Crisis Pregnancy: A Management Guide for General Practice

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Whilst every effort has been made by the Quality in Practice Committee to ensure the accuracy of the information and material contained in this document, errors or omissions may occur in the content.

This guidance represents the view of the ICGP which was arrived at after careful consideration of the evidence available.

The guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

Evidence-Based Medicine

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

In this document you will see that evidence and recommendations are graded according to levels of evidence (Level 1 – 5) and grades of recommendations (Grades A-C) respectively. This grading system is an adaptation of the revised Oxford Centre 2011 Levels of Evidence.

Levels of Evidence

Level 1: Evidence obtained from systematic review of randomised trials
Level 2: Evidence obtained from at least one randomised trial
Level 3: Evidence obtained from at least one non-randomised controlled cohort/follow-up study
Level 4: Evidence obtained from at least one case-series, case-control or historically controlled study
Level 5: Evidence obtained from mechanism-based reasoning

Grades of Recommendations

A Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (Evidence levels 1, 2)
B Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation. (Evidence levels 3, 4).
C Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (Evidence level 5).

ICGP Quality in Practice Committee

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Section 1 Introduction

1.1 Definition
Crisis pregnancy is “a pregnancy which is neither planned nor desired by the woman concerned and which represents a personal crisis for her”. The HSE Crisis Pregnancy Programme interprets this definition to include those women from whom a planned or desired pregnancy develops into a crisis over time due to a change in circumstances. Crisis pregnancy can also have a profound effect on the woman’s partner and wider family, in addition to its effect on the woman herself. In this document, we refer primarily to the individual woman but the information and advice provided is applicable to the others affected by the crisis pregnancy.

1.2 Background
Crisis pregnancy can affect women of childbearing age, of any social group or in any geographical community. Effective management requires attention to a broad range of clinical, social, educational, religious and legislative issues. The response of the GP or other healthcare professional at the initial consultation can have a profound impact on her experience of this life crisis. The widespread availability of contraception from GPs and clinics and the work of the HSE Crisis Pregnancy Programme both directly and through the work of funded services have contributed to increasing the usage of effective contraception. The number of women having abortions in England and Wales giving Irish addresses has fallen by 38% between 2001 and 2011.

The 2010 Irish Contraception and Crisis Pregnancy Survey surveyed more than 3,000 randomly selected adults and reports that:

- 35% of women and 21% of men who have been pregnant describe having at least one crisis pregnancy.
- 13% of all pregnancies were considered to be crisis pregnancies.
- Outcome of all crisis pregnancies for women: parenthood (62%), miscarriage (14%), abortion (21%), adoption (1%) and currently pregnant (1%).

4,149 Irish women had abortions in the UK in 2011 and much smaller numbers in other countries, including 33 in the Netherlands in 2011. The number of these women who consult their GPs before arranging an abortion overseas or attend for post-abortion care is unknown. In a study of Irish GPs in 2011, 97% report having had consultations dealing with abortion. GP registrars report low levels of awareness of Irish support services and express a need for more information on managing crisis pregnancies.

1.3 Aim of the Document
The aim of this guideline is to ensure that all women with crisis pregnancies receive high quality care when they present to general practice. This guideline provides evidence-guided information and recommendations to support GPs when providing this care.

1.4 Key Points
- 35% of Irish women who have been pregnant describe having at least one crisis pregnancy.
- Women requesting emergency contraception should be informed about all the different methods. These include levonorgestrel (Levonelle and Norlevo), ulipristal acetate (Ella-One) and the copper containing intrauterine device.
- There is a legal obligation on those providing pregnancy counselling in Ireland to discuss all options in a non-directive manner where a woman wants information on abortion.
- Where the GP feels that the woman needs specialist counselling, a number of centres around the country provide free crisis pregnancy counselling (funded by the HSE Crisis Pregnancy Programme). These can be found at www.positiveoptions.ie. All service providers listed will provide counselling on all options but two of the services listed will not provide contact details for abortion service providers. A woman and/or her partner may also avail of free counselling post-abortion irrespective of how long after the procedure she/he presents.
- The two major organisations providing private abortion services in the UK have websites tailored to Irish women with crisis pregnancies. These are the British Pregnancy Advisory Services www.bpas.ie and the Marie Stopes Clinics www.reproductivechoices.ie.
- Abortion is a safe procedure provided it is carried out in an accredited setting. Women commonly experience a range of physical symptoms after medical or surgical abortion that is considered to be within the normal range. GPs should be aware of these common side effects and be able to offer women reassurance.
- Major complications post abortion are rare, however GPs should be aware of the symptoms and signs that require urgent referral.
- Women who have undertaken an illegal medical abortion at home may be more likely to present with complications post abortion.
Section 2 Role of GP in Prevention and Management of Crisis Pregnancy

GPs may be involved in
- Prevention – education, contraception, emergency contraception
- Confirming the pregnancy
- Advice / counselling
- Support/referral/provision of information – depending on the woman’s choice
- Ante-natal combined care
- Post-natal care
- Post-abortion care.

A woman in a crisis situation needs non-judgemental support in reaching and implementing her decision. GPs act in the best interests of their patients if they clearly identify the limit of their own comfort in this area and refer if necessary (Grade C recommendation).

