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Background

Over the last decade the total number of abortions undertaken in England and Wales has remained fairly constant at about 200,000 per year [1]. The abortion rate for residents is 16 per 1000 women aged 15-44 [1], and an estimated 1 in 3 women in Britain will have an abortion in their reproductive lifetimes [2]. In 2015, there were 5,190 abortions provided to women resident outside England and Wales; 66% from the Irish Republic. Ninety-eight percent of abortions for resident women are paid for by the National Health Service. Non-residents, including those from Northern Ireland, must pay for their abortions themselves.

Women from all racial, ethnic, religious and socio-economic backgrounds have abortions. Some demographic characteristics are more strongly associated with the decision to end a pregnancy by abortion than others. Age is one of the strongest factors, likely reflecting a readiness for parenthood. For example, 63% of pregnancies in girls aged under 16 end in abortion compared to 13% of those in women aged 30-34 years [3]. Most women resident in England and Wales who have abortions are single (with or without a partner) and White, although those who identify as Asian, Black or Black British are over-represented relative to their proportions of the general population. Scottish statistics demonstrate a clear relationship between greater economic deprivation and a higher rate of abortion [4]. More than 50% of women who have an abortion have already had a child.

Just over one third of women having an abortion in Britain will have had more than one abortion. Older age and having children already are associated with having more than one abortion. Other characteristics are identifying as Black, having left school at an earlier age, living in rented accommodation, reporting an earlier age at first sexual experience, being less likely to have used a reliable method of contraception at sexual debut, reporting a greater number of sexual partners, and domestic violence [2, 5].

Over 90% of pregnancies that end in abortion were unintended [6]. The reasons women give for choosing abortion are complex. Common themes include an understanding of the responsibilities of parenthood, financial constraints, and lack of partner support [7]. A small but important proportion of abortions are ended for maternal or fetal indications but are not a focus of this paper.

Over 90% of abortions occur at less than 13 weeks' of gestation. Teenagers, economically disadvantaged women, those who did not suspect they were pregnant or who face barriers to services are more likely to undergo abortion in the second trimester [8,9].

The law and abortion

In the United Kingdom, the 1861 Offences Against the Person Act (OAPA) made having or providing an abortion a crime carrying a potential life sentence. The 1967 Abortion Act, which does not extend to Northern Ireland, did not replace the OAPA or decriminalise abortion. Rather, it defined the circumstances in which an abortion could be performed without the risk of prosecution. These include having two doctors agree that a woman meets one of five grounds (Table 1). In cases where an abortion is necessary emergently to save a woman's life or prevent grave permanent injury, only one doctor need authorise the abortion.

Table 1. Statutory grounds for legal abortion in Britain

Ground	% of abortions for residents of England and Wales (2015)*
A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated	<1%
B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman	<1%
C 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	98%
D the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing child(ren) of the family of the pregnant woman	1%
E 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.	2%

*Note: percentages are rounded and may not add up to 100

Most abortions in Britain are undertaken under grounds C or D which have an upper gestational age limit of 24 weeks. Although the risks of continuing a pregnancy to term are statistically greater than those associated with having an abortion [10], the definition of ‘health’ used by doctors in Britain tends toward the World Health Organization’s definition which is to say that health is not just the absence of disease but the presence of well-being.

There is a conscientious objection clause within the Abortion Act which permits refusal to participate in abortion treatment. This right is excepted when an abortion is necessary to save a woman’s life or prevent grave permanent injury to her physical or mental health.

In Northern Ireland it is only lawful to perform an abortion to preserve a woman’s life or if there is a risk of a ‘real and serious adverse effect on her mental or physical health, which is either longer term or permanent’ [11]. Almost all women in Northern Ireland needing abortion care therefore travel to Britain or Europe and there is evidence that many women obtain medications online to induce their own abortions outside the legal framework [12].

Assessment for abortion

The assessment of a woman requesting an abortion is focused on confirming that she is sure of her decision and providing sensitive decision-making support if needed, determining gestational age, identifying whether any methods are contraindicated, and deciding whether treatment needs to be performed in hospital or in consultation with doctors from other medical specialities. The assessment also provides an opportunity to discuss any contraceptive needs.

