Location of services

1.1.9 Consider providing abortion assessments by phone or video call, for women who prefer this.

1.1.10 Consider providing abortion services in a range of settings (including in the community and in hospitals), to meet the needs of the local population.

Workforce and training

1.1.11 Abortion providers should maximise the role of nurses and midwives in providing care.

1.1.12 Trainee healthcare professionals and students who may care for women who request an abortion (for example nurses, midwives, and GPs) should have the chance to gain experience in abortion services during their training.

1.1.13 For specialties that include training in abortion as part of the core curriculum:

- ensure all trainees have the training, unless they opt out due to a conscientious objection
- include practical experience of abortion services and procedures in the curriculum.

1.1.14 If a trainee's placement service does not provide abortions, the trainee should gain experience with whoever is providing this service (either in the NHS or in the independent sector).

Complex comorbidities

1.1.15 Specialist centres should be available as locally as possible, to reduce delays and travel times for women with complex needs or significant comorbidities.

1.1.16 Providers should develop pathways for women with complex needs or significant comorbidities to:

- refer them to specialist centres if needed
- minimise delays in accessing care.

Avoiding stigma

1.1.17 When caring for women who are having an abortion, be aware of:

- the anxiety they may have about perceived negative and judgemental attitudes from healthcare professionals
- the impact that verbal and non-verbal communication may have on them.

1.1.18 Services should be sensitive to the concerns women have about their privacy and confidentiality, including their concerns that information about the abortion might be shared with healthcare professionals not directly involved in their care.

To find out why the committee made the recommendations and how they might affect services, see the rationale and impact section on service organisations.

Full details of the evidence and the committee's discussion are in evidence review A: accessibility and sustainability of abortion services and evidence review B: information needs of women undergoing an abortion.

1.2 Providing information

1.2.1 Reassure women that having an abortion is not associated with increased risk of infertility, breast cancer or mental health issues.

1.2.2 Provide information about the differences between medical and surgical abortion (including the benefits and risks), taking account of the woman's needs and preferences. Do this without being directive, so that women can make their own choice. See the NICE patient decision aids to help support these decisions.

1.2.3 As early as possible, provide women with detailed information to help them prepare for the abortion. Cover:

- what it involves and what happens afterwards
- how much pain and bleeding to expect.

1.2.4 Provide information in a range of formats, for example video or written information. Include information based on the experiences of women who have had an abortion.

1.2.5 For more guidance on providing information and helping women to make decisions about their care, see the NICE guideline on patient experience in adult NHS services.

1.2.6 Ask women if they want information on contraception, and if so provide information about the options available to them (see improving access to contraception).

1.2.7 For women who are having a medical abortion, explain:

- that they may see the products of pregnancy as they are passed
- what the products of pregnancy will look like and whether there may be any movement.

1.2.8 For women who are having a medical abortion at home, explain how to be sure that the pregnancy has ended (see follow-up after medical abortion up to and

including 10^{+0} weeks).

1.2.9 Provide women with information on signs and symptoms that indicate they need medical help after an abortion, and who to contact if they do.

1.2.10 Provide women with information about the different options for management and disposal of pregnancy remains.

Information for women who are having an abortion because of fetal anomaly

1.2.11 If a woman who is having an abortion for fetal anomaly cannot have her preferred method of abortion in the maternity service, establish a clear referral pathway with ongoing communication between services so that she can:

- easily transfer to the abortion service
- receive ongoing support from the maternity service
- get more information about the anomaly.

1.2.12 Explain to women that there may not be any physical signs of a fetal anomaly.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on providing information.

Full details of the evidence and the committee's discussion are in evidence review B: information needs of women undergoing an abortion.

1.3 Anti-D prophylaxis

1.3.1 Offer anti-D prophylaxis to women who are rhesus D negative and are having an abortion after 10^{+0} weeks' gestation.

1.3.2 Do not offer anti-D prophylaxis to women who are having a medical abortion up

to and including 10^{+0} weeks' gestation.

1.3.3 Consider anti-D prophylaxis for women who are rhesus D negative and are having a surgical abortion up to and including 10^{+0} weeks' gestation.

1.3.4 Providers should ensure that:

- rhesus status testing and anti-D prophylaxis supply does not cause any delays to women having an abortion
- anti-D prophylaxis is available at the time of the abortion.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on anti-D prophylaxis.

Full details of the evidence and the committee's discussion are in evidence review C: anti-D prophylaxis for women up to 13^{+6} weeks' gestation.

1.4 Preventing infection

1.4.1 Routinely offer and recommend a HIV test to women at their first appointment with abortion services, in line the recommendations on secondary and emergency care in NICE's guideline on HIV testing. For further guidance on testing for HIV and other sexually transmitted infections, see NICE's guideline on reducing sexually transmitted infections.

1.4.2 Do not routinely offer antibiotic prophylaxis to women who are having a medical abortion.

1.4.3 Offer antibiotic prophylaxis to women who are having surgical abortion.

1.4.4 When using doxycycline for antibiotic prophylaxis in medical or surgical abortion, consider oral doxycycline 100 mg twice a day for 3 days.

1.4.5 When using metronidazole for antibiotic prophylaxis in medical or surgical abortion, do not routinely offer it in combination with another broad-spectrum

antibiotic such as doxycycline.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on preventing infection.

Full details of the evidence and the committee's discussion are in evidence review D: antibiotic prophylaxis for medical and surgical abortion.

1.5 Venous thromboembolism prophylaxis

1.5.1 For women who need pharmacological thromboprophylaxis, consider low-molecular-weight heparin for at least 7 days after the abortion.

1.5.2 For women who are at high risk of thrombosis, consider starting low-molecular-weight heparin before the abortion and giving it for longer afterwards.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on venous thromboembolism prophylaxis.

Full details of the evidence and the committee's discussion are in evidence review E: venous thromboembolism prophylaxis for women having abortion.

1.6 Choice of procedure for abortion

1.6.1 Offer a choice between medical or surgical abortion up to and including 23^{+6} weeks' gestation (surgical abortion can be performed shortly after 23^{+6} weeks' gestation only if feticide is given at or before 23^{+6} weeks' gestation, according to the 2019 clarification of the time limits in the Abortion Act). If any methods would not be clinically appropriate, explain why.

1.6.2 To help women decide between medical and surgical abortion, see the NICE patient decision aids on choosing medical or surgical abortion.

To find out why the committee made the recommendations, see the rationale and impact section on the choice of procedure for abortion.

Full details of the evidence and the committee's discussion are in evidence review B: information needs of women undergoing an abortion and evidence review K: medical versus surgical abortion between 13^{+0} and 24^{+0} weeks' gestation.

1.7 Abortion before definitive ultrasound evidence of an intrauterine pregnancy

1.7.1 Consider abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac) for women who do not have signs or symptoms of an ectopic pregnancy.

1.7.2 For women who are having an abortion before there is definitive ultrasound evidence of an intrauterine pregnancy (a yolk sac):

- explain that there is a small chance of an ectopic pregnancy
- explain that they may need to have follow-up appointments to ensure the pregnancy has been terminated and to monitor for ectopic pregnancy
- provide 24-hour emergency contact details, and advise them to get in contact immediately if they develop symptoms that could indicate an ectopic pregnancy (see symptoms and signs of ectopic pregnancy and initial assessment in the NICE guideline on ectopic pregnancy and miscarriage).

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on abortion before definitive ultrasound evidence of an intrauterine pregnancy.

Full details of the evidence and the committee's discussion are in evidence review F: abortion before ultrasound evidence.

1.8 Expulsion at home for medical abortion up to

and including 10^{+0} weeks

Up to and including 9^{+6} weeks' gestation

1.8.1 For women who are having a medical abortion and will be taking the mifepristone up to and including 9^{+6} weeks' gestation, offer the option of expulsion at home. Mifepristone and misoprostol can be taken at home or in the clinic or hospital.

This recommendation is based on the evidence for the safety of home expulsion. The legal limit for the gestational age at which mifepristone and misoprostol can be taken at home is specified in the Abortion Act 1967.

At 10^{+0} weeks' gestation

1.8.2 For women who are having a medical abortion and will be taking the mifepristone at 10^{+0} weeks' gestation, offer the option of expulsion at home after they have taken the misoprostol. Misoprostol can be taken in the clinic or hospital.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on expulsion at home for medical abortion up to and including 10^{+0} weeks.

Full details of the evidence and the committee's discussion are in evidence review G: expulsion at home for early medical abortion.

1.9 Medical abortion up to and including 10^{+0} weeks

In September 2019, mifepristone for abortion only has a UK marketing authorisation for:

- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 400 micrograms misoprostol orally or 1 mg gemeprost vaginally, up to and including 49 days of amenorrhoea
- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 800 micrograms misoprostol vaginally, up to and including 63 days of amenorrhoea
- 600 mg orally for medical abortion for medical reasons, followed 36 to 48 hours later by prostaglandin administration, beyond the first trimester
- 200 mg orally for cervical priming, 36 to 48 hours before first trimester surgical abortion.