2.1 Prevention of Crisis Pregnancy

35% of Irish women who have been pregnant describe having at least one crisis pregnancy (Evidence level 4). Younger people are more likely to experience crisis pregnancies and much international work has focussed on preventing crisis pregnancy in adolescents. Irish research shows that older adults, married people and those in the lower social classes were less likely to use contraception consistently than younger adults, single people and those in higher social classes (Evidence level 4).

Educational and contraceptive interventions in combination appear to reduce unintended pregnancy among adolescents (Evidence level 1). The HSE Crisis Pregnancy Programme supports a range of educational programmes, awareness raising initiatives, research and counselling and medical services that focus on prevention as well as providing services and supports during or after a crisis pregnancy. The vast majority of GPs provide contraception, emergency contraception, crisis pregnancy counselling and post-abortion care (Evidence level 4).

Factors that contribute to failure to use contraception among young people include concerns about confidentiality, fear of disapproval and lack of access (location and times) (Evidence level 3). GPs could consider taking a pro-active approach and initiating a discussion on contraceptive needs when patients attend for other reasons (Grade C recommendation).

2.2 Emergency Contraception

Discussing the necessity to take emergency contraception if normal contraceptive methods fail should be part of a standard contraception consultation (Grade C recommendation).

Women requesting EC should be informed about all the different methods (Grade C recommendation). These include both emergency contraceptive pills and a copper intrauterine device. Medical emergency contraception in the form of Levonorgestrel 1.5mg can be obtained from GPs or family planning clinics or directly from pharmacies. There is some uncertainty as to whether its efficacy decreases in the second and third days within the 72 hour time limit (Evidence Level 2). A newer medical emergency contraceptive pill, Ulipristal acetate (ellaOne) (launched in May 2012) has been demonstrated to be effective up to 120 hours after unprotected sexual intercourse and is the only oral EC licensed in Ireland for use between 72 and 120 hours. The most effective method of emergency contraception is insertion of a copper-containing intrauterine contraceptive device which can be inserted up to 120 hours after the first episode of unprotected sexual intercourse or within 5 days of the earliest expected date of ovulation (Evidence level 2). GPs should know where this can be accessed locally and consider referral for emergency IUCD insertion depending on the woman’s choice (Grade C recommendation). When women attend for EC, the risk of sexually transmitted infections should be discussed and tests offered if necessary (Grade C recommendation).

2.3 Long-Acting Reversible Contraception

Long-acting reversible contraceptive (LARC) methods are more effective than oral contraceptives or condoms in preventing unwanted pregnancies as they require much less – or are independent of the need for - adherence on the woman’s part (Evidence level 3). Doctors who wish to provide LARC for their patients should be trained in their use (Grade C recommendation). Accredited training is provided by the ICGP Women’s Health Programme (www.icgp.ie/womenshealth).
Section 3 Supporting a Woman or Couple in Making a Decision

3.1 Legal and Ethical Obligations

There is a legal obligation on those providing pregnancy counselling in Ireland to discuss all options in a non-directive manner where a woman wants information on abortion.18 The Medical Council’s guideline (2009)19 reflects the legal position on abortion and further advises of the duty to provide care, support and follow-up services for women who have had an abortion abroad (Section 21). A doctor has an ethical obligation not to allow his/her personal moral standards to influence treatment of patients. Where the doctor has a conscientious objection to a course of action (s)he must explain this to the patient and make the names of other doctors available to them19 (Section 10). The legal and ethical obligations relating to crisis pregnancy counselling and the background are described in Appendix A.

3.2 Counselling in Crisis Pregnancy

There is evidence that women who are certain of their decision should not be subjected to compulsory counselling20 (Grade C recommendation). The decision as to whether a woman requires referral for specialist counselling can be assessed on an individual basis and takes into account a number of factors.

- The level of support required by the woman in the decision-making process
- The woman’s request for counselling and/or information
- The GP’s level of comfort or expertise21 (Evidence level 5).

Women who require additional support may include young women, women with mental health problems, women with poor social support and where there is evidence of coercion20 (Evidence level 3). Free counselling for women with crisis pregnancies is available around Ireland (funded by HSE Crisis Pregnancy Programme). Locations and descriptions can be found on www.positiveoptions.ie. All service providers listed here are recognised, funded and supported by the HSE Crisis Pregnancy Programme. The listed service providers fall into two categories, those who will provide information on all options and those who provide counselling on all options but will not provide contact details for abortion clinics (Cura and Life). The services listed have counsellors/social workers or specifically trained volunteers who take a non-judgemental approach and do not seek to influence a woman in making her decision. If a GP chooses to refer a woman for counselling, it should be to a State funded service provider recognised by the HSE Crisis Pregnancy Programme4 (Grade C recommendation).

Where a GP undertakes counselling, the three main goals of the counselling process are

- To establish rapport and gain the trust of the women in crisis
- To help her to formulate a clear definition of the problem
- To enable her to establish goals for the management and resolution of the crisis19 (Evidence level 5).

Effective communication in crisis situation demands time, considerable patience and careful thought. Removing the sense of urgency and reassuring the woman that there is time before decisions need to be made are key roles of the GP. Support for a woman, or the couple if appropriate, in their decision making will usually require:

- Space in which to make a reasoned decision
- Information about the alternatives available
- The opportunity to explore the implications of each option
- The opportunity to assess her own feelings, wishes and circumstances
- Information about further supports.

The GP should aim to

- Enable a woman to reach an informed decision
- Minimise the risk of emotional disturbance, whatever decision is reached
- Lessen the risk of a further unwanted pregnancy.