Complications of abortions are lower when undertaken at earlier gestations. Services therefore need to be organized to minimize delay. In most areas of Britain, there is no requirement for a woman to see her GP for a referral; a woman may contact an abortion service directly for an appointment. Several areas offer central booking services to expedite access to services.

Most women requesting abortion have unintended pregnancies and will have decided to have a termination before coming to a healthcare provider for assistance [13]. Compulsory counselling is not recommended as it delays treatment unnecessarily and may be viewed as intrusive by a woman who is certain of her decision. A non-judgmental interaction with a provider, an explanation of treatment options and risks, and prompt referral for treatment summarises the expectations of most women once the decision to have an abortion has been made. For the small proportion of women

for whom the decision is not straightforward, healthcare providers can assist with non-directive decision-making support or arrange for counselling.

The clinical history should include a review of any medical conditions, obstetric and gynaecologic history including prior ectopic pregnancy (abnormally implanted pregnancy, often in Fallopian tubes) and sexually transmitted infections, surgical history, allergies, medications, and recreational drug or alcohol use or abuse. It is important to explore any history of pain or bleeding in the current pregnancy as this may affect the decision to use ultrasound for gestational age determination and pregnancy location. There should be routine enquiry about domestic violence with appropriate support and information provided.

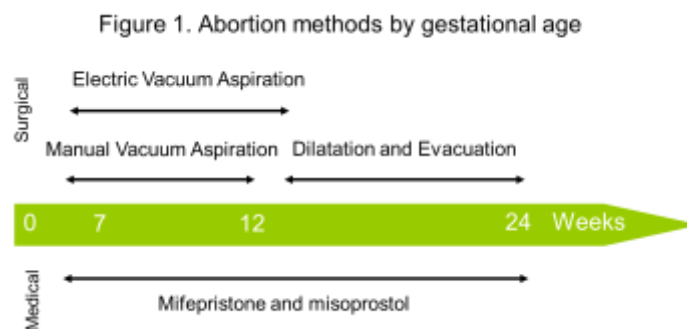
Pre-procedure testing is typically limited to determining if the woman has rhesus negative blood group meaning that she would be offered a medication known as anti-D to prevent her blood system from developing antibodies which may affect the blood cells of any future pregnancies. Testing for anaemia (low haemoglobin levels) may also be offered and testing for sexually transmitted infections is also common.

The physical examination is targeted, based on the medical history. The duration of the pregnancy is often determined by ultrasound where it is readily available. However, this should not be a barrier to service delivery as there is no evidence that the routine use of ultrasound improves the safety or effectiveness of abortion procedures [14]. The date of the last menstrual period and a pelvic examination are sufficient in most cases with ultrasound used as needed.

Most abortions can be safely carried out in day case units or freestanding clinics. Indications for treatment in hospital include conditions that require prolonged or intensive monitoring, such as severe heart and lung disease, or which place a woman at high risk of haemorrhage.

Choice of method

Choice is an integral part of abortion care. Provision of information, along with decision-making support if needed, are essential to helping a woman select an abortion method that is right for her and which will make her abortion experience as acceptable as possible. In both the first and second trimesters abortion may be performed surgically or by the administration of medications (Figure 1).



Some women prefer surgical abortion because it is predictable and quick, can be performed with a general anaesthetic or sedation, and has a low risk of complications. Others prefer medical abortion because it does not involve surgical instrumentation or anaesthesia and is perceived as more natural, like a miscarriage. In addition, medical abortions up to 9 or 10 weeks gestation may be managed by the woman at home and is often preferred over care in a clinical setting.

Information provided during the decision-making process includes which abortion methods and pain management options are available to her, the treatment pathway and what she will or may experience (such as pain and bleeding, side effects, complications), where the procedure will occur, and how long the process is likely to take. Whether follow-up will be needed and whether she will need to be discharged into the care of a responsible adult and therefore will have to arrange for an escort to the treating unit also must be addressed.