All other uses of mifepristone are off label. See NICE's information on prescribing medicines.

In September 2019, misoprostol for medical abortion only has a UK marketing authorisation for:

- 400 micrograms orally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 600 mg mifepristone orally, up to and including 49 days of amenorrhoea
- 800 micrograms vaginally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 200 mg mifepristone orally, up to and including 63 days of amenorrhoea.

All other uses of misoprostol (including for cervical priming and for abortion at later gestations) are off label. See NICE's information on prescribing medicines.

1.9.1 Offer interval treatment (usually 24 to 48 hours) with mifepristone and misoprostol to women who are having a medical abortion up to and including 10^{+0} weeks' gestation.

1.9.2 For women who are having a medical abortion up to and including 9^{+0} weeks' gestation, give them the choice of having mifepristone and vaginal misoprostol at the same time, but explain that:

- the risk of ongoing pregnancy may be higher, and it may increase with gestation
- it may take longer for the bleeding and pain to start
- it is important for them to complete the same follow-up programme that is recommended for all medical abortions up to and including 10^{+0} weeks (recommendations 1.14.1 and 1.14.2).

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on the interval between mifepristone and misoprostol for medical abortion up to and including 10^{+0} weeks.

Full details of the evidence and the committee's discussion are in evidence review H: medical abortion up to 10^{+0} weeks' gestation.

1.10 Medical abortion between 10^{+1} and 23^{+6} weeks

In September 2019, mifepristone for abortion only has a UK marketing authorisation for:

- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 400 micrograms misoprostol orally or 1 mg gemeprost vaginally, up to and including 49 days of amenorrhoea
- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 800 micrograms misoprostol vaginally, up to and including 63 days of amenorrhoea
- 600 mg orally for medical abortion for medical reasons, followed 36 to 48 hours later by prostaglandin administration, beyond the first trimester
- 200 mg orally for cervical priming, 36 to 48 hours before first trimester surgical abortion.

All other uses of mifepristone are off label. See NICE's information on prescribing medicines.

In September 2019, misoprostol for medical abortion only has a UK marketing authorisation for:

- 400 micrograms orally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 600 mg mifepristone orally, up to and including 49 days of amenorrhoea
- 800 micrograms vaginally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 200 mg mifepristone orally, up to and including 63 days of amenorrhoea.

All other uses of misoprostol (including for cervical priming and for abortion at later gestations) are off label. See NICE's information on prescribing medicines.

1.10.1 For women who are having a medical abortion between 10^{+1} and 23^{+6} weeks' gestation and who have taken 200 mg mifepristone, offer an initial dose (36 to 48 hours after the mifepristone) of:

- 800 micrograms misoprostol, given vaginally, **or**
- 600 micrograms of misoprostol, given sublingually, for women who decline vaginal misoprostol.

  Follow the initial dose with 400 microgram doses of misoprostol (vaginal, sublingual or buccal), given every 3 hours until expulsion.

1.10.2 Use a shorter interval between mifepristone and misoprostol if the woman prefers this, but explain that it may take a longer time from taking the first misoprostol dose to complete the abortion.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on medical abortion between 10^{+1} and 23^{+6} weeks.

Full details of the evidence and the committee's discussion are in evidence review J: medical abortion between 10^{+1} and 24^{+0} weeks' gestation.

1.11 Medical abortion after 23^{+6} weeks

In September 2019, mifepristone for abortion only has a UK marketing authorisation for:

- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 400 micrograms misoprostol orally or 1 mg gemeprost vaginally, up to and including 49 days of amenorrhoea
- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 800 micrograms misoprostol vaginally, up to and including 63 days of amenorrhoea
- 600 mg orally for medical abortion for medical reasons, followed 36 to 48 hours later by prostaglandin administration, beyond the first trimester
- 200 mg orally for cervical priming, 36 to 48 hours before first trimester surgical abortion.

All other uses of mifepristone are off label. See NICE's information on prescribing medicines.

In September 2019, misoprostol for medical abortion only has a UK marketing authorisation for:

- 400 micrograms orally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 600 mg mifepristone orally, up to and including 49 days of amenorrhoea
- 800 micrograms vaginally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 200 mg mifepristone orally, up to and including 63 days of amenorrhoea.

All other uses of misoprostol (including for cervical priming and for abortion at later gestations) are off label. See NICE's information on prescribing medicines.

1.11.1 For women who are having a medical abortion between 24^{+0} and 25^{+0} weeks' gestation, consider 200 mg oral mifepristone, followed by 400 micrograms misoprostol (vaginal, buccal or sublingual) every 3 hours until delivery.

1.11.2 For women who are having a medical abortion between 25^{+1} and 28^{+0} weeks' gestation, consider 200 mg oral mifepristone, followed by 200 micrograms misoprostol (vaginal, buccal or sublingual) every 4 hours until delivery.

1.11.3 For women who are having a medical abortion after 28^{+0} weeks' gestation, consider 200 mg oral mifepristone, followed by 100 micrograms misoprostol (vaginal, buccal or sublingual) every 6 hours until delivery.

1.11.4 Be aware that:

- the uterus is more sensitive to misoprostol as pregnancy advances
- risk factors for uterine rupture include a pre-existing uterine scar, increased gestational age and multiparity.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on medical abortion after 23^{+6} weeks.

Full details of the evidence and the committee's discussion are in evidence review L: medical abortion after 24 weeks' gestation.

1.12 Cervical priming before surgical abortion

In September 2019, mifepristone for abortion only has a UK marketing authorisation for:

- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 400 micrograms misoprostol orally or 1 mg gemeprost vaginally, up to and including 49 days of amenorrhoea
- 600 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 1 mg gemeprost vaginally, between 50 days and 63 days of amenorrhoea
- 200 mg orally for medical abortion of developing intrauterine pregnancy, followed 36 to 48 hours later by 800 micrograms misoprostol vaginally, up to and including 63 days of amenorrhoea
- 600 mg orally for medical abortion for medical reasons, followed 36 to 48 hours later by prostaglandin administration, beyond the first trimester
- 200 mg orally for cervical priming, 36 to 48 hours before first trimester surgical abortion.

All other uses of mifepristone are off label. See NICE's information on prescribing medicines.

In September 2019, misoprostol for medical abortion only has a UK marketing authorisation for:

- 400 micrograms orally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 600 mg mifepristone orally, up to and including 49 days of amenorrhoea
- 800 micrograms vaginally as an initial dose for medical abortion of developing intrauterine pregnancy, 36 to 48 hours after 200 mg mifepristone orally, up to and including 63 days of amenorrhoea.

All other uses of misoprostol (including for cervical priming and for abortion at later gestations) are off label. See NICE's information on prescribing medicines.

Up to and including 13^{+6} weeks

1.12.1 For women who are having a surgical abortion up to and including 13^{+6} weeks' gestation, offer cervical priming with:

- 400 micrograms sublingual misoprostol, given 1 hour before the abortion **or**
- 400 micrograms vaginal misoprostol, given 3 hours before the abortion.

If misoprostol cannot be used, consider cervical priming with 200 mg oral mifepristone, given 24 to 48 hours before the abortion.

1.12.2 Explain to women that cervical priming:

- reduces the risk of incomplete abortion for women who are parous
- makes dilation easier for women who are parous or nulliparous
- may cause bleeding and pain before the procedure.

Between 14^{+0} and 23^{+6} weeks

1.12.3 For women who are having a surgical abortion between 14^{+0} and 23^{+6} weeks' gestation, offer cervical priming.

1.12.4 For women who are having a surgical abortion between 14^{+0} and 16^{+0} weeks' gestation, consider:

- osmotic dilators **or**
- buccal, vaginal or sublingual misoprostol **or**
- 200 mg oral mifepristone, given the day before the abortion.

1.12.5 For women who are having a surgical abortion between 16^{+1} and 19^{+0} weeks' gestation, consider:

- osmotic dilators **or**
- buccal, vaginal or sublingual misoprostol.

1.12.6 For women who are having a surgical abortion between 19^{+1} and 23^{+6} weeks' gestation, offer osmotic dilators. In addition, consider:

- 200 mg oral mifepristone the day before the abortion **and**
- inserting osmotic dilators at the same time as the mifepristone.

1.12.7 For women who are having a surgical abortion between 14^{+0} and 23^{+6} weeks' gestation and are having cervical priming with osmotic dilators, consider inserting the osmotic dilators the day before the abortion.

1.12.8 Do not offer misoprostol for cervical priming if the woman has had an osmotic dilator inserted the day before the abortion.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on cervical priming before surgical abortion.

Full details of the evidence and the committee's discussion are in evidence review M: cervical priming before surgical abortion.

1.13 Anaesthesia and sedation for surgical abortion

1.13.1 For women who are having surgical abortion, consider local anaesthesia alone, conscious sedation with local anaesthesia, deep sedation or general anaesthesia. To help women make an informed choice, discuss the options with them and explain that:

- having local anaesthesia alone means they will be able to spend less time in hospital

- intravenous sedation plus local anaesthesia will help if they are anxious about the procedure
- with deep sedation or general anaesthesia they will not usually be aware during the procedure.