When counselling a woman with a crisis pregnancy it is important to consider and identify issues which make women particularly vulnerable (such as child protection needs and domestic abuse / gender-based violence) and refer / signpost them on to appropriate support services in a timely manner20 (Grade C recommendation).

3.3 Fetal Anomalies

Women who are diagnosed with fetal anomalies may have special counselling needs. It can be more complex emotionally as this may have been a wanted pregnancy that becomes a crisis. In addition, the later gestational age at diagnosis makes an abortion more medically complex if that is the option the woman chooses.

Discussion with the parents may include consideration of post-mortem examination to assist in the diagnosis of the fetal anomaly. Abortion at later gestations may require management at NHS hospitals rather than abortion clinics. GPs may consider consulting one of the recognised pregnancy counselling agencies or recommending that the woman attend there for further information. GPs may also consider consulting with the local Obstetric services.

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Section 4 Options in Crisis Pregnancy: Continuing the Pregnancy

The majority of Irish women who experience a crisis pregnancy will choose to continue the pregnancy (62%) with the vast majority choosing to raise their babies themselves, either in single or shared parenthood (Evidence level 4).

4.1 Parenting
A systematic review has found that an unwanted pregnancy may lead to an increased risk of mental health problems, irrespective of the outcome of that pregnancy (Evidence level 1). Accordingly, a woman who has had a crisis pregnancy may need additional support during the pregnancy and afterwards. Women who decide to continue with the pregnancy should be referred for ante-natal care in the usual way (Grade C recommendation). Supportive combined ante-natal care will provide ongoing opportunities for advice and follow up. Social workers at the maternity hospital and Community Welfare Officers can provide information about a woman’s entitlements and assistance with applications for financial benefits.

4.2 Adoption
Adoption is rarely chosen by women with crisis pregnancies. There were a total of 67 non-family, domestic adoptions in 2008 and three of these children were under the age of 1 at the date of the adoption order.

Under the Adoption Act 2010, adoption in Ireland can only be organised through adoption agencies that are accredited with the Adoption Authority of Ireland. Women who wish to consider adoption should be referred to adoption agencies accredited by the Adoption Authority of Ireland. The HSE Adoption Services and other accredited agencies are listed under Important Links at www.aai.gov.ie.

Under the terms of the current legislation, the entire process of an adoption cannot be managed by one adoption agency. More than one accredited agency must be involved to avoid obvious conflicts of interest. Prospective adoptive parents undergo a detailed assessment of suitability. Another agency will support the birth mother considering adoption.

Children born to married parents are not eligible for adoption under current Irish legislation. This decision was reversed in a constitutional amendment in November 2012 and legislative change to implement this is awaited. Where the child is born to an unmarried woman, and the father has no guardianship rights, only the mother’s consent is needed. Under the adoption legislation, however, the consent of the birth fathers is sought, where possible.

Children are usually placed with the prospective adoptive parents before they are 9 months old. Adoption orders are usually made between 6 to 14 months after the baby is placed with the new family. Usually a social worker arranges for the baby to be cared for in a temporary foster home (frequently with the prospective adoptive parents). This requires initial consent from the birth mother. She will then be asked to sign a final consent form subsequently and the Adoption Authority of Ireland will issue an adoption order.

The birth mother can change her mind at any stage up to the issuing of the adoption order. The prospective adoptive parents can apply to the Courts if the birth mother withdraws her consent having signed the initial consent, and the Courts will take a decision in the best interest of the child.

Adoptions may be closed (where there is no ongoing contact), semi-open (where letters and photographs are exchanged through the adoption agency) or open (where birth mother/parents and adoptive parents meet face-to-face). Such contact arrangements depend on consent of all parties and are not enforceable under current legislation.

Women considering adoption should be encouraged to make contact with the social worker at the maternity hospital she attends for ante-natal care. A useful patient information leaflet for those considering adoption can be found at www.treoir.ie.

4.3 Specialist Counselling
Where the GP feels that the woman who decides to parent or consider adoption needs specialist counselling, a number of centres around the country provide free crisis pregnancy counselling (funded by the HSE, Crisis Pregnancy Programme). These can be found at www.positiveoptions.ie. Some of these services, such as One Family, also provide ongoing support for single-parent families including counselling and access to education/information supports and services. Treoir, the national federation of services for unmarried parents and their children, also provides information about parenting. Details of support services for parents or those considering adoption and a useful information pack on single parenting can be found at www.treoir.ie.
Section 5 Options in Crisis Pregnancy: Terminating the Pregnancy

For women who decide on abortion the GP

- Should confirm pregnancy
- Consider need for dating ultrasound if dates uncertain
- May give them information on abortion and abortion clinics8
- May not make an appointment or any other arrangement on behalf of the woman.8
- May give them a copy of their medical records8
- Encourage woman to return after abortion, if any concerns
- Encourage woman to consider effective contraception after abortion and ensure that she knows where to access contraception services
- Should refer to another GP if (s)he has an objection to providing information about abortion19
- Consider referring for specialist counselling in some circumstances (www.positiveoptions.ie).

The legal and ethical considerations relating to abortion in Ireland and the UK are described at Appendix A.

5.1 Information on Abortion and Abortion Clinics

If a woman chooses to have an abortion, it is important that she be given reliable information about abortion clinics that have a good reputation to ensure that she does so safely, receives proper medical care and appropriate follow-up20 (Grade C recommendation).