Women undergoing medical abortion in the second trimester need to be advised of the possible need for an overnight stay in the clinic. Surgical abortion in the second trimester may also occur over two days although overnight admission. Other aspects of care which may be important to address are whether a woman's partner or another support person may be present during treatment and whether she may see the fetus or need to dispose of the products of conception after the abortion herself (with medical abortion at home).

Early medical abortion

The development of simple, highly effective regimens for abortion using the drug mifepristone has transformed abortion care in the Britain. Introduced in 1991, it is now the case that 55% of abortions for women resident in England and Wales and 81% for women in Scotland are conducted medically. These proportions are not reflective of the choices made by Irish women who travel to England and Wales for abortion; 19% of abortions provided to women from Ireland in 2015 were medical.

Early medical abortion refers to the use of medications for abortion up to 9 weeks of pregnancy, although some services now offer this up to 10 weeks of gestation. Along with better funding of and access to abortion services in Britain, widespread availability of medical abortion in the earliest weeks of pregnancy has likely contributed to the growing proportion of abortions performed at less than 10 weeks gestation.

Contraindications to medical abortion are few but include chronic adrenal failure, a blood abnormality called inherited porphyria, bleeding disorders, allergy to the medicines, severe uncontrolled asthma, and known or suspected ectopic pregnancy. Caution is also advised with liver or kidney failure or malnutrition. If a woman has an intrauterine contraceptive device in place, it will need to be removed before initiating treatment. Most protocols also exclude women with anaemia as blood transfusion rates, although very low, are higher with medical than surgical procedures.

Treatment begins with the administration of a single tablet of mifepristone that is swallowed. Symptoms after mifepristone are minimal but some women will have bleeding and a small number will miscarry. One to two days later, a medication called misoprostol is administered. Misoprostol can be used in the vagina or dissolved under the tongue or between the cheek and gum. Bleeding and cramping typically start within 2 hours and most women will pass the pregnancy within 4 hours. Oral pain medications like ibuprofen and codeine are often needed. Other side effects caused by misoprostol are nausea and vomiting, diarrhoea, and transient fever and chills.

Most early medical abortions are undertaken outside of a medical facility. In many countries, women are given tablets of misoprostol to take home and use within a specified time interval, followed by abortion at home. A large body of evidence demonstrates that this is safe, effective, and acceptable to women [15]. Although the Secretary of State for Health could allocate "home" as a class of place for the purposes of early medical abortion in Britain, this has not been pursued. Therefore, women must attend for both mifepristone and misoprostol administrations. Women need not be admitted after either and the vast majority go home after misoprostol to pass the pregnancy at home.

Complete abortion without surgical intervention is achieved in upwards of 95% in most studies with an ongoing pregnancy rate of 1% or less [16].

Medical abortion in the late first and second trimesters

Medical abortion with mifepristone and misoprostol may be used throughout the late first and second trimester. The most commonly used regimen starts with swallowing a single tablet of mifepristone. One to two days later the woman is admitted to a clinical facility where misoprostol is administered every 3 hours until the pregnancy passes. About half of women will complete the abortion in 6-8 hours but it can take up to a few days. If the induction is prolonged, the regimen may need to be repeated and occasionally surgical completion is required.

Medical abortions undertaken at 22 weeks or more are preceded by a procedure to cause fetal demise, such as an injection of potassium chloride into the fetal heart or the medication digoxin into the amniotic fluid, to avoid the possibility of a live birth.

The severity of pain experienced by the woman during a medical abortion increases with gestational age. Pain tablets can be taken by mouth but intravenous medications for pain are usually also made available.

Surgical abortion in the first trimester

Vacuum aspiration is the recommended method of surgical abortion in the first trimester. Vacuum aspiration uses gentle suction to remove the pregnancy and takes about 5-10 minutes from start to finish. During the procedure, a woman is positioned on a treatment couch with her legs placed in supports. The doctor will examine the uterus for size, position and shape. After this, a speculum will be inserted into the vagina so that the doctor can see the cervix. The opening of the cervix may be stretched with graduated metal or plastic rods called dilators in order to allow passage of a flexible or rigid plastic tube called a cannula into the uterus. Sometimes misoprostol is administered 1-3 hours before surgery to soften the cervix and reduce the need to use dilators. Either a hand-held suction device or a suction machine is then attached to the cannula to remove the pregnancy.