1.13.2 When using conscious sedation for a surgical abortion, use intravenous rather than oral sedation.

1.13.3 When using general anaesthesia for a surgical abortion, consider intravenous propofol and a short-acting opioid (such as fentanyl) rather than inhalational anaesthesia.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on anaesthesia and sedation for surgical abortion.

Full details of the evidence and the committee's discussion are in evidence review M: cervical priming before surgical abortion.

1.14 Follow-up and support after an abortion

Follow-up after medical abortion up to and including 10^{+0} weeks

1.14.1 For women who have had a medical abortion up to and including 10^{+0} weeks' gestation with expulsion at home, offer the choice of self-assessment, including remote assessment (for example telephone or text messaging), as an alternative to clinic follow-up.

1.14.2 Provide women with a low-sensitivity or multi-level urine pregnancy test to exclude an ongoing pregnancy.

Support after an abortion

1.14.3 Explain to women:

- what aftercare and follow-up to expect
- what to do if they have any problems after the abortion, including how to get help out of hours
- that it is common to feel a range of emotions after the abortion.

1.14.4 Advise women to seek support if they need it, and how to access it (if relevant). This could include:

- support from family and friends or pastoral support
- peer support, or support groups for women who have had an abortion
- counselling or psychological interventions.

1.14.5 Providers should be able to provide emotional support after abortions. They should tell women this support is available if they need it.

1.14.6 Providers should provide or refer women for counselling if requested.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on follow-up and support after an abortion.

Full details of the evidence and the committee's discussion are in evidence review I: follow-up after medical abortion up to 10^{+0} weeks and evidence review O: support after abortion.

1.15 Improving access to contraception

1.15.1 Commissioners and providers should ensure that the full range of reversible contraceptive options (depot medroxyprogesterone acetate [DMPA], contraceptive implant, intrauterine methods, oral contraceptives, contraceptive

patches, vaginal rings or barrier contraception) is available for women on the same day as their surgical or medical abortion.

1.15.2 Providers should ensure that healthcare professionals have the knowledge and skills to provide all contraceptive options.

1.15.3 Providers should ensure they can provide the contraceptive implant, and that women who choose this method are offered it on:

- the day of the surgical abortion **or**
- the day they take mifepristone (for medical abortions).

1.15.4 Providers should ensure they can provide intrauterine methods of contraception, and that women who choose this method are offered this:

- at the same time as the surgical abortion **or**
- as soon as possible after expulsion of the pregnancy (for medical abortions).

1.15.5 For women who are having a medical abortion and who choose DMPA intramuscular injection for contraception:

- consider providing it at the same appointment when they take the mifepristone
- explain that having the injection at this stage may increase the risk of ongoing pregnancy, although overall the risk is low.

To find out why the committee made the recommendations and how they might affect practice, see the rationale and impact section on contraception after abortion.

Full details of the evidence and the committee's discussion are in evidence review P: contraception after abortion.

Terms used in this guideline

Fetal anomaly

Defined as pregnancies falling within section 1(1)(d) of the 1967 Abortion Act. This covers pregnancies where 2 medical practitioners are of the opinion that 'there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'. This is referred to as ground E in the HSA1 form.

Feticide

Feticide is the injection of digoxin or potassium chloride into the fetus, or an injection of digoxin into the amniotic cavity, to stop the fetal heart before an abortion.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Antibiotic prophylaxis for surgical abortion

What is the optimal antibiotic prophylaxis regimen for women who are having a surgical abortion?

To find out why the committee made the recommendation for research, see the rationale section on preventing infection.

Full details of the evidence and the committee's discussion are in evidence review D: antibiotic prophylaxis for medical and surgical abortion.

2 Cervical priming before surgical abortion

What are the most effective and acceptable methods of cervical priming before dilatation and evacuation after 16^{+0} weeks' gestation?

To find out why the committee made the recommendation for research, see the rationale section on cervical priming before surgical abortion.

Full details of the evidence and the committee's discussion are in evidence review M: cervical priming before surgical abortion.

3 Anti-D prophylaxis for surgical abortion

Should women having a surgical abortion up to and including 10^{+0} weeks' gestation have anti-D prophylaxis if they are RhD (or D) negative?

To find out why the committee made the recommendation for research, see the rationale section on anti-D prophylaxis for surgical abortion.

Full details of the evidence and the committee's discussion are in evidence review C: anti-D prophylaxis for women up to 13^{+6} weeks' gestation.

4 Expulsion at home for medical abortion

For women who are having medical abortion between 10^{+1} and 12^{+0} weeks, what is the efficacy and acceptability of expulsion at home compared with expulsion in a clinical setting?

To find out why the committee made the recommendation for research, see the rationale section on expulsion at home for medical abortion between 10^{+1} and 12^{+0} weeks.

Full details of the evidence and the committee's discussion are in evidence review G: expulsion at home for early medical abortion.

5 Anaesthesia and sedation for surgical abortion

What local anaesthetic techniques are most effective for women having surgical abortion?

To find out why the committee made the recommendations and how they might affect services, see the rationale section on anaesthesia and sedation for surgical abortion.

Full details of the evidence and the committee's discussion are in evidence review M: cervical priming before surgical abortion.

Other recommendations for research

6 Medical abortion after 23^{+6} weeks

What is the effectiveness and safety of regimens using mifepristone and misoprostol for women who are having medical abortion after 23^{+6} weeks' gestation, particularly for those who have had a previous caesarean section or uterine surgery?

7 Anaesthesia and sedation for surgical abortion

What is the optimal regimen for general anaesthesia for women having surgical abortion?

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Service organisation

Why the committee made the recommendations

Making it easier to access services

Recommendations 1.1.1 to 1.1.4

Evidence showed that obtaining an abortion can be complicated for women and that the information available on how to do this is often inconsistent. There was also evidence that integrating and streamlining services would improve access.

There was evidence that women wanted a choice of abortion procedure. The committee agreed that it is not practical for all services to offer all abortion options. To ensure women still have a choice if local services do not provide the full range of options, the committee made a recommendation covering onward referral.

Evidence also showed that:

- it can be difficult to get a prompt GP appointment
- women may face negative attitudes from healthcare professionals, and that this makes it harder to get referrals for abortion.

With this in mind, the committee recommended that services enable women to self-refer. This will improve women's experiences and could also help them avoid stigma and negative attitudes when requesting an abortion. There was no evidence on the best way to enable self-referral (for example through dedicated booking systems, centralised referral, drop-in services, or online booking), so the committee could not make a more specific recommendation.

Although women can self-refer, some will still choose to see a healthcare professional. So that these women can also easily access abortion services, the committee made a recommendation for healthcare professionals on ensuring that they do not delay access because of their personal beliefs. This is in line with professional guidance on conscientious objection (for example from the General Medical Council), which protects the right to opt out of performing abortions but not the right to opt out of providing access to abortion services.

There was evidence that travel costs can be a significant barrier to accessing services. This may be a particular problem for women with low incomes and women who need to travel for a service that is not available locally. Women having an abortion often have to travel at very short notice and may have difficulty arranging funds before the appointment. The committee recognised that it will not always be possible to provide care locally, but they agreed that interventions such as upfront funding of women's travel and accommodation costs could improve access.

Waiting times

Recommendations 1.1.5 to 1.1.8

While abortion is very safe overall, there was evidence that morbidity and mortality increases for every additional week of gestation, so earlier abortions are safer. There was also evidence of long waiting times and delays for women trying to access abortion services. Reducing waiting times can ensure women have more options available, decrease adverse events, and improve women's experience.

In addition, there was strong evidence that substantial cost savings can be achieved if women present earlier for abortion. Most of this saving comes from women having a medical rather than a surgical abortion. With this in mind, the committee felt that it was important to make recommendations on minimising delays for assessment and abortion. Note that while recommendation 1.1.6 gives separate time frames for assessment and abortion, this is not intended to stop services that provide these on the same day from doing so.

In some countries there are local policies such as compulsory counselling and imposed time for reflection before women are allowed to have an abortion. The evidence showed that these can cause delays in accessing abortion services. Neither counselling nor enforced waiting periods are a legal requirement in the UK. The committee agreed, based

on their experience, that these policies can cause distress and that many women do not want counselling. Therefore, the committee agreed that these policies should not be used. However, the committee did not want to discourage services from providing or referring women for support to help make a decision if requested, so they covered this in the recommendation.

The committee recognised that it is not possible for all services to offer abortions every day of the week. This can lead to a choice between travelling further to have an abortion sooner, or waiting longer to have an abortion closer to home. Further, while most women are certain of their decision to have an abortion at the time of the assessment, some women might want more time to consider their decision after this. It is important that women understand the implications of waiting, so the committee made a recommendation to address this.

Location of services

Recommendations 1.1.9 to 1.1.10

Community services and telemedicine appointments are recommended because the evidence showed they improve access to abortion services. There was also limited evidence that patient satisfaction is the same with abortions provided by community or by hospital services, and with appointments provided via telemedicine or at the hospital.