Where the GP feels that the woman needs specialist counselling, a number of centres around the country provide free crisis pregnancy counselling (funded by the HSE Crisis Pregnancy Programme). These can be found at www.positiveoptions.ie. All agencies listed will provide counselling on all options but two agencies (Cura and Life) will not provide information about abortion service providers.

The two major organisations providing private abortion services in the UK also have websites tailored to Irish women with crisis pregnancies. These are the British Pregnancy Advisory Services www.bpas.ie and the Marie Stopes Clinics www.reproductivechoices.ie. These websites also contain practical information on travel arrangements and timing of travel etc.

In Northern Ireland, medical abortion became available at the Marie Stopes Clinic in Belfast www.mariestopes.org.uk/Our_centres/Belfast.aspx from October 2012. The Clinic offers this service in limited circumstances – up to 9 weeks gestation, and only to preserve the life of the mother or if continuing the pregnancy would have other serious permanent physical or mental health effects. The Attorney General for Northern Ireland has invited the Stormont Justice Committee to investigate the operations of the Belfast clinic (October 2012).

What happens at an abortion clinic in the UK?

1. Counselling
   A woman attending an abortion clinic will be advised about the options available to her and counselled about the options for her pregnancy.

2. Assessment by two doctors for grounds
   Two doctors will assess the woman to check that she meets one of the legal grounds for abortion under the Abortion Act 1967 (Appendix A).

3. Gestation of pregnancy
   The gestation of the pregnancy will be established, usually by ultrasound. This is particularly important where a woman is uncertain of her dates or where there are clinical reasons to suspect “wrong dates”. It may also be employed to identify abnormalities such as ectopic pregnancy. However, routine pre-abortion scanning is not necessary as there is no direct evidence that routine ultrasound improves either the safety or efficacy of abortion procedures20 (Evidence level 2).

4. Choice of abortion procedure
   The decision on the choice of abortion procedure is influenced by the woman’s preference, gestation of pregnancy, woman’s health status and clinic policy. Counselling and abortion are generally offered on the same day to an Irish woman in the UK where possible and this may influence the likelihood of her being offered a medical abortion.

5. Information
   Information on the procedure, potential complications (section 5.2.3) and possible side effects (section 5.3.1) is provided.

6. Anti-D if Rhesus negative
   Rhesus status will be routinely ascertained and anti-D given if the woman is Rhesus negative.

7. VTE risk assessment
   Routine VTE risk assessment is required by all providers of NHS acute services since June 201024 (Evidence level 2).

8. Advice regarding cervical cytology screening
   Women who have not had cervical cytology screening within the recommended interval are likely to be offered screening. Irish women are more likely to be advised to attend for screening in Ireland 6 weeks after the abortion.

9. Infection screening / Antibiotic prophylaxis
   Screening for Chlamydia trachomatis (and other STIs) may be routinely offered in some clinics or offered at an additional cost in others. Antibiotic prophylaxis is generally given in the clinics. Women are usually given azithromycin 1g orally on the day of abortion or doxycycline 100mg orally twice daily for 7 days starting on the day of the abortion plus metronidazole 1g rectally or 800mg orally prior to or at the time of abortion20 (Evidence level 3).

10. Ongoing contraception
    Advice and information regarding ongoing contraception is generally given. In some circumstances, contraception may be started on the day of the abortion. Irish women will generally be encouraged to attend their GP or family planning clinic on their return home.
11. Self-care leaflet and emergency contact number
Clinics provide self-care leaflets with emergency contact telephone contact numbers. These are also provided on their websites.

5.2 Information on Abortion Techniques
Medical or surgical abortions can be carried out at any gestation up to the 24 week gestation legal limit in the UK. Medical abortion has become more widely used in recent years. Overall, 43% of abortions in the UK in 2010 were medical abortions and the remainder were surgical (mostly vacuum aspiration, and the remainder by dilatation and evacuation).\(^5\)

A woman who travels to the UK or mainland Europe for an abortion incurs significant financial costs, including travel, accommodation and time off work. GPs who are asked specifically about the cost may direct these women to make this enquiry directly from the agencies providing abortion services.

5.2.1 Surgical abortion
Vacuum aspiration is the preferred method of surgical abortion, rather than sharp curettage up to 14 weeks gestation\(^5\) (Evidence level 1). It may be undertaken under local anaesthetic with analgesia, under conscious sedation or under general anaesthetic. A higher failure rate is reported at gestations less than 7 weeks\(^26\) (Evidence level 3).

Dilatation and evacuation (D & E) is the preferred method of surgical abortion after 14 weeks gestation\(^3\) (Evidence level 1). This is undertaken under general anaesthetic. In some instance, it may require an overnight stay. Cervical priming is usually given as it reduces the risk of uterine perforation and cervical trauma\(^3\) (Evidence level 2). Gelmaprost 1mg vaginally 3 hours prior to surgery or mifepristone 200mg orally 36–48 hours prior to surgery may be used. Most clinics will have exclusion criteria for general anaesthesia and women with significant medical conditions (examples: obesity, diabetes and hypertension) should be encouraged to discuss this with the clinic before booking the procedure.