Vacuum aspiration may be performed under local anaesthesia, conscious sedation or general anaesthesia. Local anaesthesia involves giving pain medications by mouth (such as ibuprofen) and injecting numbing medicine around or into the cervix. Pain is reduced but not eliminated entirely. Conscious sedation and general anaesthesia in abortion care are normally given as intravenous medications. Conscious sedation is associated with less pain than local anaesthesia but the woman will be awake and aware of what is happening. With general anaesthesia, the woman is unconscious; no pain is felt and she will have no recollection of the abortion procedure itself.

Recovery after a vacuum aspiration takes about 30-40 minutes after local anaesthesia or conscious sedation, and 1-2 hours following general anaesthesia. Women who have had general anaesthesia or conscious sedation should be discharged into the care of a responsible adult who can care for them overnight. The inability to afford to bring an escort or to reveal their abortion to anyone for fear of stigmatisation is a barrier to accessing these anaesthetic options for women who travel from abroad. Women do not require an escort after treatment under local anaesthesia.

Surgical abortion in the second trimester

The most frequently used method of surgical abortion in the second trimester is dilatation and evacuation (D&E). As with vacuum aspiration, D&E can be performed with local anaesthesia, general anaesthesia or sedation but the latter two predominates from about 18 weeks' gestation.

Softening and opening the cervix is an essential first step in providing D&E safely. This process may occur on the same day as the removal of the pregnancy or be undertaken more slowly, over a 24 hour period before surgery. For shorter durations of preparation (3 hours), a medicine called misoprostol is typically used. For longer durations (up to 24 hours), matchstick sized rods are inserted into the cervix which gradually swell overnight. On the day of the procedure, a woman will

be positioned on a treatment couch and the anaesthetic of choice will be given. The doctor will examine the uterus and any dilators inserted overnight are removed. If needed, the opening of the cervix may be stretched with dilators. The pregnancy is removed in multiple passes using instruments passed through the cervix. After the pregnancy and placenta are removed, suction will be used to gently complete the evacuation. A D&E takes about 10-20 minutes from start to finish and recovery times are similar to those after vacuum aspiration.

Hysterotomy (akin to a Caesarean section) and hysterectomy (removal of the uterus) are outdated methods of surgical abortion and only used when D&E or a medical abortion is not possible.

Aftercare

Although there is usually some mild discomfort and light bleeding for a week or so after an abortion, recovery is quick and most women can return to their usual activities a day or two after treatment. The normal range of emotions that women experience during and after abortion includes relief, sadness, anger, guilt and regret [17]. However, the likelihood of psychological problems after an abortion is no greater than if a woman continues an unintended pregnancy [18]. Supportive counselling is needed by a minority of women.

When a surgical or medical abortion is uncomplicated and the success of the procedure is immediately verified, routine follow-up is not necessary. Providing a 24-hour aftercare telephone line is common and ready access to follow-up visits should be available if needed. A woman should be advised to be in contact if she experiences signs of ongoing pregnancy or for other medical reasons such as prolonged heavy bleeding, fever, and persistent or severe pain.

Protocols for early medical abortion undertaken outside of a clinical setting often require the woman to return 7-14 days after treatment to confirm that she is no longer pregnant. However, increasingly urine pregnancy tests with either a follow-up phone call or a self-assessment checklist are used to determine if a woman needs to be seen in person to assess for treatment failure or another complication.

Women travelling from abroad require additional guidance on how to manage pain, bleeding and passage of the pregnancy in transit if they choose a medical abortion and plan to travel home immediately after receiving the medications. Some women will need an in-person assessment, albeit rarely urgently. Therefore a discussion needs to occur about how and where a woman will seek assistance in her home country if needed.

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