The committee were aware that it can be distressing for women who are having an abortion to attend appointments alongside women who are continuing with their pregnancies. The committee agreed that it was important to minimise distress and protect dignity, but did not make a recommendation on separating these groups because:

- the evidence on how effective this would be at reducing distress was not reviewed by the committee
- there are resource issues and safety concerns with making this a requirement for all services
- separating women who are having an abortion may stigmatise them and make them easy to identify (which is a concern for many women).

Workforce and training

Recommendations 1.1.11 to 1.1.14

There was evidence that women prefer care led by nurses or midwives. Although there are legal restrictions that prevent nurses and midwives from providing certain parts of abortion services, the committee agreed that there are ways their role could still be expanded and that this would improve care.

The committee made recommendations on training because evidence showed that a shortage of trained staff with the necessary skills is making it harder to provide some abortion procedures. There was evidence that NHS hospital-based providers are losing clinical skills because abortion is currently mainly carried out in the independent sector. Ensuring all trainees have the training is important because otherwise healthcare professionals may see this training as optional, rather than as essential training for a common healthcare procedure.

Complex comorbidities

Recommendations 1.1.15 to 1.1.16

There was no evidence on how to improve access for women with comorbid conditions. Based on their knowledge and experience, the committee recommended that services develop pathways for women having an abortion. This will reduce delays and improve access, particularly for women who need care at specialist centres.

Avoiding stigma

Recommendations 1.1.17 to 1.1.18

There was evidence that women present later if they have had a negative experience from a previous abortion. However, no evidence was available on specific interventions to reduce stigma or improve privacy, so the committee made a general recommendation highlighting that the way professionals communicate with women can negatively impact on the woman's experience.

In addition, evidence shows that women are also concerned about privacy and confidentiality and are worried about reactions from other people. Further, the committee

agreed, based on their experience, that women are often concerned that information about their abortion may be shared unnecessarily with other healthcare professionals. Therefore, the committee made a recommendation about being sensitive to those concerns.

How the recommendations might affect current practice

Improving access to abortion services is likely to result in substantial cost savings. Most of this saving comes from women having a medical rather than a surgical abortion. Earlier abortions also have lower rates of complications. Recommendations on location of services, ease of access and complex comorbidities could reduce inequalities for:

- women living in remote areas
- women with low income
- women with comorbid physical and/or mental health problems
- vulnerable women
- girls and younger women.

Funding for travel is already available for women with low income under the NHS Healthcare Travel Costs Scheme, but this policy requires that women pay upfront and claim back costs after the abortion. Setting up processes for upfront funding will involve some initial costs, but otherwise the recommendation for women with a low income will only affect the timing of the payment and not the absolute cost. There will be some costs involved with providing funding for women who do not have a low income but who are travelling for a service that is not available locally. The new costs involved with funding travel and accommodation may be regained through women having earlier abortions.

Even small reductions in waiting times would result in large cost savings. A reduction of 1 day in the average waiting time would save the NHS £1.6 million per year on procedure costs and treating adverse events. Because of this, even relatively expensive interventions would be cost saving if they decrease waiting times. To reduce waiting times, services will need to consider ways to enable more rapid referral and develop pathways for self-referral. Some abortion services may need to reconfigure so that they are available on a greater number of days per week. More collaboration between NHS services and the independent sector may also be needed. However, recommendations on expulsion at home and remote follow-up will minimise the number of appointments needed, again

leading to cost savings.

Establishing dedicated phone and online booking systems, or centralised booking services, will have upfront costs. However, they are likely to lead to substantial savings through reduced waiting times.

Many services already have videoconferencing facilities. Videoconferencing software is not expensive, so services that don't have these facilities in place will not face significant upfront costs.

There has been an increase in community-based services in recent years, so additional costs associated with providing services in the community will be minimal. Women having an abortion in the community may need to make fewer arrangements regarding time off work, childcare and travel. This may enable them to present earlier for an abortion, which would result in cost savings for the NHS.

Women prefer care led by nurses or midwives. Expanding the role of these professionals should increase the number of appointments available and enable women to present earlier. Any upfront costs associated with providing training for nurses and midwives will likely be offset by cost savings from earlier abortions and reduced doctor hours.

Commissioners will need to work with national organisations such as Health Education England to agree changes to training curriculums.

Full details of the evidence and the committee's discussion are in evidence review A: accessibility and sustainability of abortion services and evidence review B: information needs of women undergoing an abortion.

Return to recommendations

Providing information

Recommendations 1.2.1 to 1.2.10

Why the committee made the recommendations

The recommendations are based on evidence showing what women want to know about abortion, and what formats they want information in. Some evidence came from women

who were having abortions for specific reasons, such as fetal anomaly (under the Abortion Act). However, the committee agreed that improving information provision would benefit all women who are having an abortion, so made recommendations that could apply to everyone.

The committee also made some recommendations based on their knowledge and experience covering:

- medical abortions at home
- what to expect when viewing a fetus after abortion.

The committee were aware of systematic reviews and guidance from the Academy of Medical Royal Colleges (2011), American College of Obstetricians and Gynecologists (2009) and Royal College of Obstetricians and Gynaecologists (2011; 2015) that indicate there is no evidence that an abortion increases the risk of infertility, breast cancer or mental health issues. As there was evidence that women looked on the internet for information about abortion, and the committee were concerned that some of this information may be inaccurate, they made a recommendation about these risks to inform women.

The committee were aware that women wanted information on the options for management and disposal of pregnancy remains (including burial) after an abortion. However, the committee did not make a detailed recommendation in this area as this is covered by 2015 guidance from the Human Tissue Authority that outlines:

- the options (including the right to take remains home)
- the information that should be provided to the woman and how this should be communicated
- the importance of meeting religious and cultural needs where possible.

Information for women who are having an abortion because of fetal anomaly

Recommendations 1.2.11 to 1.2.12

For women having an abortion because of fetal anomaly, there was evidence that they wanted more information on the nature of the anomaly. The committee agreed that this would be better addressed by the maternity service that diagnosed the fetal anomaly, so

included communication between services in their recommendation on service organisation.

There was evidence that women wanted information about how to tell other people (for example friends and family members) about the end of their pregnancy, but there was not enough evidence to make a recommendation.

How the recommendations might affect current practice

Services already provide women with information about their abortion. These recommendations may mean services need to change what information they are providing, but the cost of giving women more information is minimal and will result in women being better informed about their options and the process for abortion.

Full details of the evidence and the committee's discussion are in evidence review B: information needs of women undergoing an abortion.

Return to recommendations

Anti-D prophylaxis

Recommendations 1.3.1 to 1.3.4

Why the committee made the recommendations

There was no evidence on anti-D prophylaxis for women having an abortion up to and including 13^{+6} weeks' gestation. There is also no international consensus on this, with significant variation between different international and national guidelines.

Current practice in the NHS is to give anti-D to all women who are having an abortion and are rhesus D negative. However, testing for rhesus status and then administering anti-D can result in significant delays for women. They may need to visit the service more than once to receive anti-D, and this can be a particular problem for women who are travelling a long way or who find it difficult to afford travel. The cost of testing for rhesus status and giving anti-D also needs to be considered.

With these points in mind, the committee made recommendations based on their

knowledge and experience. They agreed that, for women up to and including 10^{+0} weeks' gestation, the volume of fetal blood cells transmitted to the mother is unlikely to cause maternal sensitisation. The impact of delays to the abortion, travel problems, and costs to services are likely to outweigh any benefit prophylaxis provides. The NICE guideline on ectopic pregnancy and miscarriage recommends against anti-D prophylaxis for women having medical management for these conditions. The committee agreed that the risks and benefits of anti-D prophylaxis would be similar for women having a medical abortion. Therefore, the committee made a recommendation in line with the NICE guideline on ectopic pregnancy and miscarriage.

Although there is no evidence to distinguish surgical and medical abortion on this topic, the committee agreed there may be risk of more fetal blood cell transmission during a surgical abortion. Because of this, anti-D prophylaxis may be beneficial for women having a surgical abortion up to and including 10^{+0} weeks' gestation.

In the independent sector, point-of-care testing is used and anti-D is provided immediately. In contrast, NHS transfusion laboratories usually follow the same processes for managing anti-D as they do for managing whole transfusion systems. This is unnecessary and introduces delays, and means that women must choose between not having testing and prophylaxis or returning to the service after the abortion. To help reduce delays, the committee made a recommendation in line with current practice in the independent sector.

In the absence of evidence, the precise benefits and risks of anti-D prophylaxis are unclear. The uncertainty is highest for women having a surgical abortion up to and including 10^{+0} weeks' gestation, so the committee made a research recommendation covering this group.

How the recommendations might affect practice

Restricting anti-D prophylaxis to women who are most likely to benefit from it could potentially produce cost savings of over £1 million annually across the NHS. Staff will be freed up to focus on more important and beneficial areas of the abortion service.

NHS Trusts and transfusion laboratories may need to amend their systems and processes to ensure they can provide rhesus status testing and anti-D prophylaxis without introducing delays to the abortion process.