5.2.2 Medical abortion
In medical abortions in the first trimester, combined regimens are more effective than single agents and vaginal misoprostol is more effective than oral administration\(^9\) (Evidence level 1). Medical abortion regimens using 200mg mifepristone and misoprostol are effective at any gestation\(^10\) (Evidence level 2). Mifepristone (the “abortion pill”) is a progesterone receptor agonist. It is given orally and stops the growth of the pregnancy. Side effects such as light bleeding, nausea or vomiting may follow. It is followed by a prostaglandin analogue, either misoprostol or gemeprost, which causes the uterus to contract and expel the pregnancy.

Early medical abortion (up to 9 weeks gestation): Mifepristone, 200mg orally, is followed 6 hours – 3 days later by a prostaglandin analogue, usually misoprostol given vaginally. Most abortions will occur within 4–6 hours of the prostaglandin analogue. For women from Ireland, this may mean that this will occur at their accommodation or on their travel back to Ireland.

The 2011 RCOG Guidelines recommend that the interval between the two drugs should be 24–48 hours as the most effective option. A number of the UK abortion clinics have already adopted this approach. In these cases, it will not be possible for a woman to have a medical abortion over the course of a single day. Clinics advise that confirmation of the success of the medical abortion be confirmed by a negative pregnancy test three weeks later\(^13\) (Evidence level 5).

Late medical abortion (from 9+1 weeks to 23+5 weeks gestation): Mifepristone and prostaglandin analogue are given 24–48 hours apart. An overnight stay may be required at the second visit as repeat doses of the prostaglandin analogue may be required at 3 hour intervals until the abortion occurs. The time sequence for late medical abortion makes it less likely to be offered or chosen by Irish women who travel to the UK.

5.2.3 Complications of abortion
Abortion is a safe procedure provided it is carried out in an accredited setting\(^20\) (Evidence level 2). Women may experience a range of physical symptoms after medical or surgical abortion that is considered to be within the normal range. These are described in Section 5.3.1 (Table: Common Side Effects).

<table>
<thead>
<tr>
<th>SIGNIFICANT COMPLICATION</th>
<th>RISK</th>
</tr>
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<tbody>
<tr>
<td>Severe bleeding requiring transfusion</td>
<td>Less than 1 in 1,000 in early abortions, rising to 4 in 1000 at gestations beyond 20 weeks.</td>
</tr>
<tr>
<td>Uterine rupture (surgical abortion only)</td>
<td>Less than 1–4 in 1,000. Lower for early abortions and those performed by experienced clinicians. More likely in second trimester abortions in women who have previously had a caesarean section.</td>
</tr>
<tr>
<td>Cervical trauma (surgical abortion only)</td>
<td>Risk of damage to external os is no greater than 1 in 100 and is lower for early abortions and those performed by experience clinicians.</td>
</tr>
<tr>
<td>Failed abortion</td>
<td>Less than 1 in 100 (applies to both surgical and medical abortions). 2.3/1,000 for surgical abortion at 6–12 weeks gestation. 0.9% for medical abortion and 0.55 for surgical abortion in first trimester in comparative review.</td>
</tr>
<tr>
<td>Post-abortion infection</td>
<td>Infection of varying degrees of severity may occur after medical or surgical abortion and is usually caused by pre-existing infection. Prophylactic antibiotic use and bacterial screening for lower genital tract infection reduces this risk. 0.92–2.54% in different systematic reviews and UK studies.</td>
</tr>
</tbody>
</table>
Major complications and mortality are rare at all gestations (1–2 per 1,000 abortions). The earlier in pregnancy an abortion is performed the safer it is (Evidence level 3). The mortality rate is extremely low (maternal mortality rate 0.32 / 100,000 maternities in the UK from 2006 to 2008). There are no significant differences in complications between medical and surgical abortions in the first trimester (Evidence level 1) while current evidence reports fewer complications from surgical abortion (D & E) than with combined medical regimens in second trimester abortion (Evidence level 1).

5.2.4 Long-term Consequences

There is no association between abortion and:
- Breast cancer risk (Level 1 evidence)
- Subsequent ectopic pregnancy, placenta praevia or infertility (Level 2 evidence).

There is a small increase in the risk of subsequent preterm birth, which increases with the number of abortions (Grade 2) but the evidence is not sufficiently robust to support causation.

With regard to psychological sequelae, a systematic review by the National Collaborating Centre for Mental Health and the Academy of Medical Royal Colleges published in December 2011 made the following findings on the best evidence available “taking into account the broad range of studies and their limitations”:

**Findings on Abortion and Mental Health**

1. The rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth
2. An unwanted pregnancy was associated with an increased risk of mental health problems
3. The most reliable predictor of post-abortion mental health problems was having a history of mental health problems before the abortion
4. The factors associated with increased rates of mental health problems for women in the general population following birth and following abortion were similar
5. There were some additional factors associated with an increased risk of mental health problems specifically related to abortion, such as pressure from a partner to have an abortion and negative attitudes towards abortions in general and towards a woman’s personal experience of the abortion

5.3 Care of a Woman after Abortion

Very few women living in the UK, return to abortion clinics for routine checkups and the most recent RCOG guideline recommends that there is no medical need for routine follow-up after surgical or medical abortion, provided that the abortion has been confirmed to be complete at the time of the procedure (Grade B recommendation). It goes on to suggest that women should be able to choose to return for routine follow-up if they wish to do so (good practice point) and that all women should be advised where to seek help if they have any concerns or if they need further contraceptive advice or provision (good practice point). Only 15% of those women who attended a Dublin specialist clinic in 2011 returned to that clinic for medical check up after an abortion, despite this service being offered free of charge.