Full details of the evidence and the committee's discussion are in evidence review C: anti-D prophylaxis for women up to 13^{+6} weeks' gestation.

Return to recommendations

Preventing infection

Why the committee made the recommendations

Recommendations 1.4.1 to 1.4.5

The evidence on antibiotic prophylaxis for women who are having medical abortion showed lower rates of severe infection with antibiotic prophylaxis compared with no antibiotic prophylaxis. However, the committee had concerns with the quality of the evidence, and the absolute risk of severe infection was very low. In addition:

- routinely prescribing antibiotics after medical abortion may increase the risk of antibiotic resistance
- adherence is likely to be low
- if using routine antibiotics the potential reduction in the risk of post-abortion infection is uncertain.

With these points in mind, the committee did not recommend routine antibiotic prophylaxis for women who are having a medical abortion. The committee believed that prophylaxis may be appropriate for women who are at high risk of infection, or who would find it difficult to access treatment at a later date if they screened positive for a sexually transmitted infection. However, there was no evidence to support recommending prophylaxis for a specific group.

Antibiotic prophylaxis is part of current clinical practice for women having a surgical abortion. The committee wanted to encourage this, so they made a recommendation in support.

The evidence reviewed did not identify which specific antibiotic regimen is most effective. Because of this, the committee agreed that further research would be beneficial and made a research recommendation. However, the committee were aware of a Cochrane review

which showed the effectiveness of nitroimidazoles (such as metronidazole), tetracyclines (such as doxycycline) and beta lactams (such as amoxicillin).

A 7-day course of doxycycline is currently used in practice. There was no evidence comparing doxycycline with other antibiotics; however, there was some limited evidence on duration of doxycycline. The evidence was unclear on whether or not there were clinically important differences between 3-day and 7-day courses of doxycycline in the rates of pelvic inflammatory disease after abortion, patient adherence, vomiting, or diarrhoea. The committee recommended a 3-day course because this may be as effective and adherence is likely to be better with a shorter course.

Metronidazole in combination with another broad-spectrum antibiotic is not routinely recommended because:

- compared with doxycycline alone for surgical abortion, it was unclear if it made a clinically important difference to the rate of pelvic inflammatory disease after abortion in women who had elevated vaginal pH and amines in vaginal discharge, or a positive gram stain for bacterial vaginosis
- although there was no evidence on the gastrointestinal side effects when compared with doxycycline alone, the committee agreed that in clinical practice metronidazole may be poorly tolerated with significant side effects.

However, the committee agreed that metronidazole is effective for anaerobic infections, so there may be situations where it is clinically indicated.

The evidence for the recommendations on doxycycline and metronidazole was based on antibiotic prophylaxis for surgical abortion. However, the committee agreed that the recommendations would also be appropriate if there is a need to use antibiotic prophylaxis for medical abortion as the causes of infection would be similar for both procedures, although the level of risk may differ.

The committee could not make recommendations about screening for sexually transmitted infections, because they did not review the evidence on this. A cross-reference has been included to the NICE guideline on reducing sexually transmitted infections.

How the recommendation might affect practice

Despite the shortage of evidence, it is current clinical practice to offer antibiotic

prophylaxis to women who are having medical abortion. Because of this, the recommendations will reduce the number of women having antibiotic prophylaxis for medical abortion. This has the potential to be cost saving and to reduce the risk of antibiotic resistance. The recommendation may also increase the number of women who accept screening for sexually transmitted infections. This is because women are more likely to accept screening if they are not given prophylactic antibiotics (which could make them believe screening and treatment for sexually transmitted infections, if present, was not needed).

The recommendation for surgical abortion supports routine antibiotic prophylaxis, which is current practice.

The 7-day course of doxycycline is currently used in practice. Metronidazole is also currently used in combination with other broad-spectrum antibiotics. Switching to shorter courses of doxycycline and not using metronidazole in combination with other broad-spectrum antibiotics may lead to cost savings.

Full details of the evidence and the committee's discussion are in evidence review D: antibiotic prophylaxis for medical and surgical abortion.

Return to recommendations

Venous thromboembolism prophylaxis

Recommendations 1.5.1 to 1.5.2

Why the committee made the recommendations

There was no evidence on the optimal timing and duration of venous thromboembolism (VTE) prophylaxis for women having an abortion who need pharmacological thromboprophylaxis. In the absence of evidence, the committee made a recommendation based on the recommendations for women who have had a termination in the last 6 weeks in the NICE guideline on reducing the risk of venous thromboembolism.

The recommendation for women at high risk is based on the committee's knowledge and experience. They agreed that it may be safer to start prophylaxis earlier and provide it for longer in this group. However, the lack of evidence meant they were unable to be more specific. The recommendation is in line with antenatal and postnatal risk assessment tools

from the Royal College of Obstetricians and Gynaecologists.

How the recommendations might affect practice

These recommendations are in line with the NICE guideline on reducing the risk in venous thromboembolism. Unlike that guideline, the recommendations here cover all women at risk, rather than just those admitted to hospital. This means there may be an increase in the number of women receiving prophylaxis.

There will be increased costs from the increased use of low-molecular-weight heparin and the training needed to administer it. The size of this increase will depend on current local practice and the number of women who are at risk of thrombosis. These costs will be partially offset by a reduction in the incidence of VTE, but the savings associated with this may be small as VTE is rare in this context.

Full details of the evidence and the committee's discussion are in evidence review E: venous thromboembolism prophylaxis for women having abortion.

Return to recommendations

Choice of procedure for abortion

Recommendations 1.6.1 to 1.6.2

Why the committee made the recommendation

The evidence showed that women having an abortion for fetal anomaly preferred a choice between medical or surgical abortion, and in the committee's experience women having an abortion for other reasons also valued having a choice of procedure.

Comparing medical and surgical abortion in women between 13^{+0} and 23^{+6} weeks' gestation, the evidence showed that it was unclear whether or not there was a clinically important difference in:

- haemorrhage that needed transfusion, or blood loss of 500 ml or more
- abortion completed by the chosen method

- uterine injury
- infection within 1 month of the abortion.

It was also unclear from the evidence whether or not there was a clinically important difference in cervical injury between medical and surgical abortion. However, the committee agreed that the risk of cervical injury with medical abortion would be extremely low as no instruments or dilators are inserted into the cervix. There was a higher clinically important rate of incomplete abortion needing surgical intervention for women who had medical abortion. There was also some evidence that women prefer surgical abortion. However, the evidence in this area was limited, and the committee did not feel confident in making a recommendation in favour of one method. This guideline did not review evidence comparing medical and surgical abortion for women up to and including 12^{+6} weeks' gestation, because it is well established that both methods are highly safe at this gestational age and that they have similar effectiveness. In addition, evidence for abortions after 23^{+6} weeks was not reviewed because all abortions in England and Wales after this gestational age are medical procedures, with the exception of surgical abortions when feticide has been given at or before 23^{+6} weeks.

Given the evidence that women preferred a choice of procedure, and the lack of evidence that either procedure is superior, the committee recommended offering women up to and including 23^{+6} weeks a choice (as long as it is clinically appropriate).

How the recommendation might affect current practice

This recommendation will lead to a change in practice because abortion services for women vary widely nationally. Many services only offer either surgical or medical abortion. There are also relatively few doctors trained to provide surgical abortion in the second trimester in the NHS, and most independent sector services are not set up to provide inpatient medical abortion.

To address these issues, greater collaboration may be needed between and across sectors to provide women with a choice of methods. Theatre teams in the NHS may also need support if they are going to introduce a new service offering surgical abortion by dilatation and evacuation. Modern dilatation and evacuation practice uses ultrasound scanning during surgery, so scan machines need to be in theatre and staff need to be able to undertake intraoperative scanning when needed.

Before services can start offering medical abortion, they need to ensure they have beds

available and nursing staff who are trained to care for women having medical abortion in the second trimester.

Full details of the evidence and the committee's discussion are in evidence review B: information needs of women undergoing an abortion and evidence review K: medical versus surgical abortion between 13^{+0} and 24^{+0} weeks' gestation.

Return to recommendation

Abortion before definitive ultrasound evidence of an intrauterine pregnancy

Recommendations 1.7.1 to 1.7.2

Why the committee made the recommendations

Only limited evidence was available for this area. However, it suggested that abortion (medical or surgical) works just as well before there is definitive ultrasound evidence of an intrauterine pregnancy (that is, a yolk sac) as it does afterwards. There was no clinically important difference in the rates of complete abortion, whereas it was unclear whether or not there was a clinically important difference in the rates of missed ectopic pregnancy and ongoing pregnancy.

These findings matched the clinical experience of the committee for medical abortion at this stage for women who do not have signs or symptoms of an ectopic pregnancy. In addition, evidence from other areas of the guideline showed that women prefer to have the abortion as soon as possible.

As the evidence was limited, the committee felt that it was important to make women aware of the potential risk of not identifying an ectopic pregnancy, and what they should do if there is a problem.

How the recommendations might affect current practice

Some services do not currently provide abortion before there is definitive ultrasound evidence of pregnancy. As a result, the recommendation will make abortion available earlier than it is currently provided. This will make it easier for women to access services

and reduce waiting times. There may be a larger impact on providers of surgical abortion, as this is not always offered as early as medical abortion.

Services providing surgical abortion before ultrasound evidence will need to have systems to confirm that the pregnancy has been aspirated. For example, they will need to have staff trained to inspect the products of conception for the presence of chorionic villi and a gestational sac, and provide the necessary equipment to do this (typically a light box and a clear receiver) or immediate access to ultrasound. Services offering surgical or medical abortion before ultrasound evidence of pregnancy will also need to be able to assess serum human chorionic gonadotrophin (hCG), and have staff trained in interpreting test results. If an ectopic pregnancy is suspected, services will need to have processes in place to refer the woman promptly to an early pregnancy assessment unit.

Full details of the evidence and the committee's discussion are in evidence review F: abortion before ultrasound evidence.

Return to recommendations

Expulsion at home for medical abortion up to and including 10^{+0} weeks

Recommendations 1.8.1 to 1.8.2

Why the committee made the recommendation

These recommendations are based on the evidence on the safety of home expulsion. Separate recommendations were made for women up to and including 9^{+6} weeks gestation and women at 10^{+0} weeks gestation due to the legal limit at which misoprostol can be taken at home.

Comparing women up to and including 9^{+0} weeks' gestation at the time they take mifepristone with women who take it between 9^{+1} and 10^{+0} weeks, the evidence on home expulsion showed no difference in:

- the risk of serious complications, such as the need for emergency care or hospitalisation, haemorrhage needing transfusion, or 500 ml or more blood loss

- the rate of adverse events such as pain, vomiting and diarrhoea.

It was unclear whether or not there was a difference in rates of completed abortion without the need for surgical intervention in women who were up to and including 9^{+0} weeks when home expulsion was performed or between 9^{+1} and 10^{+0} weeks. Evidence on patient satisfaction showed it was the same in both groups.

The committee noted that the evidence on women having home expulsion up to and including 12^{+0} weeks was from a single low-quality study from settings outside the UK. They agreed that further research on home expulsion up to and including 12^{+0} weeks in the UK would be beneficial to inform future practice and made a research recommendation.

How the recommendation might affect current practice

Currently, medical abortion with expulsion at home is offered for women who are up to and including 10^{+0} weeks gestation at the time they take mifepristone in some areas, but only up to and including 9^{+0} weeks in others. As well as standardising practice, the recommendations are likely to result in more women being able to have an early medical abortion at home. In current practice women need to be admitted to hospital and have to wait for bed availability. Expanding home expulsion would reduce the number of women admitted to hospital, reducing waiting times.

Full details of the evidence and the committee's discussion are in evidence review G: expulsion at home for early medical abortion.

Return to recommendation

Medical abortion up to and including 10^{+0} weeks

Recommendations 1.9.1 to 1.9.2

Why the committee made the recommendations

There was limited evidence comparing simultaneous mifepristone and misoprostol with interval treatment (misoprostol given 23 to 48 hours after mifepristone) for abortion in women who were up to and including 9^{+0} weeks' gestation. The evidence that was available showed no difference in:

- ongoing pregnancy rate
- rates of haemorrhage that needed transfusion, or blood loss of 500 ml or more
- patient satisfaction
- the need for repeat misoprostol
- incomplete abortion needing surgery.

However, for all of these outcomes apart from patient satisfaction, it was unclear whether or not there was a clinically important difference. In addition, the committee were concerned that the findings from this review were inconsistent with their experience. There is also another study (Lohr 2018) with different results to the studies that were covered in the evidence review. This study was not included in the review because it was not a randomised controlled trial. However, it was a much larger study (nearly 29,000 participants compared with 1,100 in the largest randomised controlled trial) and had a similar population to the studies in the evidence review. This study showed that:

- the success rates of simultaneous administration were inversely proportional to the gestational age
- as gestational age increases simultaneous administration becomes increasingly inferior to interval administration
- for ongoing pregnancy, while the risk was low in both groups, the absolute risk was 1.5% higher after simultaneous treatment (2.4%) than after interval treatment (0.9%).

Given the size and relevance of this study, the committee believed it was important to take these findings into account when making recommendations.

There was evidence that bleeding and pain started later with simultaneous mifepristone and misoprostol. This may be an advantage for women who are taking both of the drugs in hospital or clinic before travelling home to complete the abortion. In addition, the total time from start to completion of abortion is shorter, and women may prefer simultaneous mifepristone and misoprostol because of this.

The committee specified vaginal misoprostol for simultaneous treatment because that was the only route of administration used in the evidence. The committee did not recommend simultaneous treatment as an option for women between 9^{+1} and 10^{+0} weeks' gestation because there was no evidence for women with a longer gestation period. Interval

treatment was recommended for these women because it is standard clinical practice.

How the recommendations might affect current practice

Simultaneous administration of mifepristone and misoprostol is not routinely offered, so these recommendations could result in changes to practice.

Full details of the evidence and the committee's discussion are in evidence review H: medical abortion up to 10^{+0} weeks' gestation.

Return to recommendations

Medical abortion between 10^{+1} and 23^{+6} weeks

Recommendations 1.10.1 to 1.10.2

Why the committee made the recommendations

Most studies included a vaginal loading dose of 800 micrograms misoprostol in their regimen. The dose for vaginal misoprostol is the same dose used for abortion up to and including 10^{+0} weeks' gestation, so this will be simpler for services to provide for women between 10^{+1} and 23^{+6} weeks' gestation. The evidence showed no significant difference between an initial dose of vaginal misoprostol compared with sublingual misoprostol on time to expulsion or rate of completed abortion. Some women will prefer not to have vaginal misoprostol, so giving the option of sublingual administration takes account of patient preference. The sublingual dose was taken from the study comparing the vaginal and sublingual doses. The evidence showed that oral misoprostol had more side effects than sublingual or vaginal regimens and also had a longer interval between induction and abortion. There was no evidence available regarding effectiveness of oral misoprostol administered as a loading dose. Because of this, no recommendation was made on oral misoprostol.

For follow-up doses, most of the studies reviewed used 400 micrograms misoprostol given vaginally, orally, sublingually or buccally. In addition, there was limited evidence that this dose had a shorter time to expulsion than the 200 microgram dose.

There was evidence that time to expulsion was shorter when there was a longer interval

between mifepristone and misoprostol administration. In comparisons of different intervals:

- a 36- to 38-hour interval gave a shorter time to expulsion than simultaneous administration
- a 48-hour interval gave higher rates of completed abortion and shorter time to expulsion than a 24-hour interval.

The committee noted that some women would prefer not to wait 36 to 48 hours between taking mifepristone and taking misoprostol, because of factors such as travel difficulties. To take account of patient preference, they recommended giving women the option of a shorter interval.

The committee were aware of guidelines from the Royal College of Obstetricians and Gynaecologists that recommend feticide for abortion after 21^{+6} weeks' gestation. However, the committee did not review the evidence on feticide, so they could not make recommendations on this.

How the recommendations might affect current practice

These recommendations will reduce variations in practice in the use of misoprostol for abortion between 10^{+1} and 23^{+6} weeks. The recommendations will also reduce the use of oral misoprostol, which is used currently.

Full details of the evidence and the committee's discussion are in evidence review J: medical abortion between 10^{+1} and 24^{+0} weeks' gestation.

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Medical abortion after 23^{+6} weeks

Recommendations 1.11.1 to 1.11.4

Why the committee made the recommendations

Abortion after 23^{+6} weeks' gestation is rare. In 2017, these abortions accounted for 0.1% of the total. The statutory grounds for abortion at this stage are for fetal anomaly or, in an

emergency, either:

- when continuing the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated **or**
- to prevent grave permanent injury to her physical or mental health.

There was no evidence on which regimen is optimal for medical abortion after 23^{+6} weeks. In the absence of evidence, the committee based the recommendation for women between 24^{+0} and 25^{+0} weeks' gestation on the dose regimens for women having an abortion up to and including 23^{+6} weeks. Considering the increased sensitivity of the uterus to misoprostol as gestational age increases, the initial high loading dose of misoprostol was not included in the regimen for this group.

For women between 25^{+1} and 28^{+0} weeks' gestation, the recommendation is based on the committee's knowledge and experience. They noted that the uterus becomes more sensitive as gestational age increases and so the dose of misoprostol should be reduced. The recommendation is also in line with the International Federation of Gynecology and Obstetrics (FIGO) guidance on misoprostol for women at this gestation.

For women after 28^{+0} weeks' gestation, the committee recommended the regimen based on their expertise and on the guidance from FIGO.

Because the uterus becomes more sensitive to misoprostol later in gestation, women who have had a previous caesarean section or uterine surgery may be at higher risk of uterine rupture with increased doses of misoprostol. In the absence of evidence to recommend a different regimen for this group, the committee agreed that clinicians should be made aware of this risk. Given this risk and the lack of evidence in this area, the committee made a research recommendation on drug regimens for medical abortion after 23^{+6} weeks, particularly for women who have had a previous caesarean section or uterine surgery.