Irish women may have unmet health needs, in terms of physical, psychological or social ill-effects, because they have to travel overseas to access abortion (Evidence level 5). These circumstances are not specifically addressed in existing international guidelines. GPs may wish to encourage women to with a crisis pregnancy to return for follow up care after an abortion, taking these particular complexities into account (Grade C recommendation). At this visit a woman may require:
- A medical check-up
- Contraceptive advice or provision
- Counselling and support.

A woman may present relatively soon after the procedure:
- with questions or seeking reassurance regarding comparatively minor or common side effects
- with a physical problem that warrants urgent attention
- with a non-physical issue such as sleeping problems or emotional concerns
- with a request for a certificate for time off work.

She may present some time after the procedure with emotional symptoms which may be treatable in the general practice setting or may require referral for specialist counselling.

GPs should consider the possibility that a woman who presents with abnormal vaginal bleeding, crampy abdominal pain or related symptoms may have had an abortion in the UK or have undertaken an illegal medical abortion at home. She may be reluctant to disclose for fear of judgement or prosecution.
5.3.1 Common Side Effects

<table>
<thead>
<tr>
<th>COMMON SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bleeding</strong></td>
<td>Similar to period for 2–3 weeks, including small clots, with intermittent spotting until next period (Evidence level 2)</td>
</tr>
<tr>
<td><strong>Abdominal pain / Cramps</strong></td>
<td>Similar to menstrual cramps</td>
</tr>
<tr>
<td><strong>Vaginal discharge</strong></td>
<td>Odourless, brownish discharge for 2–3 weeks</td>
</tr>
<tr>
<td><strong>Continuing symptoms of pregnancy</strong></td>
<td>May persist for up to one week. Pregnancy test may remain positive for up to 2 weeks</td>
</tr>
<tr>
<td><strong>Emotional responses</strong></td>
<td>Short-term distress common. Woman may experience relief, sadness, anger, guilt or regret (Evidence level 3)</td>
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</tbody>
</table>

Women who have a medical abortion under 14 weeks gestation report significantly more pain and gastrointestinal symptoms during the procedure and more bleeding over the following 2 weeks compared with women who have a surgical abortion (Evidence level 3). The duration of bleeding is also longer after medical than surgical abortion and longer for abortion at 10–13 weeks gestation compared with abortion at earlier gestations (Evidence level 3).

A vaginal examination is not routinely required and should only be undertaken if specific symptoms require it, such as heavy vaginal bleeding, pelvic pain or fever.

Consider the need for a Pregnancy Test (Evidence level 5). It is not routinely necessary. It should be considered where symptoms of pregnancy persist. Where a woman has had an early medical abortion (gestation less than 9 weeks) she may have been provided with a pregnancy test and advised to return if it is positive after three weeks.

Women who have undertaken an illegal medical abortion at home may be more likely to present with complications. As they may not have had a medical assessment in advance, there is a greater likelihood that their dates may be incorrect. The possibility of an ectopic pregnancy has not been ruled out. It may be unclear what medications or what doses they have taken.

Where a moderate infection is suspected, a GP may consider management without referral. It is advisable to investigate by taking appropriate swabs.

**Recommended empiric antibiotic regimen for treating post-abortion infection** (Evidence level 2)

- Ofloxacin 400mg orally twice daily for 14 days
- OR ceftriaxone 500mg intramuscularly single dose followed by doxycycline 100mg orally twice daily for 14 days
- PLUS Metronidazole 400mg orally twice daily for 14 days

5.3.3 Contraception

All women should be given advice about contraception when they attend a UK abortion clinic, in compliance with RCOG guidelines (Grade C recommendation). If a woman attends for a post abortion medical check up it provides an opportunity to advise and prescribe an appropriate contraceptive method if she has not already started one. More than 90% of women will ovulate within 4 weeks of a first trimester abortion (Evidence level 4) and therefore will require effective contraception as soon as possible after the abortion if she does not wish to get pregnant. Women should be advised of the greater effectiveness of long-acting reversible methods of contraception (Grade B recommendation). All methods can be started on the day of surgical or second part of medical abortion and offer immediate protection (Grade B recommendation). Waiting until her next menses to commence contraception carries a higher risk of another crisis pregnancy (Grade C recommendation).

Condom use should be encouraged, irrespective of the contraceptive method chosen, to reduce the risk of STIs (UK national guidelines on Safer Sex Grade C recommendation). They may also serve as bridging contraception where it is decided to start contraception at the next menses.
### Starting Contraception after Abortion

(The WHO Medical Eligibility Criteria (WHOMEC) adapted for the UK by the Faculty of Sexual and Reproductive Healthcare, 2009 and Quick Start Guideline 2010 Grade C recommendation)