The committee were aware of guidelines from the Royal College of Obstetricians and Gynaecologists that recommend feticide for abortion after 21^{+6} weeks' gestation. However, the committee did not review the evidence on feticide, so they could not make recommendations on this.

How the recommendations might affect current practice

There is currently no guidance on what regimen to use for medical abortion after

23^{+6} weeks. Current practice varies as a result, and some services use lower doses of misoprostol that may not be as clinically effective as higher doses. These recommendations will help to standardise practice.

Full details of the evidence and the committee's discussion are in evidence review L: medical abortion after 24 weeks' gestation.

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Cervical priming before surgical abortion

Why the committee made the recommendations

Up to and including 13^{+6} weeks

Recommendations 1.12.1 to 1.12.2

There was good evidence that vaginal and sublingual misoprostol reduce the risk of an incomplete abortion and reduce the force needed to dilate the cervix, compared with no cervical priming.

The timings given were chosen to minimise the amount of time spent with preoperative pain and bleeding while still ensuring adequate priming. More force was needed to dilate the cervix when vaginal misoprostol was given 1 hour before the procedure, so this regimen needs to be given earlier than sublingual misoprostol. This means women will spend more time with preoperative pain and bleeding if they have vaginal misoprostol. However, based on the committee's experience, sublingual misoprostol causes more gastrointestinal side effects than vaginal misoprostol. It may therefore be less acceptable to women, and managing the side effects can place additional demands on the service. Because of these advantages and disadvantages, the committee recommended both so that women can choose which is best for them, and so that providers can be flexible (for example with appointment times) based on what works best for each woman.

The dose of 400 micrograms was chosen for both routes of misoprostol administration because there was more evidence for this than for 200 micrograms, and because it was unclear whether or not there were clinically important differences in side effects between the two.

There was very little evidence for mifepristone. However, the evidence that was available suggested that mifepristone may be as effective as misoprostol. Because of this, the committee recommended mifepristone when misoprostol cannot be used, so that women in this situation have another option. The dose is based on the evidence reviewed and on standard clinical practice. The timings are based on the evidence available, but a range is recommended because there was limited evidence comparing mifepristone given 48 hours before the procedure with mifepristone given 24 hours before the procedure.

While cervical priming makes the procedure safer, women may be put off by the possibility of preoperative pain and bleeding associated with its use. Women are more likely to choose cervical priming if the benefits and harms are fully explained to them, so the committee made a recommendation to ensure this happens.

Between 14^{+0} and 23^{+6} weeks

Recommendations 1.12.3 to 1.12.8

Cervical priming is standard clinical practice for women having a surgical abortion between 14^{+0} and 23^{+6} weeks.

There was good evidence that cervical priming regimens using same day or overnight osmotic dilators either increase cervical dilation, make procedures easier to carry out, or both, compared with cervical priming without dilators. However, there was evidence that osmotic dilators are less acceptable to women than mifepristone or misoprostol. In addition, the evidence comparing single priming agents against each other was unclear on whether or not there are differences between dilators and mifepristone in a number of important outcomes, such as cervical trauma, uterine perforation and preoperative expulsion. It was also unclear whether misoprostol alone and osmotic dilators alone gave equivalent baseline cervical dilation, or whether there are clinically important differences. Therefore, the committee recommended all 3 options.

Mifepristone and misoprostol are only recommended between 14^{+0} and 16^{+0} weeks and between 14^{+0} and 19^{+0} weeks respectively because there was no evidence for them beyond these stages. There was evidence for the 200 mg oral dose of mifepristone given the day before the abortion, but not enough evidence to recommend a specific dose or timing for misoprostol.

There was no evidence for alternatives to osmotic dilators after 19^{+0} weeks. There was

good evidence that mifepristone combined with osmotic dilators reduces procedural difficulty compared with osmotic dilators alone. However, it was unclear if there were differences in safety outcomes such as uterine perforation or cervical trauma. The committee recommended this regimen for women who were between 19^{+1} and 23^{+6} weeks' gestation, because later gestational age is associated with increased procedural difficulty.

The committee agreed that further research on whether pharmacological priming is an effective and acceptable alternative to osmotic dilators would be useful, so made a research recommendation.

Limited evidence showed that inserting osmotic dilators the day before the abortion will also make the procedure easier, compared with inserting them on the same day. However, this would involve an additional visit to the clinic, and this may not always be possible. The evidence on inserting osmotic dilators the day before the procedure only covered women having an abortion up to and including 17^{+6} weeks' gestation. Despite this, the committee agreed that women at later gestations may have the greatest benefit from inserting osmotic dilators the day before, as abortion becomes more complicated at later gestational ages. The committee agreed that further research comparing the timing of osmotic dilator insertion would be beneficial to inform future practice, so made a research recommendation.

Misoprostol does not provide any benefit when used in combination with osmotic dilators, and it may have additional side effects. Further, it was unclear from the evidence whether or not there was an increased risk of preoperative expulsion when the combination was used compared with dilators alone. It is feasible that this risk may increase with additional cervical priming. Therefore, the committee recommended that the combination is not used.

How the recommendations might affect practice

Up to and including 13^{+6} weeks

These recommendations will reduce variations in practice in the use of cervical priming. The recommendations will also reduce the use of oral misoprostol, which is currently used but which has worse side effects than sublingual or vaginal regimens. The option to have misoprostol one hour before the procedure may make it easier and more convenient for women to have cervical priming, particularly if they live in remote areas with longer journey times.

The recommendations will likely increase the use of cervical priming, which may increase costs. The cost to individual services will depend on their current practice. However, this increased cost may be offset by savings from fewer additional operations for incomplete abortions.

Between 14^{+0} and 23^{+6} weeks

These recommendations may lead to greater use of osmotic dilators, and may increase the number that are inserted the day before, requiring more women to attend an appointment for cervical priming the day before the abortion. This additional appointment will result in increased costs and burden on the woman and may not be possible for some women. There may be further costs for services that provide accommodation for women who have travelled for their abortion, but this will depend on local policies.

Overall, few women have a surgical abortion during the second trimester, so the absolute cost impact is likely to be small, although the impact on the woman and her family may be considerable.

Full details of the evidence and the committee's discussion are in evidence review M: cervical priming before surgical abortion.

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Anaesthesia and sedation for surgical abortion

Recommendations 1.13.1 to 1.13.3

Why the committee made the recommendations

There was only limited evidence comparing different types of sedation or anaesthesia for surgical abortion. The evidence that was available did not show that any particular method was more effective. The committee are aware that women have different preferences on anaesthesia. For example:

- some women need to minimise their recovery time (if they are driving home, or if they care for dependents)
- some women are anxious about the procedure and would prefer not to be conscious

during it.

With this in mind, the committee recommended discussing all the anaesthesia options and explaining the differences to the woman.

There was not enough evidence to recommend a specific method for administering local anaesthesia. The committee agreed that further research on local anaesthesia methods (including intrauterine anaesthesia) would be beneficial, so made a research recommendation.

There was good evidence that women who had intravenous conscious sedation experienced less pain and nausea than women who had oral conscious sedation. Women who had intravenous sedation were also more likely to say they would choose it again.

Inhalational anaesthetics cause dose-dependent uterine relaxation. This may cause more bleeding compared with other medications used for general anaesthesia, such as propofol. The evidence comparing propofol and sevoflurane did not show any difference in haemorrhage requiring transfusion or blood loss greater than 500 ml. However, this is a rare event and the evidence was from a single study, so the committee recommended more research.

How the recommendations might affect practice

These recommendations will increase awareness of the options available for sedation or anaesthesia for surgical abortion, reduce variations in practice, and increase the choice available to women.

The recommendations will also reduce the use of oral conscious sedation, which is currently used but is not as effective as intravenous conscious sedation. Intravenous conscious sedation takes effect quicker than oral conscious sedation and has a shorter recovery time, so resource use should be reduced and scheduling flexibility may be improved as women spend less time in hospital. The recommendations may lead to a rise in the number of women opting for intravenous conscious sedation, causing an increased need for staff trained in administering it. Although conscious sedation is not currently used in all abortion services in the NHS, its use is widespread in other areas (such as endoscopy and assisted conception). As there are staff experienced in administering conscious sedation for other procedures, the resource impact in terms of staff training is not likely to be large.

Full details of the evidence and the committee's discussion are in evidence review M: cervical priming before surgical abortion.

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Follow-up and support after an abortion

Why the committee made the recommendations

Follow-up after medical abortion up to and including 10^{+0} weeks

Recommendations 1.14.1 to 1.14.2

Limited evidence was available showing no clinically important difference between remote and clinic follow-up for rates of adherence to follow-up. It was unclear whether or not there was a clinically important difference between remote and clinic follow-up in rates of:

- missed ongoing pregnancy
- unscheduled phone calls or visits
- surgical intervention.

There was only very limited indirect evidence on patient satisfaction, suggesting a preference for remote over clinic follow-up. No randomised controlled trial evidence was available for self-assessment, but the committee included this in the recommendation because it is offered in current practice, and it gives women an additional option.

Evidence on pregnancy tests was also limited, showing that it was unclear whether or not there was a clinically important difference in rates of missed ongoing pregnancy or surgical intervention with multi-level urine pregnancy tests (these have several thresholds of human chorionic gonadotrophin [hCG], such as 25, 100, 500, 2,000 and 10,000 international units [IU]), compared with high-sensitivity urine pregnancy tests (with a typical detection threshold of 10 to 25 IU hCG). Rates of patient satisfaction also appeared to be the same with both types of test. However, the committee did not recommend high-sensitivity tests because these can lead to higher clinically important rates of unscheduled clinic visits due to high rates of false-positive results in the month following the abortion. Instead, the committee recommended either multi-level or low-

sensitivity tests (detection limit 1,000 IU hCG), which are reliable 2 weeks after the abortion. Low-sensitivity tests are already widely used in the UK and the rest of Europe, and are approved for home use.

The evidence only included women having abortion up to and including 9^{+0} weeks' gestation. However, the committee agreed that the recommendations were appropriate for women having an abortion up to and including 10^{+0} weeks' gestation because:

- this is current standard clinical practice **and**
- the range of hCG remains above the detection limit (1,000 IU) into the second trimester.

Support after an abortion

Recommendations 1.14.3 to 1.14.6

The recommendations are based on evidence showing that some women sought support for a number of reasons after an abortion. The evidence showed that they sought support from various different sources and they valued support that was specific to their circumstances. However, it also suggested that women sometimes found it difficult to get the support they need.

While most of the evidence came from women having an abortion for fetal anomaly, the committee agreed that all women would benefit from information about what to expect and how to access support following an abortion, should they wish this. The committee also made a recommendation covering aftercare, based on their knowledge and experience.

How the recommendations might affect practice

Follow-up after medical abortion up to and including 10^{+0} weeks

The use of low-sensitivity or multi-level pregnancy tests instead of a routine clinic visit for ultrasound will reduce the number of clinic visits needed for women and be associated with cost savings for services. The recommendations should also reduce variation in practice by reducing the use of high-sensitivity pregnancy tests. These tests are associated with more clinic visits and a longer time period before the outcome of the

abortion can be confirmed.

Support after an abortion

These recommendations should make it easier for women to get support after an abortion, and reduce the variation in what support is offered.

The impact for providers will vary according to what support they currently offer but many providers already offer emotional support and have arrangements in place for referring women to counselling services.

Full details of the evidence and the committee's discussion are in evidence review I: follow-up after medical abortion up to 10^{+0} weeks and evidence review O: support after abortion.

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Improving access to contraception

Recommendations 1.15.1 to 1.15.5

Why the committee made the recommendations

Service organisation

There was evidence that providing contraception immediately after a surgical abortion improved uptake and continued contraception use, compared with providing contraception later. There was some variation in these outcomes after medical abortion, but providing contraception immediately (or as soon as possible) after abortion still reduced rates of subsequent abortions. There were also higher rates of patient satisfaction when contraception was provided immediately.

There was limited evidence that:

- more women received long-acting reversible contraception when providers had staff who were skilled in providing all types of contraception
- having the full range of contraceptive methods available increased uptake and

continued contraception use, and reduced the rate of subsequent abortions.

Skilled healthcare professionals are needed to administer a number of long-acting methods of contraception and ensure that the full range of contraceptive methods are available. Without them, it may not be possible for women to receive their preferred choice of contraception immediately. Therefore, although the evidence was limited, the committee made a recommendation that providers ensure they have the full range of contraceptive methods available, and staff with the skills to provide them.

Effectiveness and safety

When compared with delayed insertion, immediate implant insertion provides a clinically important reduction in the rates of subsequent unintended pregnancy, and higher rates of patient acceptability and satisfaction. The evidence also showed that it was uncertain whether or not there were clinically important differences in the rates of:

- continuing pregnancy
- incomplete abortion with the need for surgical intervention
- complete abortion without the need for surgical intervention
- subsequent unintended pregnancy at 3 months.

The evidence showed that, compared with delayed intrauterine insertion, early or immediate insertion of intrauterine devices provides either higher rates or no clinically important difference in rates of levonorgestrel intrauterine system (LNG-IUS) or copper intrauterine device (IUD) uptake and continued use. There was also evidence covering all gestational periods for LNG-IUS and covering gestations up to and including 9^{+0} weeks for IUD looking at:

- uterine perforation
- infection within 1 month
- subsequent pregnancy within 1 year.

However, the evidence was unclear on whether or not there were clinically important differences in any of these outcomes. For uterine perforation, the absolute risk was very small. For infection, the evidence did not distinguish between infections caused by intrauterine device insertion and those caused by the abortion in the women who received

the device early or immediately.

Immediate depot medroxyprogesterone acetate (DMPA) intramuscular injection provides a clinically significant improvement in patient satisfaction, compared with delayed injection. In addition, the evidence showed that it was unclear whether or not there were clinically significant differences between the 2 interventions in the rates of:

- incomplete abortion with the need for surgical intervention
- complete abortion without the need for surgical intervention
- subsequent unintended pregnancy.

There was a potentially higher rate of ongoing pregnancy with immediate DMPA intramuscular injection compared with the delayed injection. However, there was uncertainty around this estimate, the absolute risk was small, and it was only seen in one study reviewed. Because of this, the committee agreed that immediate injection can be recommended as long as women are advised of the potential risk. There was no evidence to recommend a specific timing for DMPA administered subcutaneously.

How the recommendations might affect practice

Currently, some providers do not offer DMPA intramuscular injection immediately, due to concerns that this might affect the efficacy of the abortion. Therefore, these recommendations will reduce variations in practice. There may be an initial cost associated with providing training for staff in abortion services to administer long-acting reversible contraception. However, this will be offset by not needing an additional appointment to administer contraception, and increased access leading to fewer subsequent unintended pregnancies and abortions.

There is unlikely to be a significant change in practice resulting from these recommendations as intrauterine contraception is currently already offered to women after a medical abortion; all that is likely to change is the timing.

These recommendations will reduce variation in practice on contraception provision after abortion. They will also increase the choices available to women. The impact on individual services will depend on current practice. In the independent sector, most services are commissioned to provide all forms of contraception whereas, in the NHS, some trusts have difficulty getting funding for certain contraceptive methods.

Overall, these recommendations should not increase costs or resource use, as the range of contraceptive methods covered is already available to women. However, there may be a change in who is funding contraception, with greater funding from clinical commissioning groups compared with local authorities. This will mean changes in the way services are organised, and commissioners will need to develop services to enable the recommendations.

Full details of the evidence and the committee's discussion are in evidence review P: contraception after abortion.

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Context

Abortion is a common procedure. In 2018, 200,608 women in England and Wales had an abortion. Almost all of these abortions were funded by the NHS, but 72% were performed by the independent sector.

Most abortions are carried out because the pregnancy was unintended, and the majority of procedures (80% of abortions in England and Wales in 2018) are conducted in the first 10 weeks of pregnancy. Abortion is a safe procedure, and can be carried out medically (taking mifepristone followed by misoprostol) or surgically.

The trend in England and Wales over the past decade has been towards increasing use of medical abortion. In 2018, 71% of all abortions in England and Wales were medical, and this rises to 83% of abortions in the first 10 weeks of pregnancy.

In recent years, there have been changes in how and where abortion services are delivered. This has resulted in variation in the type and choice of procedures available across the NHS, for example, in the offer of local anaesthesia and sedation for a surgical procedure. In addition, the procedure used for medical abortion has been refined and women in the first 10 weeks (up to 9 weeks and 6 days) may now self-administer misoprostol at home in England and Wales. Furthermore, methods for checking whether a medical abortion has been successful have also been simplified. Some of these developments could significantly reduce costs to the NHS and be more acceptable to women.

Abortion services also provide other important sexual and reproductive health services to women, including contraceptive services. However, there is marked variation across the country, involving different types of providers and, increasingly, organisations outside the NHS. In addition, accessing abortion services may be difficult for women who live in remote areas, who are in the second trimester of pregnancy, or who have complex pre-existing conditions or difficult social circumstances. In particular, abortion care is challenging for women living in Northern Ireland who currently have to travel to other parts of the UK in order to access services.

This guideline will help ensure that abortion procedures are carried out based on the best available evidence, and that a choice of services is easily accessible to all women who request an abortion.

Finding more information and committee details

To find out what NICE has said on topics related to this guideline, see the NICE topic page on pregnancy.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put guidance into practice.

Update information

Minor changes since publication

February 2025: We amended recommendation 1.4.1 to clarify that testing for HIV should be routinely offered in line with NICE's guideline on HIV testing.

September 2022: We updated recommendation 1.8.1 to bring it in line with the amended legislation on early medical abortion in the Abortion Act.

October 2019: Links to the NICE patient decision aids on abortion before 14 weeks and abortion from 14 weeks up to 24 weeks were added.

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