<table>
<thead>
<tr>
<th>Contraceptive Type</th>
<th>Alternative Start Times</th>
<th>Additional Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrauterine device / Intrauterine system</td>
<td>Within 48 hours</td>
<td>Not needed</td>
</tr>
<tr>
<td></td>
<td>Or Delay for 4 weeks and if reasonably certain that she is not pregnant</td>
<td>For 7 days (IUS)</td>
</tr>
<tr>
<td></td>
<td>Days 1–5 of next menses</td>
<td>Not needed</td>
</tr>
<tr>
<td>Progestogen injection or implant</td>
<td>Up to and including day 5 after abortion</td>
<td>Not needed</td>
</tr>
<tr>
<td></td>
<td>Any time after abortion if reasonably certain that she is not pregnant</td>
<td>For 7 days</td>
</tr>
<tr>
<td></td>
<td>Days 1–5 of next menses</td>
<td>Not needed</td>
</tr>
<tr>
<td>Combined oral contraceptives</td>
<td>Up to and including day 5 after abortion</td>
<td>Not needed</td>
</tr>
<tr>
<td></td>
<td>Any time after abortion if reasonably certain she is not pregnant</td>
<td>For 7 days</td>
</tr>
<tr>
<td></td>
<td>Days 1–5 of next menses</td>
<td>Not needed</td>
</tr>
<tr>
<td>Progestogen only pill</td>
<td>Up to and including day 5 after abortion</td>
<td>Not needed</td>
</tr>
<tr>
<td></td>
<td>Any time after abortion if reasonably certain she is not pregnant</td>
<td>For 48 hours</td>
</tr>
<tr>
<td></td>
<td>Days 1–5 of next menses</td>
<td>Not needed</td>
</tr>
</tbody>
</table>

#### 5.3.4 Sexually Transmitted Infections

Some women may have had testing for Chlamydia +/- other STIs at the abortion clinic. It is likely that she will have been given prophylactic antibiotics in any event. Where testing was carried out she may be contacted if the results were positive. In this case, check if she was prescribed antibiotics and if she completed the course, and that the infections detected were sensitive to the antibiotics prescribed. Consider the need for contact tracing of sexual partners (Grade C recommendation).

#### 5.3.5 Emotional and Psychological Issues

Crisis pregnancy may cause emotional and psychological sequelae, irrespective of whether the woman chooses to continue or terminate the pregnancy (2011 Evidence Level 1). Women with a past history of mental health problems are more likely to develop such problems (Evidence level 1). However, there is considerable evidence that the vast majority of adult women who have an abortion do not experience mental health problems (Evidence level 1). Approximately 25% of those women who attended one Dublin specialist centre for crisis pregnancy counselling in 2011 returned to that clinic for free counselling after abortion. Many of these women were dealing with other issues not directly linked to the abortion itself.

Where the GP feels that the woman needs specialist counselling, a number of centres around the country provide free post abortion counselling (funded by the HSE Crisis Pregnancy Programme). These can be found at [www.abortionaftercare.ie](http://www.abortionaftercare.ie). Women are eligible for this counselling even if they have not previously attended for crisis pregnancy counselling. Women who have undertaken an illegal medical abortion at home are also eligible for this counselling.
References


Appendix A: Legal and Ethical Considerations Relating to Crisis Pregnancy

Consent Considerations

The age of consent to sexual activity and medical treatment differ in Ireland.

Under current legislation children under the age of 15 may not consent to any sexual activity while those between the age of 15 and 17 may consent to sexual activity but not to sexual intercourse. In addition females below the age of 17 cannot be charged with statutory rape, but males under the age of 17 can. According to the Irish Health Behaviour in School-Aged Children (HBSC) Study 2010, 27% of 15–17 year olds report having had sex, of which 59% reported having used the birth control pill as a form of contraceptive.

Minors aged 16–18 can consent to medical treatment in Ireland (Non Fatal Offenses Against the Person Act 1997). For those under 16, the legal basis of determining consent is more difficult. An under 16 year old may be considered mature enough on occasion to consult with a doctor alone, though Irish law does not currently support this. Although they have no legal footing in Ireland, the Fraser Guidelines (derived from the Gillick case in England) nevertheless provide a useful template for decision making when considering treatment to under 16s without parental knowledge or permission: this is usually only referenced to offering contraceptive services. Considering the psychological difficulties of dealing with a crisis pregnancy, the necessity for close support networks and the issues surrounding travel and finance, if abortion is a likely option it is highly desirable that any minor would consult with their parent/guardian regarding a decision about termination of pregnancy. Advice from medical indemnity organisations may be helpful in individual cases.

With regard to patients who do not have the capacity to consent, the Medical Council Guidelines (2009) state:

“Where an adult patient is deemed to lack capacity to make a healthcare decision, you should take reasonable steps to find out whether any other person has legal authority to make decisions on the patient’s behalf. If so, you should seek that person’s consent to the proposed treatment.” (Section 34.5) 

Irish Legal Position regarding Crisis Pregnancy

Contraception, crisis pregnancy and the question of abortion have been the subject of considerable focus in Ireland over the past thirty or more years. Abortion in Ireland is illegal under the Offences against the Person Act, 1861. Its provisions were confirmed in the Health (Family Planning) Act 1979. Article 40.3.3 was inserted into the Irish Constitution following a referendum in 1983. This acknowledges “the right to life of the unborn” with “due regard to the equal right to life of the mother”.

In 1992, in the case of a pregnant 14 year old rape victim (the X case), the Supreme Court interpreted Article 40.3.3 to mean that termination of pregnancy is permissible where there is a “real and substantial risk to the life, as distinct to the health, of the mother”. The Court included the risk of suicide as a ground for allowing termination of pregnancy in its judgement. It also found that only women whose lives were endangered as a result of pregnancy could legally travel abroad to secure an abortion and encouraged the Government to introduce legislation on this issue.

Later that year, the Constitution was further amended to guarantee a pregnant woman’s right to information about abortion and her right to travel to access lawful abortion abroad. A third proposal, to exclude suicide risk as a threat to the life of the mother, was rejected by the people by referendum. Subsequently, the Regulation of Information (Services outside the State for Termination of Pregnancies) Act, 1995 was passed to regulate the dissemination of information on abortion.

- Information on abortion can only be given by a doctor or counselling agency if solicited.
- It must be provided as part of non-directive counselling, where all options are discussed and where there is no advocacy of abortion.
- Abortion referral is specifically prohibited under the Act. Doctors may not make an appointment at an abortion clinic but can provide women with a copy of her medical notes.

The risk of suicide as a real and substantial risk to the right to life of the mother was confirmed in 1997 in the C case, involving a pregnant 13 year old rape victim. A government Green Paper (1997) and the Fifth Progress Report on Abortion (2000) explored possible approaches to abortion but failed to reach consensus on the content of legislation. The Crisis Pregnancy Agency was established in 2001 to address the identified need for measures to reduce the number of crisis pregnancies in Ireland and to support services for women during and after crisis pregnancy. A further attempt to introduce legislation, linked to Constitution so that it could only be amended by subsequent referendum, was defeated at a referendum in 2002.

The European Court of Justice in the A, B and C cases (2011) found that the Irish state is in contravention of the European Convention for Human Rights in that it has failed to implement Article 40.3.3 of the Constitution as it has not provided a procedure by which one of the women could have established whether she qualified for a lawful abortion in Ireland on grounds of the risk to her life of her pregnancy. The Court has obliged the Irish state to put in place a legal framework to allow pregnant women to test their entitlements in such circumstances. An expert group reported to the Minister on legislative options in November 2012 and the Government has agreed to consider the findings in framing legislation in this area.

Ethical Considerations regarding Abortion

The Medical Council’s guideline (2009) reflects the legal position on abortion and further advises of the duty to provide care, support and follow-up services for women who have had an abortion abroad (Section 21). It further states that you must not allow your personal moral standards to influence your treatment of patients and obliges doctors with a conscientious objection to a course of action to explain this to the patient and make the names of other doctors available to them (Section 10).
UK Legal Position on Abortion
Induced abortions carried out in England, Scotland and Wales are governed by the Abortion Act 1967. Two registered medical practitioners are required to assess the woman’s legal right to an abortion. There are a number of grounds for abortion, with the vast majority (97%) being undertaken under ground C, namely:

- The pregnancy has not exceeded its 24th week and the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.

The Abortion Act does not apply in Northern Ireland. It is lawful to perform an abortion in Northern Ireland only where:
- It is necessary to preserve the life of the woman, or
- There is a risk of real and serious adverse effect on the woman’s physical or mental health, which is either long-term or permanent.

On-line Prescription of Medical Abortion Pills
Under the Medicinal Products (Prescription and Control of Supply) Regulations 2003-2011 it is illegal to supply a prescription only medicine by mail order (this includes via the internet). The Irish Customs Authorities have made a number of seizures of abortifacients. The 2011 figures represent the detention of 28 attempted supplies, addressed to 20 females and 8 males.

<table>
<thead>
<tr>
<th></th>
<th>MISOPROSTOL TABS</th>
<th>MIFEPRISTONE TABS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>1,118</td>
<td>98</td>
<td>1,216</td>
</tr>
<tr>
<td>2010</td>
<td>666</td>
<td>149</td>
<td>815</td>
</tr>
<tr>
<td>2011</td>
<td>620</td>
<td>15</td>
<td>635</td>
</tr>
</tbody>
</table>

10% of GPs have dealt specifically with women who have taken an illegal abortifacient in the country (Murphy et al, 2012).

Adoption Legislation in Ireland
Both domestic adoption and inter-country adoptions are regulated by the Adoption Act, 2010. Adoption in Ireland can only be arranged through agencies accredited by the Adoption Authority of Ireland. The HSE Adoption Services and other accredited agencies are listed under Important Links at www.aoi.gov.ie.
Appendix B: Directory of Services

www.crisispregnancy.ie HSE Crisis Pregnancy Programme provides information on services, research and publications and training opportunities

www.positiveoptions.ie Information on state-funded crisis pregnancy counselling services

www.abortionaftercare.ie Information on state-funded post-abortion medical care and counselling services

www.icgp.ie/womenshealth Information on training, research and publications for GPs and practice nurses

www.aai.gov.ie The Adoption Authority of Ireland website. Accredited adoption agencies are listed under “Important Links”

www.treoir.ie Treoir is the national federation of services for unmarried parents and their children. Information pack for unmarried parents in the “Publications” section. Information leaflet for those considering adoption

www.healthpromotion.ie You can download a range of leaflets on sexual health from the “Publications” sections. You can also register on the site to order hard copies of these leaflets sent to your surgery

www.bpas.ie The Irish website of the British Pregnancy Advisory Service. Has link to their UK website

www.reproductivechoices.ie The Irish website of Marie Stopes International. Has link to their UK website

www.fsrh.org The Faculty of Sexual and Reproductive Healthcare is a faculty of the RCOG and provides clinical guidances on a range of contraception topics

www.bashh.org The British Association for Sexual Health and HIV provides guidelines on a range of sexual health topics including management of STIs and safer sex